

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395912	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/17/2024
NAME OF PROVIDER OR SUPPLIER  Suburban Woods Health & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</b></p> <p>Based on observations and interviews with residents and staff, it was determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment for one of two nursing units observed (2 floor nursing unit).</p> <p>Findings include:</p> <p>Facility policy titled Occupied Resident Room Cleaning Procedure last revised on August 30, 2022 revealed</p> <p>Proper cleaning and disinfecting of environmental surfaces is necessary to break the chain of infection. Cleaning refers to the removal of visible soil from surfaces through the physical action of scrubbing with detergents/surfactants and rinsing with water. This step is to reduce the volume of organisms on a surface and remove foreign material that could interfere with disinfection. Occupied resident rooms will be cleaned daily to maintain a sanitary environment.</p> <p>On May 14, 2024, at 11:23 a.m. observations on the Second-floor unit room [ROOM NUMBER] B bed revealed quarter of the privacy curtain was falling off as there was no curtain hooks. There was a floor mat with all four edges ripped. The floor mat covered with spots. room [ROOM NUMBER] the wall was chipped by the door.</p> <p>On May 14, 2024, at 11:43 a.m. an interview with Resident R34 who was residing in room [ROOM NUMBER] B bed revealed that the bathroom sink is very slowly draining the water. The wall behind the bed was observed to be scrapped off, wall on the left side of the room when you are facing the window was scrapped off. Bathroom had brown spots all over the bathroom wall and around the toilet. The sink was not draining the water once the water was running. Resident R34's dresser which was located between the two closet had a missing third shelve. The dresser had a layer of dust, with sugar spilled. The air conditioning unit had a layer of dust, brown spots of old spills which went into the wall. Resident's clothing was laying on the floor in large bags on the top of each other by the bedside of an A bed.</p> <p>room [ROOM NUMBER] the edges of the floor were dirty with brown spots. The bathroom had brown spots all over the walls and toilet. Bathroom had running water in the sink and the hot water handle was broken which did not allow the water to turn off. The floor was dirty and there was an unrolled toilet paper laying on the dirty floor.</p> <p>(continued on next page)</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 14, 2024, at 11:57 a.m. an interview with the unit manager, Employee E9 and Maintenance and Housekeeping Director Employee E10 confirmed, the above observations.</p> <p>On May 14, 2024, at 12:28 p.m. Maintenance and Housekeeping Director, Employee E10 tested the hot water in room [ROOM NUMBER] with his hand and it never got hot. room [ROOM NUMBER] hot water revealed temperature 97 F. (Fahrenheit). Further observation revealed that there was a bug running on the wall. Employee E10 killed the bug while testing the water.</p> <p>Hot water tested the water on the Second-floor shower room revealed that the hot water was between 95 F. -99 F. which was not comfortable hot water temperatures for the residents.</p> <p>On May 14, 2024, at 1:44 p.m. Resident R38's family interview revealed that facility was not clean, and that there was a urine smell present. Two months ago, there was a dry stool all around the restroom in room [ROOM NUMBER]. Nursing assistant provided a family with wipes and family member had to clean up the stool. Since it was dry family member knew that it was there a for a while.</p> <p>On May 15, 2024, room [ROOM NUMBER] sink was unclogged, and the water temperature went to 99 F. and there was a basin observed collecting drips of water from the sink pipe.</p> <p>On May 15, 2024, at approximately 1:15 p.m. observation was taken place in room [ROOM NUMBER] Resident's R49 call bell's plate was off the wall and exposed wires were visible. This observation was confirmed by the Maintenance and Housekeeping Director, Employee E10.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 204.15(a) Windows</p> <p>28 Pa Code 205.67(c) Electric requirements for existing construction</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48347</p> <p>Based on review of facility policies, review of clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans related to medication administration and recovery of history alcohol abuse to meet the care needs for one of three residents reviewed. (Resident R50)</p> <p>Findings include:</p> <p>Review of the facility's policy titled Comprehensive Care Planning Policy revealed that the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes a measurable objective and timetables to meet the resident medical nursing, and mental and psychosocial need that are identified in the comprehensive assessments. There may be additional problem area not triggered by the MDS (Minimum Data Set, federal mandated process for clinical assessment of all residents) which will need to be addressed in the care plan.