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	03/19/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, clinical record review and staff interview, it was determined that the facility failed to ensure that residents were afforded privacy related to the use of a telephone and medical assessment for two of 23 residents. (Resident R8 and Resident 82) Findings include: A review of the facility policy titled Resident's Rights and Facility Responsibilities Policy. last revised 09/30/2020 revealed, It is facility's policy to comply with all resident's rights, and to communicate these rights to residents and their designated representatives in a language that they can understand. Review of Resident R82's annual Minimum Data Set (MDS - a periodic assessment of care needs) dated March 4, 2026, revealed a Brief Interview for Mental Status (BIMS) of 3 which indicated that the resident cognition was severely impaired. On March 16, 2026, at 10:45 a.m., an observation was made of Resident R82 sitting in the dining room with approximately 15 residents, two staff members, and two otolaryngology consulting staff present, who were providing Ear, Nose, and Throat (ENT) evaluations to residents. Resident R82 received an evaluation in the dining room without privacy. It was observed that the otolaryngologist, Employee E4, approached Resident R82 and examined his/her ear and throat. On March 16, 2026, at 10:48 a.m., an observation was made with the Unit Manager, Employee E3, of the otolaryngologist, Employee E4, performing assessments in the dining room. Upon validation, the Unit Manager, Employee E3, contacted Employee E4 and notified them of the concern, after which Employee E4 ceased conducting assessments in the dining room. Review of Resident R8's annual Minimum Data Set (MDS - a periodic assessment of care needs) dated February 20, 2026, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact. On March 16, 2026, at 11:15 a.m., an observation was made of Resident R8 making a personal phone call using the dining room telephone on speakerphone. There were approximately 15 residents, two staff members, and two otolaryngology consulting staff present which did not afford privacy during a phone conversation. After Resident R8 finished the call, an interview was conducted. Resident R8 reported that she/he does not have access to private conversations because the telephone only has a speakerphone function. Resident R8 does not have a cell phone and does not have a telephone in her/his room. Resident R8 stated that the facility had previously provided a working phone line; however, it became broken and was never replaced. As a result, the entire conversation between Resident R8 and her family member was audible to others due to the phone only having a speakerphone function available. On March 16, 2026, at 11:26 a.m., an observation was made with the Unit Manager, Employee E3, who confirmed that the telephone in the dining room does not have a ringtone and only has a speakerphone function available. Additionally, it was validated with Resident R8 that there was no phone line available in Resident R8's room. Maintenance was contacted to repair the dining room telephone and to provide a functional telephone in Resident R8's room. On March 17, 2026, at 10:45 a.m., a Resident Council meeting was held with five alert and oriented residents (R11, R53, R65, R68, and R98). The residents reported that licensed nurses administer medications wherever they can catch you, including in hallways and the dining room. The residents also reported that they received dental screenings in the hallways. 28 Pa. Code 201.29(a) Resident Rights.

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical records, and facility documentation and policy, it was determined that the facility failed to ensure an investigation related to a resident's fall was complete and thoroughly investigated to rule out neglect for one 24 resident records reviewed (Resident R6). Findings include: Review of the facility's Fall Prevention and Management policy updated in February 2025, stated, Falls will be reviewed such review should include results of the new fall risk assessment, discussion with resident and/or any witnessing partied as to potential causal factors, review of the environment where the fall occurred and discussion as to any new interventions which may help to prevent further falls. Resident R6's clinical records revealed the resident was alert and oriented, admitted to the facility on [DATE], with chronic compression fracture (small breaks in your spine) recently hospitalized for weakness. The resident was care planned for incontinent of bowel and bladder needing one person to assist with toileting and a fall risk, that included, keeping the resident's bed in the lowest position and using proper footwear for safety. Review of Resident R6's progress notes indicated the resident had an unwitnessed fall and was found lying on the floor in the resident's room on December 20, 2025. Interview with the resident's daughter on March 17, 2026, at 10:20 a.m. stated that the resident would never get out of bed without calling for help. The resident told the daughter the resident put the call bell on and when no one came the resident attempted to get out of bed herself and fell on a wet floor. Interview with the resident immediately afterwards confirmed the daughter's allegations. Review of the facility's investigation revealed a witness statement was not obtained from the alert and oriented resident, instead a quote that indicated the resident stated, I was trying to get up and that the resident's undergarment was wet when found. In addition, the facility's investigation failed to include the environmental conditions when the fall occurred as a potential causal factor in the investigation. Interview with the Director of Nursing on March 19, 2026, at 10:00 a.m. confirmed the investigation was incomplete and agreed Resident R6 does use the call bell for assistants. 