STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395912	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suburban Woods Health & Reha	2751 Dekalb Pike Norristown, PA 19401

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395912	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suburban Woods Health & Reha	2751 Dekalb Pike Norristown, PA 19401

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, interviews with residents and staff and reviews of the job descriptions, it was determined that the facility failed to ensure the safety of one of two resident reviewed after the resident was returned to the facility from a contracted transportation company, who transported the resident to a medical appointment. (Resident R1) Findings include:Observation of Resident R1 at 10:45 a.m., on December 3, 2025, revealed that this resident was only able to have vision from the left eye. Interview with Resident R1 at the time of the observation revealed that he was having problems with vision in the left eye. Review of Resident R1's clinical record revealed a physician's assessment dated [DATE], that indicated Resident R1 had a history of right eye exenteration for melanoma. Continued review of the physician's report revealed that Resident R1 had been recommended prescription eyeglasses and at this time was diagnosed with a cataract of the left eye. Review of Resident R1's comprehensive assessment MDS (an assessment of care needs) dated September 12, 2025, indicated that this resident had visual impairment. The assessment indicated that this resident could only see large print. The assessment also indicated that this resident did not have corrective lenses. The resident's had a diagnosis of diabetes mellitus (failure of the body to produce insulin). The resident was assessed with having pain was present routinely. Clinical record review revealed physical therapy and occupational therapy assessments for Resident R1 dated August 8, 2025, and September 12, 2025. The assessments indicated that Resident R1 was able to ambulate with a rollator walker on level surfaces and uneven surfaces with the supervision of staff. The assessment indicated that pacing was advised for Resident R1. The assessment also indicated that community mobility was not determined for this resident. Interview with the occupational therapist, Employee E13, at 10:30 a.m., on December 4, 2025, confirmed Resident R1's ambulation ability was that which requiring supervision of staff for level and unlevel surfaces inside and outside the facility. The occupational therapist also confirmed Resident R1 was not evaluated for community mobility (crossing a four-lane highway or walking on a roadway or sidewalk or inclines). Interview with the Administrator, Employee E1 at 10:30 a.m., on December 3, 2025, revealed that Resident R1 was using the contracted medical transport service to go to medical appointments outside the facility on a routine basis since the resident's admission to the facility in July 2025. Clinical record review revealed that Resident R1 had a physician's approval for a leave of absence from the facility with supervision by a staff member, resident family or other authorized individual. The supervision was assumed by the person responsible for the resident during such time. Clinical record review for Resident R1 revealed that this resident left the facility at 8:00 a.m., on November 24, 2025, for a medical appointment. Interview with Licensed Practical Nurse, Employee E4, at 1:00 p.m., on December 3, 2025, revealed that at 3:30 p.m., on November 24, 2025, the nurse began to question the whereabouts of Resident R1. The Administrator, Employee E1 and Director of Nursing, Employee E2 also reported at 1:30 p.m., on December 3, 2025, that they were not able to find Resident R1 at 3:54 p.m., on November 24, 2025, anywhere inside the building. The Administrator and Director of Nursing also reported on December 3, 2025, at 2:00 p.m., that they had no policies and procedures in place to ensure that Resident R1 was returned safely to the facility and into the care of the nursing staff after medical appointments. The administrator and director of nursing had no documentation or procedure for the medical transportation services to bring Resident R1 into the building and sign Resident R1 into the care of the staff (nursing) at the facility. On December 3, 2025, at 2:00 p.m., the Administrator and Director of Nursing reported that they had no idea where Resident R1 was, since the resident was not inside the building. The administrative staff said that they had to contact the driver of the transportation services company on November 24, 2025, to inquire the whereabouts of Resident R1. The Director of Nursing reported that the driver of the transportation services reported dropping Resident R1 off at the facility, did not escort the resident into the building, sign the resident back into the facility or positively identify the resident with the nursing staff for continuation of care. Interview with the Licensed nurse, Employee E4, responsible for Resident R1 on November 24, 2025, revealed that it was at 4:35 p.m., on November 24, 2025, that she recognized Resident R1 walking through the parking lot of the facility toward the front entrance of the building. Licensed nurse, Employee E4 reported that Resident R1 told her that he walked down the road adjacent to the facility alone after being left off by the transportation driver near the front entrance of the facility at about 3:54 p.m. The resident then crossed the four-lane highway that was under construction to get some food at a fast- food restaurant. Licensed nurse, Employee E4 reported that