</p> <p>Review of residents clinical record revealed that Resident R50 has a diagnosis of Diabetes type 2 (chronic condition which blood glucose level are too high), muscle weakness, spinal stenosis (narrowing of the spine resulting in pressure on the spinal cord and nerves), bipolar disorder (a mental illness that causes unusual shifts in a person's mood), anxiety(an emotion of fear or worry), neuromuscular dysfunction of bladder (loss of control of the bladder muscles), toxic encephalopathy(abnormal brain function caused by toxins in the brain), morbid obesity (a body mass index of 40 or more).</p> <p>Continued review of Resident R50's May 2024 physician orders revealed an order for insulin Lispro (a fast-acting insulin that works by lowering levels of sugar in the blood) 100/ml order to give 6 units three times a day with meals.</p> <p>Review of resident R50's May 2024 medication administration record (MAR), revealed that Resident R50 routinely refuses accu check s(a blood glucose test) and insulin.</p> <p>Review of Resident R50's current care plan revealed that Resident R50 has a diagnosis of diabetes mellitus containing a goal to be free of signs and symptoms of hypoglycemia and hypoglycemia with intervention of assessment, documents, and reports sign and symptoms of hypoglycemia and encourage the resident to practice good health practices. Continued review of the resident's are plan revealed that there was no care plan developed to address refusal of medication, education of resident and staff, and any plan or implementation of hypoglycemia (low blood sugar, require immediate treatment).</p> <p>Interview with Licensed nurse, Employee E8 on May 15 at 8:30 a.m. on the second-floor nursing floor during medication pass, employee was observed distributing medication for Resident R50. Interview with Licenced nurse E8 during the observation revealed that Resident R50 declines her daily accu checks. Employee E8 stated that Resident</p> <p>R50 notifies the staff when she feels the need for the prescribed insulin.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R50 May 16, 2024 at 11:25a.m., revealed that she does not have her blood sugar levels taken with accu checks. She stated that she just lets the nurses know when she feels like she needs it.</p> <p>Continued interview with Resident R50 May 16, 2024, at 11:30 a.m. revealed that this resident greatest accomplishment of her life was maintaining sobriety. Although Resident R50 has been alcohol free for many years and she still feels the need to attend meeting twice a week outside the facility. Observation of Resident R50's room revealed diplomas on the wall and a picture by her bed that was explained as her greatest's supporter, her sponsor.</p> <p>Continued review of Resident R50's care plan did not included the diagnosis of soberness and there was no care plan developed related to coordinating care and support for the resident as well of implementing resident assistance to prepare and travel outside the facility of group meeting.</p> <p>Interview with Director of Nursing, Employee E2 confirms the above findings.</p> <p>28 Pa Code 211.10(c) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(3) Nursing Services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>43923</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, review of facility policy, clinical record review, resident and staff interviews, it was determined that the facility failed to provide appropriate Activity of Daily Living (ADL) for three of 21 residents reviewed who were unable to carryout ADL care independently. (Resident R19, R29, and R75)</p> <p>Findings include:</p> <p>A review of the Facility Policy titled, Personal Care last revised on November 8, 2023, revealed Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing. Residents who can perform their own personal care are encouraged to do so but will be provided with setup assistance if needed. Showers and baths are scheduled two times weekly or more or less often according to resident preference. Further under procedures number 7. Provide shaving as desired by resident 9. Provide fingernail care</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R19 dated April 24, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, and toileting. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 8 which indicated that the resident's cognitive status for daily decision making was moderately impaired.