28 Pa Code 211.12(c) Nursing services28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for two of three residents observed during medication administration (R13, R124).Findings include: On March 17, 2026, at 9:51 a.m., observed that Employee E5, a Licensed Nurse, administered the medicine, Aspirin Tablet Chewable 81 milligrams (MG), to Resident R13. Review of physician order dated May 15, 2026, for R13, revealed an order to administer Aspirin Tablet Delayed Release 81 MG, by mouth one time a day. This represents administration of the incorrect medication formulation. March 17, 2026, at 9:53 a.m., review of Physician order revealed that R13 was signed onto hospice services with a hospice service provider, with a diagnosis of End Stage PVD (PVD stands for Peripheral Vascular Disease; End-stage Peripheral Vascular Disease is the most severe form of PVD, where blood flow to the limbs is critically reduced, causing pain at rest, non-healing wounds, or tissue damage (gangrene), and care is focused on comfort rather than cure). On March 17, 2026, at 9:51 a.m., observed that Employee E5, a Licensed Nurse, administered the medicine, Tamsulosin 0.4 mg, by mouth to Resident R13. Review of physician order dated May 15, 2026, for R13, revealed an order to administer Tamsulosin 0.4 mg, one Capsule, by mouth, in the evening for Elevated PVR. This represents incorrect medication administration. (PVR stands for Post-Void Residual, which refers to the amount of urine left in the bladder after a person has finished urinating. It's commonly measured to assess how well the bladder is emptying).Review of literature revealed as follows: Physicians usually prescribe Tamsulosin in the evening to reduce side effects and improve nighttime comfort. It can cause dizziness or a drop in blood pressure, so taking it at night helps you rest during these effects. It also relaxes the bladder to reduce nighttime urination (nocturia), improving sleep. Taking it after dinner ensures proper absorption and aligns its peak effect with sleep, while lowering the risk of daytime dizziness. At the time of the observation, interview with Employee E5 confirmed the above findings. On March 18, 2026, at 9:38 a.m., observed that Employee E6, a Registered Nurse, administered the medicine, Vitamin B-12, tablet by mouth to Resident R124, and R124 swallowed it. Review of physician order dated March 11, 2026, for R124, revealed an order to administer Cyanocobalamin (Vitamin B-12), 1000 mcg, tablet, sublingual. This represents incorrect medication administration. Review of literature revealed that Sublingual Vitamin B12 is used to bypass digestive barriers and low stomach acid, providing a fast, needle-free alternative to injections for better absorption. At the time of the observation, interview with Employee E6 confirmed the above findings.The facility incurred a medication error rate of 10.71%. Pa Code:211.12(d)(1)(2)(5) Nursing Services.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of resident records, it was determined that the facility failed to promptly notify physician of a change in residents' condition when radiology report confirmed positive for fracture for one of 23 records reviewed (Resident R6). Findings include: Resident R6's clinical records revealed the resident was alert and oriented, admitted to the facility on [DATE], with chronic compression fracture (small breaks in your spine) and recently hospitalized for weakness. The resident was care planned for incontinent of bowel and bladder needing one person to assist with toileting and a fall risk, that included, keeping the resident's bed in the lowest position and using proper footwear for safety. Review of Resident R6's nursing notes indicated the resident had an unwitnessed fall and was found lying on the floor in the resident's room on December 20, 2025 at 8:00 a.m. An order was received from on-call doctor to obtain an x-ray of 2 views of the resident's right Femur. (thigh bone) Review of Resident R6's x-ray results dated December 20, 2026, indicated a right femoral neck fracture (hip fracture). Further review of Resident R6's progress notes indicated the resident was transferred to the hospital on December 23, 2026, due to the resident's hip fracture. Interview with the Director of Nursing on March 16, 2026, at 1:30 p.m. indicated nursing failed to inform the physician of the resident's fracture until December 23, 2026. 28 Pa Code 211.12(c) Nursing services28 Pa Code 211.12(d)(1)(5) Nursing services