

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/25/2025
NAME OF PROVIDER OR SUPPLIER: SANATOGA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 225 EVERGREEN ROAD POTTSTOWN, PA 19464		
STATE LICENSE NUMBER: 233702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0584	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and an Abbreviated survey completed on July 25, 2025, it was determined that Sanatoga Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0584		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	The wall in 114-A and 112-A was wiped down from noted streaks Room 112 wallpaper was glued back from peeling and handle on dresser was replaced Room 232 A and B bedside tables were replaced The second floor shower room floor and right side of the shower stall were scrubbed by ESD. An initial audit will be completed by the Maintenance Director or designee to identify any other noted damaged walls, closets and baseboards that require repair by the maintenance department. The ESD, maintenance or designee will re-educated housekeeping and nursing staff to ensure we maintain a sanitary and home-like environment. The NHA or designee will complete 5 resident room audits weekly x 4, monthly x 2 to identify any other noted damaged walls, closets and baseboards that require repair by the maintenance department. Results of the audit will be reported to the	Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025

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F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	Quality Assurance Performance Improvement Committee monthly.	

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F 0584 SS=D	Continued from page 3 Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of two nursing units. (First and Second floors) Findings include: Observations on July 22, 2025, from 9:30 a.m. through at 2:30 p.m. and July 25, 2025, from 8:00 a.m. through 12:00 p.m. revealed the following: The wall between the door and dresser in room 110 was damaged. The wall beside the resident's bed was streaked with dried liquid in room 112-A. Room 112-A had scuffed and peeling wallpaper, and a broken handle on the resident's dresser. The wall beside the resident's bed was streaked with dried liquid in room 114-A.	F 0584		

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F 0584 SS=D	Continued from page 4 The wall beneath the towel rack in the bathroom in room 127 was damaged. The wall was damaged at the baseboard at the closet in room 128. Room 232 A and B bedside tables had chipped wood on the tops. The second floor bathing room shower stall on the right side of the room had a thick black substance on the floor and molding.	F 0584		
F 0677 SS=D		F 0677		

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F 0677 SS=D	Continued from page 5 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Resident 7 received assistance with her hair and fingernails. Resident 9 received assistance with nail care.. Resident 116 received nail care. An initial audit will be completed by the DON or designee on current residents requiring assistance with ADLs to review they are being provided fingernails care. The nursing staff will be re-educated by the NPE/Designee to ensure that personal hygiene services will be provided to residents that require assistance with activities of daily living with focus on fingernails, hair grooming and shaving. The DON/ Designee will complete audits of 5 residents weekly x 8, monthly x 2 to ensure that personal hygiene services are being provided with the focus on fingernails care. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025

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F 0677 SS=D	Continued from page 6 Based on observation, clinical record review, and staff and resident interviews, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for three of 22 sampled residents. (Residents 7, 9, and 116) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included polyneuropathy, cognitive communication deficit, and congestive heart failure. A review of the Minimum Data Set (MDS) assessment dated May 7, 2025, revealed that Resident 7 was alert and oriented and required moderate assistance with personal hygiene. Review of the care plan dated May 24, 2025, revealed that the resident required assistance with activities of daily living (ADLs) including grooming and bathing. On July 23, 2025, at 11:43 a.m., the resident was observed in his wheelchair. His fingernails were long and dirty. The resident stated that his fingernails needed to be cut. On July 24, 2025, at 12:04 p.m., the resident was again observed in his wheelchair.	F 0677		

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F 0677 SS=D	Continued from page 7 His fingernails remained long and dirty. Clinical record review revealed that Resident 9 had diagnoses that included polyneuropathy, shoulder pain, and muscle weakness. A review of the MDS assessment dated July 7, 2025, revealed that Resident 9 was alert and oriented and required moderate assistance with personal hygiene. Review of the care plan dated July 9, 2025, revealed that the resident required assistance with ADLs including grooming and bathing. On July 22, 2025, at 12:37 p.m., July 23, 2025, at 8:50 a.m., and on July 24, 2025, at 9:57 a.m. and 12:45 p.m., the resident was observed in his wheelchair. His fingernails were long and dirty. In an interview on July 25, 2025, at 9:57 a.m., Resident 9 stated he prefers his nails short, that staff had not offered to trim them before today, and that he had trouble cutting them himself without injury due to his numbness, pain, and weakness in his upper extremities. Clinical record review revealed that Resident 116 had diagnoses that included Parkinson's disease and	F 0677		