</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R29 dated May 14, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, toileting, dressing, bed mobility. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 13 which indicated that the resident's cognitive status for daily decision making was intact.</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R75 dated April 25, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, toileting, dressing, bed mobility. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 15 which indicated that the resident's cognitive status for daily decision making was intact.</p> <p>On May 14, 2024, at 1:17 p.m. an interview and observation revealed that Resident R75 had a beard and has been asking since Sunday May 11, 2024 to shave his beard. A nursing assistant. Employee E12 responded to Resident R75 I don't have time on Sunday. Resident R75 requested two times on Monday May 12, 2024, and no one provided him a shave.</p> <p>A grievance investigation was conducted for the above concern, and it revealed that Resident R75 did request his beard to be shaved on May 13, 2024 and certified nursing assistant, Employee E12 wrote in the statement dated May 15, 2024 revealed due to lunch arriving late, need to do other residents and then passing down and collecting trays there as no time to shave Resident R75.</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 - Few</p>	<p>On May 15, 2024, at 12:20 p.m. Resident R19 was observed sitting in the dining room with facial hair and long nails. Resident R19 did want his nail to be cut and facial hair to be shaved. Unit Manager, Employee E9 did confirmed the observation.</p> <p>On May 17, 2024, at 9:42 a.m. an interview and observation revealed that Resident R29 had long nails and wanted them to be trimmed. License Nurse, Employee E8 confirmed the observations.</p> <p>On May 17, 2024, at 12:30 p.m. an interview with the Registered Nurse Assessment Coordinator, Employee E6 confirmed the Resident R19 required extensive assistance of one person from the staff for ADL care in personal hygiene, bathing, and toileting. Resident R29 required extensive assistance of two person from the staff for ADL care in personal hygiene, bathing, and toileting. Resident R75 required extensive assistance of one to two person from the staff for ADL care in personal hygiene, bathing, and toileting.</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43277</p> <p>Based on review of safety data sheet, review of facility documentation, review of clinical records, observations, and staff and resident interviews, it was determined that the facility failed to ensure residents received adequate supervision during transfers for two of three residents reviewed for falls (Resident R84 and R30) and failed to ensure the resident environment remained free of accident hazards related to access to cleaning agents and the security of windows.</p> <p>Findings Include:</p> <p>Review of facility policy Mechanical Lift revised January 7, 2022, revealed a mechanical lift may be used for transferring residents that cannot be safely transferred by themselves or with staff assistance. Two staff person assist/oversight is required for total body lifts.</p> <p>Review of Resident R84's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 15, 2024, revealed the resident was cognitively intact and was total dependence (full staff performance every time), 2-persons physical assist for transfers (how resident moves between surfaces including to or from bed, chair, wheelchair).</p> <p>Review of Resident R84's comprehensive care plan revised May 22, 2023, revealed the resident had a self-care deficit related to immobility and need for assistance with activities of daily living and transfers. Intervention dated August 5, 2022, revealed resident was hoyer lift for transfers (total body lift - device used to hoist resident with slings that hook up to the lift's arm and cradle the resident during transfer) with assist of 2 people.</p> <p>Review of facility documentation submitted to the State Survey Agency revealed on March 22, 2024, Resident R84 fell during transfer with the hoyer lift. Facility documentation indicated that Resident R84 was transferred with 1-person assist but required 2-person assistance.</p> <p>Review of facility documentation Witness Statement dated March 22, 2024, by nurse aide, Employee E4, revealed the employee was using the hoyer lift to transfer Resident R84. Nurse aide, Employee E4, stated as the hoyer lift was being turned, the lift tipped and Resident R84 fell .