

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Parkhouse Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Black Rock Road Royersford, PA 19468	

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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on a review of facility policy, nursing unit observations, and staff interviews it was determined that the facility failed to provide a clean and homelike environment on one of four nursing units (8 North Nursing Unit) and for 12 of 17 residents (Residents R1, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13, and R14). Findings include: Review of the facility policy, Resident Rights - Safe/Clean/ Comfortable/ Homelike Environment dated 1/8/25, indicated, It is the policy of the facility to provide a safe, clean, comfortable homelike environment. The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Included in the listing of the services provided were housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and clean bed and bath linens that are in good condition. During an observation on 7/28/25, at 10:59 a.m., of the nursing unit dining room it was noted that the floor appeared unclean, and the surveyor's shoes stuck to the floor when walking. During an observation on 7/28/25, 11:03 a.m., Resident R1 was noted to be lying on an unmade bed. During an observation on 7/28/25, 11:07 a.m., Resident R3's room was noted to have winter holiday decorations (penguins in a Santa hat, snowflakes, imitation snow) adhere to the walls. In addition, there were approximately 65 pieces of thick, white double-sided tape adhered to the wall and room door. During an observation on 7/28/25, 11:19 a.m., Resident R4 was observed in her room. Food was noted on the floor, soiled gloves on the windowsill, a torn soiled glove in the resident sink, and an empty Styrofoam cup on the windowsill. During an observation on 7/28/25, 11:21 a.m., of Resident R5's room, a brown object, approximately 1.5 inches in diameter, was observed under Resident R5's bed. This item appeared to be feces. Additionally, torn paper and French fries were present in the resident sink, an empty juice container on the bedside table, and the floor was sticky. During an observation on 7/28/25, 11:25 a.m., Resident R6 was observed asleep in bed. The outlet above Resident R6's bed was observed to have the cover plate missing and an empty liquid supplement container was observed to be on the floor between the nightstand and the wall. During an observation on 7/28/25, 11:27 a.m., Resident R7 was observed asleep in bed. His bedside table was turned backwards, blocking the access to the bed. The floor was sticky, an empty Styrofoam cup on the windowsill, and a soiled glove stuck between the soap dispenser at the resident sink and the wall. At this time, the surveyor utilized Resident R7's overbed table to write notes on, and when the paper was removed, it stuck to the table and ripped. During an observation on 7/28/25, at 11:30 a.m., Resident R8 was observed in bed. A clear plastic cup was noted to be upside-down on his bedside table, with a red residue dried on the inside of the cup. During an observation on 7/28/25, at 11:38 a. m., Resident R9 was observed to be lying in bed. Ripped up pieces of an incontinence brief were on the bed, bedside table, and floor. Review of the resident assignment sheet indicated that no residents were assigned to the bed Resident R9 was lying in. During an observation on 7/28/25, at 11:44 a.m., Resident R10 was observed in bed. An empty Styrofoam cup was observed on the shelf of the dresser next to her bed 7/26/25. A Styrofoam cup with liquid in it was also on the shelf, dated 7/23/25. Refuse was observed on the windowsill and on the empty bed in the room, and on the floor which was sticky. During an observation on 7/28/25, at 11:47 a.m., Resident R11 was observed bed. The floor was noted to be sticky. During an observation on 7/28/25, at 12:19 p.m., of Resident R5's room, the piece of dried feces remained under the bed. During an observation on 7/28/25, at 2:39 p.m. of Resident R13's room, the footboard was noted to be removed from the bed and placed against the side of it. Resident R13's dresser had a broken door and what appeared to be feces smeared on the bed linen. During an observation on 7/28/25, at 2:45 p.m., Resident R14 was observed asleep on a bed with no bed linens. During an interview and observation on 7/28/25, at 2:50 p.m., Nurse Aide Employee E2 was asked if he was able to identify the object under Resident R5's bed. Nurse Aide Employee E2 stated, Yeah, that's a dingleberry. During an interview on 7/28/25, at approximately 3:15 p. m., the Nursing Home Administrator confirmed that the facility failed to provide a clean and homelike environment on one of four nursing units and for 12 of 17 residents. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on review of facility documents, observations, and resident and staff interviews, it was determined that the facility failed to provide activity of daily living (ADL) assistance for 11 of 17 residents (Residents R1, R2, R3, R6, R8, R9, R10, R11, R12, R14 and R15). Findings include: Review of the facility policy Activities of Daily Living (ADLs) dated 1/8/25, indicated A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. During an observation on 7/28/25, at 10:59 a.m., Resident R12 was observed in the dining room wearing a gown and a flannel jacket. The gown had large areas of visible soilage. During an observation on 7/28/25, at 11:03 a.m., Resident R1 was observed asleep on a bed with no bed linens. During an observation on 7/28/25, at 11:05 a.m., Resident R2 was walking in the hallway with one sock only partially on his left foot (approximately four inches of loose sock hanging off the toe end) and a different type of sock on his foot, with visible soilage. During an observation on 7/28/25, at 11:25 a.m., Resident R6 was observed asleep in his bed. Resident R6 was noted to be wearing a gown, was unshaven, and had untrimmed fingernails with a brown substance under them. During an observation on 7/28/25, at 11:30 a.m., Resident R8 was observed asleep in his bed. Resident R8 was noted to be wearing pants with wet spots and to have greasy appearing, unbrushed hair. During an observation on 7/28/25, at 11:33 a.m., Resident R15 was observed in the unit solarium. Resident R15 was noted to have ungroomed hair. During an observation on 7/28/25, at 11:38 a.m., Resident R9 was observed to be lying in bed. Ripped up pieces of an incontinence brief were on the bed, bedside table, and floor. Review of the resident assignment sheet indicated that no residents were assigned to the bed Resident R9 was lying in. During an observation on 7/28/25, at 11:44 a.m., Resident R10 was observed asleep in her bed. Resident R8 was noted to have greasy appearing, unbrushed hair. During an observation on 7/28/25, at 11:47 a.m., Resident R11 was observed asleep in his bed. Resident R8 was noted to have wet pants on, a circle of wetness on the sheet under him, and a brown substance under his fingernails. During a second observation on 7/28/25, at 12:20 p.m., Resident R11 was noted to still be in wet clothing and bed linen. During an observation on 7/28/25, at 12:30 p.m., the noon meal was served to residents in the dining room. During an interview on 7/28/25, Licensed Practical Nurse (LPN) Employee E4 was asked if the resident in the room at the end of the hall (Resident R9) was going to be provided lunch. At this time, LPN Employee E4 proceeded to the room, and assisted Resident R9 to his own room. Resident R9 was not provided lunch until this time. During a third observation on 7/28/25, at 12:51 p.m., Resident R11 was being assisted to a sitting position to be able to eat his meal by LPN Employee E4. Resident R11 remained in wet clothing and bed linen at this time. During an observation on 7/28/25, at 2:45 p.m., Resident R14 was observed asleep on a bed with no bed linens. During a fourth observation on 7/28/25, at 2:48 p.m., Resident R11 was noted to be in a clean gown and have clean bed linen. Review of Resident R11's nurse aide point of care record for 7/28/25, failed to reveal any entries for toileting or incontinence care between 12:51 p.m. and 2:48 p.m. Documentation indicated toileting/incontinence care had been provided at 12:54 a.m., and not again until 9:07 p.m. Review of facility grievances filed in January 2025, through March 2025, revealed the following: -On 2/7/25, Resident R3 had voiced a concern about not being assisted to shower. Review of Resident R3's shower record for January 2025, through March 2025, revealed that Resident R3 had documented showers on 1/29/25; 2/1/25; 2/12/25; and 3/17/25. -On 2/7/25, Resident R8 had voiced a concern about not being assisted to shower. Review of Resident R8's shower record for January 2025, through March 2025, revealed that Resident R8 had documented showers on 1/23/25; 2/7/25; 3/10/25; and 3/17/25. -On 2/7/25, Resident R9 had voiced a concern about not being provided assistance from the overnight nurse aide until 5:00 a.m. The conclusion of the grievance confirmed that the nurse aide did not the resident. Review of facility provided Resident Council minutes revealed the following concerns: January 2025: Snacks not being passed to residents and catheter bag not being emptied. February 2025: Snacks and ice water not being passed to residents. March 2025: Nurse aides not providing care, ice water not being passed, long call light response times, not receiving showers, and staff not completing rounds to check on residents. During an interview on 7/28/25, at approximately 3:15 p.m., the Nursing Home Administrator confirmed the facility failed to provide activity of daily living assistance for nine of 17 residents 28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on a review of facility documents, nursing unit observations, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one of four nursing units (Nursing Unit 8 North). Findings include: Review of the Facility Assessment most recently reviewed 5/23/25, indicated that the facility will provide care for residents with Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and non-Alzheimer's dementia (a group of symptoms that affects memory, thinking and interferes with daily life). The Facility Assessment further stated that they will provide therapeutic recreation as a service to their resident population. During an observation of the 8 North nursing unit (secure unit for residents with memory impairments) on 7/28/25, at 10:45 a.m., three residents were observed folding towels. Observations throughout the remainder of the day failed to reveal any further recreational activities provided to the residents. Review of the posted Activities calendar on 7/28/25, indicated the day's scheduled activities were TBA (to be announced) daily chronicle packets and visits. Further review of the July 2025 Activities Calendar revealed the following: 7/4/25: Happy 4th of July 7/5/25: Blank 7/6/25: Blank 7/7/25: TBA Visits (1:00 RCC meeting), and 2:00 Zoom call for designated residents. 