

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2025
NAME OF PROVIDER OR SUPPLIER Garden Spring Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1113 North Easton Road Willow Grove, PA 19090	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for two of eight sampled residents who required assistance with activities of daily living (ADLs). (Resident 2, 6) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included aphasia, hypertension, and had severe physical limitations. The Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 2 was dependent on staff for personal hygiene, grooming, and bathing. Review of the care plan revealed that the resident required assistance from staff for activities of daily living (ADLs). On July 11, 2025, at 10:40 a.m., the resident was observed in bed. Her fingernails were long and dirty. There was no documented evidence that staff assisted Resident 2 with trimming and cleaning her nails. Clinical record review revealed that Resident 6 had diagnoses that included a tracheostomy, heart failure, and weakness to an upper extremity. The MDS assessment dated [DATE], revealed that Resident 6 was alert and oriented required assistance from staff for personal hygiene, grooming, and bathing. Review of the care plan revealed that the resident required assistance from staff for ADLs. On July 11, 2025, at 11:10 a.m., the resident was observed in bed. His fingernails were long and dirty. In an interview at that time the resident stated he wanted his nail trimmed but needed help from staff. There was no documented evidence that staff assisted Resident 6 with trimming and cleaning his nails. In an interview on July 11, 2025, at 3:49 p.m., the Director of Nursing confirmed that nail care was to be done when nursing staff provided routine care and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of eight sampled residents. (Resident 2) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included a history of stroke, dysphagia, and had a feeding tube. A physician's order dated January 21, 2025, directed staff to flush the feeding tube with 200 milliliters (ml) of water every six hours for a total volume of 800 ml daily. On July 11, 2025, at 10:48 a.m., the water flush bag was observed on the pole and infusing into Resident 2's feeding tube. The flush rate was observed to be 30 ml per hour. In an interview, Licensed Practical Nurse 1 stated that the pump ran for 22 hours per day and confirmed the rate was set for 30 ml per hour. The pump rate as observed infused 660 ml per day, which was 140 ml less than the total flush amount ordered by the resident's physician. In an interview on July 11, 2025, at 3:46 p.m., the Director of Nursing confirmed the pump should have been programmed to deliver the total water amount per the physician's order. CFR 483.25 Quality of Care Previously cited 10/18/2428 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide interventions to prevent pressure ulcers for one of eight sampled residents with a history of wounds. (Resident 2) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included aphasia (a communication disorder that creates impaired ability to comprehend or formulate language due to a brain dysfunction), hypertension, and had severe physical limitations. Review of the Minimum Data Set assessment, dated June 9, 2025, revealed the resident was at risk for pressure ulcers, was immobile, and could not communicate her needs. Review of the care plan revealed that the resident had potential for impairment to skin integrity due to deconditioning and staff were to apply cushioned heel boots to bilateral feet when the resident was in bed. Multiple observations on July 11, 2025, between 10:40 a.m. and 12:00 p. m., revealed that Resident 2 was in bed. The heel boots were not in place and her heels were not elevated. In an interview on July 11, 2025, at 3:45 p.m., the Director of Nursing confirmed that Resident 2 should have had bilateral heel boots on while in bed.28 Pa. Code 211.12 (d)(1)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of eight sampled residents. (Resident 5) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed on October 10, 2024, revealed that staff were to wear a gown and gloves during high contact resident care activities such as tracheostomy care to reduce the spread of multi-drug resistant organisms (MDRO) to residents with indwelling medical devices regardless of their MDRO colonization status. Review of Resident 5's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis of respiratory failure requiring a tracheostomy, history of a stroke, and had a feeding tube. Review of the care plan revealed that Resident 5 required Enhanced Barrier Precautions and called for staff to wear gloves and gowns during close contact interactions. Observations on July 11, 2025, at 11:30 a.m., revealed a sign outside of Resident 5's room which directed staff to follow Enhanced Barrier Precautions by wearing a gown and gloves when providing high contact care including tracheostomy care. During the same observation period, Licensed Practical Nurse (LPN) 1 entered Resident 5's room and performed suctioning of the tracheostomy only wearing gloves. LPN1 did not wear a gown. In an interview on July 11, 2025, at 3:40 p.m., the Director of Nursing confirmed that staff should have worn a gown when providing care. 28 Pa Code 201.14(a) Responsibility of licensee</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and resident interview, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents and staff on two of two nursing units toured. (Section Two, Section Four)Findings include:Review of the facility policy entitled, Oxygen Storage Policy, last reviewed on October 10, 2024, revealed that oxygen cylinders must be secured in a cylinder rack or holder to prevent tipping. Observations on July 11, 2025, at 10:30 a.m., in room [ROOM NUMBER] revealed the top and front of the air conditioning unit was covered in a black substance. Resident 4 was observed standing next to bed A. The fitted sheet had a large brown stain on it and two pillows without case covers on them. Resident 8 was observed in bed B. There was an uncapped 50 milliliter syringe, typically used for flushing feeding tubes, lying on the resident's bed. The resident was observed sleeping in bed and a tube feeding was infusing.In an interview on July 11, 2025, at 10:30 a.m., Resident 4 stated that his linens were dirty, and he needed new pillowcases and sheets, staff were aware. The resident stated that the air conditioner has had the black substance on it. On July 11, 2025, at 10:35 a.m., staff entered room [ROOM NUMBER] and provided Resident 4 with new pillowcases but did not change the dirty fitted sheet, remove the syringe from the B bed, or address the black substance on the air conditioner unit.Observations on July 11, 2025, from 10:38 a.m. to 12:00 p.m., in room [ROOM NUMBER], revealed that Resident 2 was lying in the B bed, the fitted sheet was worn. There was an unsecured oxygen tank standing at the bottom of the bed, between the air conditioner and the dresser. Staff entered the room multiple times during the observation period but did not change the sheet. Observations on July 11, 2025, at 10:45 a.m., in room [ROOM NUMBER] revealed an unsecured oxygen tank standing in between the two dressers. Observations on July 11, 2025, at 11:05 a.m., of the shower room on Section 4 revealed the following:There was a commode chair with a black dirt ring on the seat. There were two wash cloths on the grab bars.There was a thermometer to check water temperatures hanging from the faucet. The front of the blue thermometer was covered in a dried black substance. The shower curtain had gray stains on the bottom end of it. In an interview on July 11, 2025, at 3:47 p.m., the Administrator confirmed the environmental problems should have been addressed.28 Pa. Code 201.18 (b) (1) Management.</p>		