</p> <p>Review of facility documentation Witness Statement dated March 22, 2024, by Director of Nursing, Employee E2, revealed the employee responded to a call for help in Resident R84's room. Upon arriving, Resident R84 was on the floor near the night stand and bed with the hoyer lift tilted to the side. Director of Nurse, Employee E2, asked nurse aide, Employee E4, who assisted with the transfer and nurse aide, Employee E4, responded no one.</p> <p>Interview on May 17, 2024, at 12:40 p.m. with Resident R84 confirmed nurse aide, Employee E4, did not have assistance during transfer with hoyer lift at the time of the fall on March 22, 2024.</p> <p>Review of Resident R30's clinical record revealed that resident has a diagnoses of encephalopathy (disturbance of brain function) and schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis) .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident R30's care plan developed March 27, 2024, revealed that resident was at risk for falls related to history of placing self on floors, decreased mobility, seizure disorder, lack of coordination, abnormal gait and insomnia.</p> <p>Review of Resident R30's MDS (Minimum Data Set , a federal mandated process for clinical assessment of all residents), revealed that Resident R30's functional status determined that this resident required total dependence of 2 person assists for transfers.</p> <p>Interview with Resident R30 on May 17, 2024, at 10:45 a.m. revealed that the resident confirmed falling while he was been transferred to his bed by one employee.</p> <p>Review of the facility documentation reported to the State Agency revealed a written statement by nursing assistant, Employee E20 which stated was asked to help put patient [Resident R30] . in the bed he was sliding out of the hoyer pad. Employee E21 assisted in the transfer and the hoyer lift was used. Patient was sliding out of chair for the most part to he day assisted with putting him up.</p> <p>Review of the written statement by nursing assistant, Employee E21 revealed that she asked another nurse aide to help with the transfer of Resident R30 with the hoyer lift he said yes he push the resident down to this room while I grab the brief and washcloths when I got back down to the room the resident was already transfer into the bed.</p> <p>The facility concluded that the resident did not substantiate any injuries. Employee E20 was terminated for failure to follow the resident's care plan appropriately.</p> <p>Tour and Observation of the laundry room conducted on May 16, 2024 at 9:43 a.m. accompanied by Maintenance Director, Employee E10 revealed that the facility outsource's their linens. The facility laundry room is available to the residents for personal use. Observation of the laundry room revealed an industrial soap hung on the wall available for use. This observation concluded that there were no instruction for detergent use nor any measuring apparatus for use.</p> <p>Interview with Employee E10 at time of observation stated that the instruction is for about a cup when question where the measuring cup was, Employee E10 had no response. Employee E10 confirmed that the bottle instructions states for industrial use only .</p> <p>Review of the laundry detergent manufacture produces the product Pyxis Enzyme laundry Detergent, Safety data sheet for the laundry detergent / state industrial products has a hazard identifying serious eye damage category 2A, oral and acute toxicity, dermal category 5. Handling and storage instruction to store locked up.</p> <p>Interview with Resident R95 on May 16, 2024 at 1:25 p.m. revealed that this resident has used the provided laundry detergent. Resident R95 admitted not knowing the instructions for the detergent. This resident has stopped using the detergent due to a skin sensitivity. Resident R95 admitted to acquiring a rash and has since stopped using the detergent.</p> <p>Interview with Licenced nurse, Employee E14, revealed that she has assisted the resident with the laundry. Employee E14 allowed the resident to measure the detergent and pour it in the machine. Employee E14 confirmed not being aware of the instructions for the detergent.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with nursing assistant, Employee E15 stated that this employee has assisted residents with the laundry of their personal items. Employee E15 stated that the residents did not wear gloves of PPE (personal protective equipment).</p> <p>Continued tour of the facility accompanied with Maintenance Director, Employee E10 on May 16, 2024, at 10:05 a.m. revealed a window on the second-floor dementia unit not possessing a safety lock on the resident's window. Resident R72 and Resident R373 occupied a room that the window was equipped to open as wide as 17.5 inches.