7/8/25: 10:15 - 1:00 Salon for designated residents. 2:00 p.m. 1to1 visits. 7/12/25: 10:00 a.m. Pinocle club. 7/13/25: Blank 7/15/25: 10:15 - 1:00 Salon for designated residents. 2:00 p.m. 1to1 visits. 7/16/25: 2:00 p.m. Noodle ball. 7/19/25: Blank 7/20/25: Blank 7/21/25: TBA Daily Chronicle Packets and visits. 2:00 p.m. Zoom call for designated residents. 7/22/25: TBA Visits. 10:15 - 1:00 Salon for designated residents. 7/25/25: TBA Visits. 7/26/25: 10:00 a.m. Pinocle club. 7/27/25: Blank 7/28/25: TBA Daily Chronicle Packets and visits. 7/29/25: TBA Visits. 7/30/25: 2:30 Movie Day and TBA Visits. 7/31/25: TBA Visits. During an interview on 7/28/25, at approximately 11:50 a.m. Activities Employee E5 was asked about the lack of activities on the unit. Activities Employee E5 stated that they had folded laundry during the morning and had socialization while completing that. When asked about the lack of structured activities on the unit, Activities Employee E5 stated he has recently returned to the facility and had put that calendar out in five minutes to at least have a calendar posted. Further observations throughout the day on 7/28/25, failed to reveal any structured activities provided to the residents and failed to reveal nursing staff engaging with the residents in a non-clinical manner. During an interview on 7/28/25, at approximately 3:15 p.m., the Nursing Home Administrator confirmed the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents on one of four nursing units. 28 Pa. Code: 201. 18(b)(3) Management. 28 Pa. Code: 207.2(a) Administrators Responsibility.</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>Based on observations, policy review, clinical record review, and staff interviews, the facility failed to provide drinking water consistent with resident needs and preferences for one out of four units sampled (8 North nursing unit). Findings include: Review of information published by the Alzheimer's Society, titled Drinking, Hydration and Dementia indicated, Someone with dementia may not recognize that they are thirsty, or they may forget to drink. They might also struggle to get themselves a drink or tell you when they are thirsty. Review of the facility policy, Quality of Care - Nutrition/Hydration Status Maintenance dated 1/8/25, indicated It is the policy of the facility to provide Nutrition/Hydration Status Maintenance Services in accordance with State and Federal regulations and that a resident is offered sufficient fluid intake to maintain proper hydration and health. During observations completed on the memory impaired unit on 7/28/25, the following was noted: 11:03 a.m. Resident R1 was observed in bed. No drinking cups were noted in his room. Resident R1 had no other beverages available to him. 11:05 a.m. Resident R2 was observed in the hallway. Observation of his room at this time revealed no drinking cups were noted in his room. Resident R1 had no other beverages available to him. 11:19 a.m. Resident R4 was observed in bed. An empty Styrofoam cup was observed on the windowsill, dated 7/26/25. 11:19 a.m. Resident R5 was observed in bed. No drinking cups were noted in her room. 11:21 a.m. Resident R5 had no other beverages available to him. An empty apple juice container was noted to be on the nightstand for the other bed in the room. 11:25 a.m. Resident R6 was observed in bed. No drinking cups were noted in his room. Resident R6 had no other beverages available to him. 11:27 a.m. Resident R7 was observed in bed. An empty Styrofoam cup was observed on the windowsill, dated 7/26/25. 11:30 a.m. Resident R8 was observed in bed. No drinking cups were noted in his room. A clear plastic cup was noted to be upside-down on his bedside table, with a red residue dried on the inside of the cup. 11:44 a.m. Resident R10 was observed in bed. An empty Styrofoam cup was observed on the shelf of the dresser next to her bed 7/26/25. A Styrofoam cup with liquid in it was also on the shelf, dated 7/23/25. 11:47 a.m. Resident R11 was observed in bed. No drinking cups were noted in his room. Resident R11 had no other beverages available to him. During an interview on 7/28/25, at 11:50 a.m. with Nurse Aides (NA) Employees E1, E2, and E3, NA Employee E1 stated that for those residents who are able to use the call light, when they push it and ask for water, she brings it to them. NA Employee E2 stated that the overnight shift takes care of that. NA Employee E3 confirmed that she had not provided any fresh water to residents on 7/28/25. All three nursing aides confirmed at this time that they were unaware that persons with dementia may no longer have the ability to verbalize the desire for a drink or to recognize feelings of thirst and hunger. During an interview on 7/28/25, at 11:52 a.m., Licensed Practical Nurse (LPN) Employee E3 stated she gives the residents water when she passes medications, but she does not pass out drinking water. During an observation of the 8 North nursing unit at 3:00 p.m. to confirm if fresh water was provided, it was noted that there still remained no water available to residents. During an interview on 7/28/25, at approximately 3:15 p.m., the Nursing Home Administrator confirmed that the facility failed to ensure the availability of drinking water consistent with resident needs and preferences on one of four nursing units. 28 Pa. Code 211.12 (d)(1)(5) Nursing services</p>		