

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395634	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Souderton Mennonite Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 207 West Summit Avenue Souderton, PA 18964	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to develop and/or implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of five sampled residents. (Resident 1) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included a history of falls, muscle weakness, and lack of coordination. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident used a motorized wheelchair. Review of a therapy Discharge summary dated [DATE], revealed that the resident required distant supervision when using his motorized wheelchair outdoors. Further review of the clinical record revealed that the resident left the nursing unit daily to visit with his wife in another level of care in the building and staff were aware. Review of the care plan revealed that the resident was non-compliant with requesting staff supervision to use his motorized wheelchair outside. In an interview on October 27, 2025, at 10:57 a.m. the Director of Nursing confirmed that the resident was not compliant with requesting supervision with use of his motorized wheelchair outdoors. There was a lack of documented evidence that the facility developed an individualized care plan to meet the resident's need for supervision and implemented interventions to address his continued non-compliance with notifying staff when he desired to leave the building. 28 Pa. Code 211.12(d)(1)(3)(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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