</p> <p>Interview with Maintenance Director, Employee E10 at time of observation revealed that this employee was aware that the windows must have a safety lock that disable the window from opening beyond a specific level and was unaware that the window in the resident's room was able to be open to 17.5 inches.</p> <p>28 Pa. Code 204.7 Laundry</p> <p>28 Pa. Code 210.18(1) Management</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 211.10 (d) Resident Care Policies</p> <p>28 Pa Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>43277</p> <p>Based on review of facility documentation, observations, and staff and resident interviews, it was determined that the facility failed to ensure meals were served in accordance with resident preferences for two of two nursing units (1st and 2nd floor).</p> <p>Findings Include:</p> <p>Interview on May 14, 2024, at 12:30 p.m. with Resident R100 revealed lunch used to be served at noon. Recently, lunch has been coming later since change in process of delivering food trucks.</p> <p>Interview on May 14, 2024, at 12:35 p.n. with alert and oriented Resident R68 and R81 revealed residents were upset because lunch is supposed to be served at noon but still has not been delivered. Further interview revealed lunch has been getting served late and has come late as 2:00 p.m.</p> <p>Observations on May 14, 2024, at 12:42 p.m. revealed a lunch truck was just delivered to the 1st floor dining room.</p> <p>Interview on May 14, 2024, at 1:00 p.m. with Nurse Aide, Employee E3, revealed the 1st floor nursing unit is still waiting for 2 more food trucks to be delivered. Further interview revealed a total of 3 food trucks are delivered to the 1st floor nursing unit, and were waiting for about 30-35 more lunch trays for the residents.</p> <p>Continued interview on May 14, 2024, at 1:00 p.m. with Nurse Aide, Employee E3, revealed there was a change in process for the delivery of meal trays and that breakfast is now served too early on the 1st floor nursing unit, and most residents are not awake when breakfast is delivered. Further interview revealed lunch and dinner are now served later and most residents are upset with the change in meal times.</p> <p>Observations on May 14, 2024, at 1:06 p.m. revealed the 2nd food truck was delivered to the 1st floor nursing unit.</p> <p>Interview on May 14, 2024, at 1:15 p.m. with Resident R6 revealed the resident was upset because she was not served lunch yet. Resident R6 reported lunch and dinner are always late and that dinner was not served until almost 7:00 p.m. the night prior.</p> <p>Interview on May 14, 2024, at 1:24 p.m. with Resident R13 revealed the resident did not get lunch yet and that lunch is usually late. Resident R13 reported he would like his lunch earlier.</p> <p>Observations on May 14, 2024, at 1:34 p.m. revealed the 3rd lunch truck was delivered to the 1st floor with approximately 16 meal trays.</p> <p>Observations on May 14, 2024, revealed Residents R69 and R3 were the last to be served lunch on the 1st floor nursing unit at 1:42 p.m.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0809  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	On May 15, 2024, at 10:30 a.m. a resident council meeting was held with nine alert and oriented Residents (R103, R95, R76, R81, R8, R66, R85, R53). Residents reported that breakfast is being served too early in the morning and lunch is being served too late.  28 Pa. Code 201.18(b) Management		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395912	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/17/2024
NAME OF PROVIDER OR SUPPLIER  Suburban Woods Health & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43923</p> <p>Based on observation, review of facility policy and staff interviews, it was determined that the facility failed to ensure that residents call systems was accessible for 11 out of 11 residents reviewed (Residents R29, R49, R75, R103, R95, R76, R81, R8, R66, R85, R53).</p> <p>Findings:</p> <p>Facility policy titled Operations last revised on February 24, 2023, revealed It is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas. The facility responds to resident needs and requests. It further revealed under procedures number 3. Staff will respond to call lights promptly.</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R29 dated May 14, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, toileting, dressing, bed mobility. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 13 which indicated that the resident's cognitive status for daily decision making was intact.</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R49 dated February 13, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, toileting, dressing, bed mobility. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 12 which indicated that the resident's cognitive status for daily decision making was moderately impaired.