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F 0677 SS=D	Continued from page 8 diabetes. A review of the MDS assessment dated July 8, 2025, revealed that Resident 116 was alert with some confusion and required moderate assistance with personal hygiene. Review of the care plan dated July 2, 2025, revealed that the resident required ADLs including grooming and bathing. On July 22, 2025, at 12:57 p.m., July 23, 2025, at 12:40 p.m., and July 24, 2025, at 12:18 p.m., the resident was observed in his wheelchair. His fingernails were long and dirty. In an interview on July 24, 2025, at 12:14 p.m., the resident stated that he prefers his nails short, he wanted his fingernails cut, but he needed assistance. In interviews on July 25, 2025, at 10:00 a.m. and 10:16 a.m., the Director of Nursing confirmed that the residents' fingernails should have been trimmed when residents were bathed and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0677		

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F 0684 SS=D		F 0684		
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F 0684 SS=D	Continued from page 10 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Immediate action to correct the alleged deficient practice included notification to MD regarding missed weights on Residents 5, 8, and 9 with weights then taken and documented. The MD was notified of resident 10's BP medication being given outside parameters. An initial audit will be completed by the DON or designee of current residents receiving blood pressure medications with parameters and weight orders to ensure BP medication parameters are followed and weights are taken per MD orders. Licensed nursing staff will be re-educated by DON or Designee on FTag 684 with focus on following physician orders to ensure BP medication parameters are followed and weights are taken per MD orders. The DON/ Designee will complete audits of 5 residents for weights and 5 residents on BP medication with parameters to be reviewed that	Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025

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F 0684 SS=D	Continued from page 11	F 0684	physician order was followed weekly x 8, monthly x 2 .Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	

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F 0684 SS=D	Continued from page 12 Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for four of 22 sampled residents. (Residents 5, 8, 9, and 10) Findings include: Clinical record review revealed that Resident 5 had diagnoses that included diabetes mellitus and dysphagia (difficulty swallowing.) A physician's order dated July 11, 2025, directed staff to weigh Resident 5 two times per week, on Tuesdays and Fridays, for four weeks. Review of Resident 5's medication administration record (MAR) revealed that staff failed to weigh the resident as ordered on July 11, 18, and 22, 2025. Clinical record review revealed that Resident 8 had diagnoses that included post traumatic seizures, chronic systolic (congestive) heart failure, and diabetes mellitus. A physician's order dated January 31, 2025, directed staff to weigh the resident every Monday, Wednesday, and Friday. Review of	F 0684		

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F 0684 SS=D	<p>Continued from page 13</p> <p>Resident 8's MARs revealed that staff failed to weigh the resident as ordered five times in April 2025, once in May 2025, and once in June 2025.</p> <p>Clinical record review revealed that Resident 9 had diagnoses that included hypertensive chronic kidney disease and diabetes mellitus. A physician's order dated July 7, 2025, directed staff to weigh Resident 9 every Monday for four weeks. Review of Resident 9's MAR revealed that staff failed to weigh the resident as ordered on July 21, 2025.</p> <p>Clinical record review revealed that Resident 10 had diagnoses that included congestive heart failure and chronic kidney disease. A physician's order dated June 26, 2025, directed staff to administer a medication (metoprolol succinate) two times a day for hypertension. The medication was to be held if the resident's systolic blood pressure (SBP) was lower than 110 millimeters of mercury (mm/Hg) or if the resident's heart rate was less than 60 beats per minute. Review of Resident 10's MARs revealed that staff administered the medication two times in</p>	F 0684		

