STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395329	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Hood Dunwoody Care Ctr	3500 West Chester Pike Newtown Square, PA 19073

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to notify the physician of a change in the condition of a resident's urinary status for one of the three residents reviewed (Resident 39). Findings include: A review of the facility's policy titled Change in Resident status Notification, revised on May 17, 2023, revealed that the charge nurse will notify the resident's physician or on-call physician when there has been a significant change in the resident physical/mental/emotional condition, and a need to alter the resident's medical treatment. Notification will be made promptly with the exemption of non-emergency incidents on the 11-7 shift. Notification of non-emergent incidents on the 11-7 shift may be passed on to the 7-3 shift for a morning notification. Clinical record review revealed Resident 39 had an Indwelling Urethral Catheter (A thin, flexible tube inserted into the bladder through the urethra to collect and drain urine) for diagnosis of urinary retention and neuromuscular dysfunction of the bladder. A review of the Resident laboratory report dated March 5, 2025, revealed a normal WBC (White Blood Cell count) result (Normal range 4.8-10.8). (a blood test that measures the number of white blood cells in your blood, helping to identify infections, inflammation, and other conditions.) A review of the nursing progress notes dated March 9, 2025, at 1:47 a.m., revealed that during the start of the shift, resident's family member reported feeling something was off with the resident. Further assessment revealed no urine output in the urine drainage bag, but the resident's brief was wet twice. The same note revealed that the catheter (tube) was outside the body more than normally should be. The same note revealed the following, Indwelling cath (catheter) removed and new 18Fr/10cc (size of the tube) placed with immediate [NAME] red bloody urine, then odorous amber colored urine, ending with tan sludge - 1700 cc. The responsible party was notified. The review of the clinical records failed to reveal that the physician was notified of the significant change in the resident's urinary status and change in the condition of urine. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's note dated March 13, 2025, at 4:55 p.m., revealed that during the visit, the resident was noted to be somnolent (sleepy, lethargic, drowsy), not as vocal as his baseline. The condition was discussed with the wife and nursing, urine, and blood work was ordered. A review of Resident 39's blood work dated March 15, 2025, revealed WBC was 21.6 and the urine had (+) 3 Leucocytes (indicative of a urinary tract infection). Urine culture and sensitivity (test to determine the kind of bacteria causing the infection and the antibiotics that are effective against the bacteria) were pending. Clinical records review revealed that the physician was notified of the laboratory result and ordered to start the Resident with Macrobid (antibiotic) 100mg twice daily for seven days while waiting for the culture and sensitivity. The physician's order was followed. An interview was conducted with the Director of Nursing on April 4, 2025, at 10:00 a.m. The DON confirmed that there was no documented evidence that the physician was notified when Resident 39 had 1700 cc of bloody, with tan sludge and odorous urine output on March 9, 2025. The facility failed to ensure physician was notified of Resident 39's significant change in urinary status resulting in a delay in treatment. 28 Pa Code 211.10(c) Patient care policies Previously cited 5/3/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 5/3/24

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical records review and staff interview, it was determined that the facility failed to ensure wound treatment for a pressure ulcer was provided for one of five residents reviewed (Resident 39). Findings include: A review of the nursing progress notes dated March 13, 2025, at 7:40 a.m., revealed that a new DTI (Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration) was observed on the resident's left lower back. The wound was cleansed with a wound cleanser and Desitin (An ointment used to treat and prevent a rash) was applied. The Nurse practitioner was notified. A review of the skin assessment dated [DATE], revealed a DTI to the left lower back measuring 8.9 x 4.5 cm (centimeters). A review of Resident 39's March TAR (Treatment Administration Record) failed to reveal a wound treatment was done for the identified DTI on the resident's left lower back from March 14, 2025, until the time the resident was sent to the hospital for an abnormal laboratory result on March 17, 2025. An interview with the DON (Director of Nursing) conducted on April 4, 2025, at 10:00 a.m., confirmed that there was no documented evidence that the Resident's identified DTI to the left lower back on March 13, 2025, was treated from March 14, 2025, until March 17, 2025. The facility failed to ensure wound treatment was provided for Resident 39's DTI to the left lower back. 28 Pa Code 211.10(c) Patient care policies Previously cited 5/3/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 5/3/24

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to ensure a significant weight change was timely addressed for one 10 residents (Resident 42). Findings include: A review of the facility's policy titled Weights, last revised on October 11, 2024, revealed the facility will have the residents' weights monitored as an indicator of their health and wellness. Residents will be weighed weekly for a total of four weeks to monitor health status. Weights will be reviewed by the nurse and dietitian. Weights that are three pounds greater than or less than the resident's prior weight will be reweighed within 24 hours to verify accuracy. Weights that are less than 5% of the previous weight will be reported to the physician and noted on the resident record. A plan of care will be developed to address residents with weight concerns. Clinical records review revealed resident was admitted to the facility on [DATE], with a diagnosis of Dementia (A term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), and Dysphagia (Difficulty in swallowing). A review of the resident nutritional care plan initiated on December 30, 2024, revealed: Screening Score 7-Malnourished (Resident 42) have the potential for continued alteration in nutrition r/t (relate to) history of dysphagia. Interventions include monitoring the need for the addition of appropriate high-calorie/protein house supplements within the limits of the therapeutic diet order. A review of Resident 42's weights revealed an admission weight of 122.6 pounds on December 27, 2024. Weekly weights were done with the following result: 124.3 pounds on December 31, 2024, 124 pounds on January 1, 2025, and 116.8 pounds on January 10, 2025, an 8.8 pounds (5.81%) weight loss in five days. Clinical record review failed to reveal that the resident was reweighed within the 24-hour period to verify the significant weight loss. There was no documented evidence that a nurse and/or the dietitian reviewed the resident's identified weight loss. There were no interventions put in place to prevent further weight loss. There was no documented evidence that the physician was notified of the significant weight loss until January 30, 2025. A review of Resident 42's weight and vitals revealed a weight of 113.6 on March 24, 2025, a 7.34 % weight loss from admission. There were no interventions put in place upon identifying further weight loss within tthree-month period from December 27, 2024, until March 24, 2025. An interview with the Dietitian and the DON (Director of Nursing) conducted on April 4, 2025, at 11:00 a.m., confirmed that there were no interventions put in place for the significant weight loss identified on January 10, 2025, and further weight loss from admission identified on March 24, 2025. The facility failed to ensure Resident 42's significant weight loss was addressed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.10(c) Patient care policies Previously cited 5/3/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services Previously cited 5/3/24