</p> <p>Review of MDS (Minimum Data Set-assessment of resident care need) for Resident R75 dated April 25, 2024, revealed that the resident was dependent on the staff for personal hygiene, transfer, toileting, dressing, bed mobility. MDS also revealed that the resident had a BIMS (Brief Interview for Mental status) score of 15 which indicated that the resident's cognitive status for daily decision making was intact.</p> <p>On May 14, 2024, at 1:17 p.m. an interview was held with Resident R75 who reported that yesterday May 13, 2024, R75 pressed his call bell at 3:50 p.m. and was responded at 4:50 p.m. Many times, Resident R75 uses his phone to call the nursing station to get his call bell answered because staff would not respond to his call bell.</p> <p>On May 15, 2024, at 10:30 a.m. a resident council meeting was held with nine alert and oriented Residents (R103, R95, R76, R81, R8, R66, R85, R53) Residents reported that when they pressed the call bell, facility staff would enter the room and turn off the bell without providing assistance. They were often told, I'm not assigned to you, I'll let your staff know, but no one would return to help. Overall, the response to call bells was poor.</p> <p>On May 15, 2024, at approximately 1:15 p.m. observation was taken place in room [ROOM NUMBER] Resident's R49 call bell was underneath the bed and was not accessible to Resident R49. This observation was confirmed by the Maintenance and Housekeeping Director, Employee E10.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Suburban Woods Health & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE 2751 Dekalb Pike Norristown, PA 19401	
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 17, 2024, at 9:39 a.m. observations were taken place in room [ROOM NUMBER], Resident's R49 call bell was on the floor, not in accessible position. Resident R49 reported I need to be changed and I can't locate the call bell . This observation was confirmed by the license nurse, Employee E8.</p> <p>On May 17, 2024, at 9:42 a.m. Resident R29 was observed in bed and his call bell was located on the dresser. Resident R29 was not able to reach it. License nurse, Employee E8 reported that she will get a clip for Resident R29 to clip his call bell to the sheets.</p> <p>28 Pa. Code 201.14 Responsibility of Licensee</p> <p>28. Pa. Code 201.18 (b)(1)Management</p> <p>28 Pa. Code 211.12 (d)(1) Nursing Services</p>		

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

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43923</p> <p>Based on the review of facility policy, observations and interviews with resident and staff, it was determined that the facility failed to ensure a functional, sanitary environment on one of two nursing units observed (2nd floor nursing units) and for for 6 out of 10 residents reviewed. (Residents R4, R131, R66, R56, R29, and R50).</p> <p>Findings:</p> <p>Review of facility policy titled Occupied resident room cleaning revised August 30, 2022, revealed that occupied resident room will be cleaned daily, it is housekeeping's responsibility to inspect room and report any maintenance issues noted during cleaning.</p> <p>On May 14, 2024, at 11:37 a.m. on the Second-floor north side of the nursing unit at the end of the hallway there was a strong urine odor. License nurse, Employee E11 confirmed the observations and reported that Resident R39 was incontinent and has behavioral issues with her incontinence.</p> <p>On May 14, 2024, at 12:54 p.m. observation was confirmed by the Maintenance and Housekeeping Director, Employee E10 that there was strong urine odor by the second-floor nursing when facing to go into the dining room.</p> <p>On May 14, 2024, at 1:44 p.m. Resident R38's family interview revealed that facility was not clean, that a urine smell was present. Family member was wearing a surgical mask and reported that there was frequent urine odors at the facility and the conditions were unsanitary.</p> <p>On May 15, 2024, at approximately 11:15 a.m. room [ROOM NUMBER] had strong urine odor. Maintenance and Housekeeping Director, Employee E10 confirmed the odor.</p> <p>Observation of Resident R131's room on May 16, 2024 at 10:10 a.m. revealed broken blinds that did not open.</p> <p>Observation of Resident R66 on May 16, 2024 at 10:15 a.m. revealed stained windows and wall.</p> <p>Observation of Resident R56 and R29's room on May 16, 2024 at 10:20 a.m. revealed the privacy curtain between the beds was found to be stained.</p> <p>Interview on May 16, 2024 at 10:20 a.m. with Maintance Director, Employee E19 during above observations confirmed the above findings.</p> <p>28 Pa. Code. 207.2(a) Administrator's responsibility.</p> <p>28 Pa Code 201.18 (b)(3) Management</p> <p>28 Pa Code 214.15 Windows</p>