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F 0684 SS=D	Continued from page 14 July 2025, when the resident's systolic blood pressure was below 110, and staff administered the medication once and held it once in July 2025 without assessing the blood pressure or heart rate. In interviews on July 25, 2025, at 10:00 a.m. and 11:23 a.m., the Director of Nursing confirmed that weights for residents 5, 8, and 9 had not been completed and medications were administered outside of the established parameters for Resident 10 on two occasions and administered or held without documented blood pressure on two occasions. CFR 483.25 Quality of Care Previously cited 8/16/24 28Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 15 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The second floor controlled medication box was permanently affixed to the refrigerator. An initial audit was conducted by DON or designee on all other controlled medication storage boxes in the facility. Nursing staff will be in-educated by DON/designee on proper storage and ensuring all controlled medications are secured and locked, in a permanently affixed compartment at all times. The DON/ Designee will complete audits weekly x 8, monthly x 2 to ensure Controlled medication storage boxes are secured and locked, in a permanently affixed compartment Results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly.	Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025

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F 0761 SS=D	Continued from page 16 Based on observation and staff interview, it was determined that the facility failed to ensure that medications with the potential for abuse (controlled substances) were secured in a locked, permanently affixed compartment at all times in one of two medication rooms. (Second Floor medication room) Findings include: Observation on July 25, 2025, at 11:50 a.m., revealed that the Second Floor medication room refrigerator contained four two-milligram vials of a Schedule IV anti-anxiety medication (lorazepam). The vials of medication were in a locked box, but the box was easily removable and not permanently affixed to the refrigerator. The refrigerator was not locked. In an interview on July 25, 2025, at 2:20 p.m., the Director of Nursing stated that the controlled medication storage box should have been permanently affixed to the refrigerator.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 07/25/2025
NAME OF PROVIDER OR SUPPLIER: SANATOGA CENTER STATE LICENSE NUMBER: 233702			STREET ADDRESS, CITY, STATE, ZIP CODE: 225 EVERGREEN ROAD POTTSTOWN, PA 19464		
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F 0761 SS=D	Continued from page 17 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0761			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/25/2025
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NAME OF PROVIDER OR SUPPLIER: SANATOGA CENTER STATE LICENSE NUMBER: 233702	STREET ADDRESS, CITY, STATE, ZIP CODE: 225 EVERGREEN ROAD POTTSTOWN, PA 19464
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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>All residents received care in accordance with their plan of care and attending physician orders.</p> <p>The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff.</p> <p>All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted.</p> <p>To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for review and revision as needed.</p>	<p>Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/25/2025
NAME OF PROVIDER OR SUPPLIER: SANATOGA CENTER STATE LICENSE NUMBER: 233702		STREET ADDRESS, CITY, STATE, ZIP CODE: 225 EVERGREEN ROAD POTTSTOWN, PA 19464		
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P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for ten of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 2 to 22, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on July 5, 6, 13, 19 and 20, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on July 8, 11, 12 and 14, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 15 residents on night shift (11:00 p.m. to 7:00 a.m.) on July 8, 13 and 18, 2025.	P 5520		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/25/2025
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P 5520	Continued from page 2	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395904	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 07/25/2025
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P 5640	Continued from page 3 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	All residents received care in accordance with their plan of care and attending physician orders. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for review and revision as needed.	Completion Date: 09/05/2025 Status: APPROVED Date: 08/05/2025

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P 5640	Continued from page 4 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 hours of direct care for each resident for 13 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from July 2, 2025 through July 22, 2025, revealed the following total nursing care hours below minimum requirements: Thursday July 3, 2025: 3.06 care hours per resident. Saturday July 5, 2025: 2.95 care hours per resident. Sunday July 6, 2025: 3.11 care hours per resident. Tuesday July 8, 2025: 2.78 care hours per resident. Wednesday July 9, 2025: 3.16 care hours per resident.	P 5640		

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P 5640	Continued from page 5 Thursday July 10, 2025: 3.08 care hours per resident. Saturday July 12, 2025: 3.04 care hours per resident. Sunday July 13, 2025: 2.86 care hours per resident. Wednesday July 16, 2025: 3.18 care hours per resident. Thursday July 17, 2025: 3.09 care hours per resident. Friday July 18, 2025: 3.03 care hours per resident. Saturday July 19, 2025: 3.03 care hours per resident. Sunday July 20, 2025: 3.05 care hours per resident.	P 5640		



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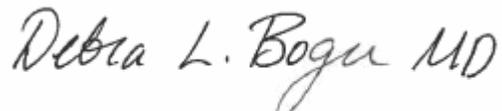
SANATOGA CENTER

STATE LICENSE NUMBER: 233702

SURVEY EXIT DATE: 07/25/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY