

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowcrest		STREET ADDRESS, CITY, STATE, ZIP CODE Albert Einstein Med Ctr Philadelphia, PA 19141	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include: Observations conducted on December 29, 2025, at 9:56 a.m. with the Food Service Director (FSD), Employee E4, and Chef, Employee E5, in the main kitchen revealed food items were improperly labeled, undated, uncovered, or stored in a manner that could lead to contamination. Observations in the main refrigerator revealed blue cheese (2lbs- pounds) that was undated and additional 3 lbs. without a use-by-date; 3lbs of Monterey [NAME] cheese with no date; 5 lbs. [NAME] cheese with use-by dates of 12/12 and 12/30; 5lbs [NAME] cheese that was undated; mild cheddar slices that were opened, exposed, and undated; and Swiss cheese that was opened and undated. Continued observation revealed three 4-8 lb. bags of beef vegetable soup without thaw or pull dates, and approximately 70 lbs. of roast beef (10 pieces) were observed stored uncovered. Raw turkey was observed leaking red fluid and was undated. Continued observations of the main freezer revealed shrimp with ripped-open packaging and exposed product, with freezer burn present. The shrimp was stored on the lowest rack, with poultry stored above it and beef stored above vegetables, creating a risk for cross contamination. Interview with the Food Service Director, Employee E4, and Chef, Employee E5, throughout the kitchen tour confirmed the above-mentioned findings. 28 Pa. Code 201.14(a) Responsibility of licensee		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that the residents and/or their representative received written notice notifying them of the transfer and the reason for the move in writing and in the language and manner they understood for one of three closed records reviewed (Resident R50).Findings include: Review of Resident R50's medical records revealed that on December 11, 2025, the resident was admitted to the hospital for shortness of breath. Continued review failed to reveal documentation of a written notification to the residents or resident's representative notifying them of the transfer and the reasons for the move in writing. Interview with the facility administrator, Employee E1 on January 5, 2026, at 1:00 p.m. confirmed this finding. Continued interview with the facility administrator, Employee E1 on January 5, 2026, at 1:05 p.m. confirmed the above-mentioned findings and stated that it is not facility practice providing the residents and/or their representative with a written notice for transfers. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, review of clinical records, and staff interviews it was determined that the facility failed to review and revise a resident care plan with new interventions status prior and post a fall incident for one of 12 residents reviewed (Resident R24). Findings include: Review of facility policy titled Resident Assessment and Plan of Care revised July 2018 states the process of systematically reviewing a resident's physical functional mental and psychological status to identify strengths and weaknesses for which the interdisciplinary team can develop a plan of care for each resident. Review of the November 20, 2025, therapy note assessed Resident R24 with impairments and limitations with the resident's ADL's (activities of daily living), bed mobility, cognitive, decreased knowledge of condition, decreased knowledge of precautions, and safety awareness. Therapist noted that the resident tended to favor the resident's left side (weak side). To incorporate bed mobility and safe positioning in bed, the nursing staff were notified to use a wedge pillow with dycem mat positioned on the left side in bed and fall mat on the resident's right side. Review of Resident R24's care plan was not revised and updated to include these new interventions. Further review of Resident R24's clinical record revealed that on December 9, 2025, nursing note indicated that Resident R24 was in bed using the bed pan and the resident fell out of the bed onto the floor. During an interview with the Director of Nursing (DON), Employee E2 on December 31, 2025, at 11:00 a.m. stated that after the fall the new intervention was for the staff to stand nearby while being toileted. Further review of Resident R'24's care plan revealed the facility failed to develop and implement interventions in accordance with the resident's assessed needs, goals for care, and failed to recognize standards of practice that addressed Resident R24's identified limitations and revised the care plan appropriately. Interview with the DON, Employee E2 on January 2, 2026, at 10 a.m. confirmed there was no documented evidence that the facility reviewed and revised Resident R23's care plan based upon the therapist assessment and failed to address new interventions that related to the residents fall. 28 Pa. Code 211.10 (d) Resident care policies.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility documentation and interview with staff, it was determined that the facility failed to ensure an incontinent resident who was unable to carry out activities of daily living received the appropriate services with toileting for one of 12 resident records reviewed (Resident R24). Findings include: Review of Resident R24's occupational therapy (OT) assessment notes dated November 20, 2025, revealed the resident was admitted to the facility on [DATE], with a history of traumatic intracranial hemorrhage (bleeding in the brain), right Middle Cerebral Artery (aka MCA stroke) in October 2025 which left the resident with left residual weakness and left sided body pain. The therapist assessment indicated the resident's impairments included impaired safety/judgment, and functional communication impairments, that included Dysarthria, (speech disorder leading to slurred or low speech) and aphasia (a language disorder caused by brain damage). The same assessment noted Resident R24 with complaints of leg pain and increased pain 10 out of 10 after gentle stretching when therapist positioned the residents lower left leg in relation to bed mobility while cleaning and diaper changing in bed. Physical Therapy note dated November 19, 2025, assessed the resident as dependent with bed mobility, rolling, going from sitting to lying and lying to sitting on the edge of bed required the assistance of 2 or more helpers. The same note noted the resident had profound left side pain to light touch and pressure when rolling, scooting, and repositioning in bed. Details of the speech therapy note dated December 4, 2025, stated Resident R24 was seen up in a wheelchair, grimacing, fidgeting appeared in pain. The therapist attempted to have the resident use the call button to request help but required repositioning of call button two times to accurately grip and call. Speech therapy note dated, December 9, 2025, indicated the resident appeared in pain and needed repositioning. Nursing Aide (NA) Employee E8 re-adjusted the resident to improve the resident's positioning and comfort. The resident later in the note told the therapist, the resident needed to use the toilet and wanted to use the bathroom. The therapist indicated that Nurse aide Employee E8 told the therapist that the resident could Go and be changed after. The therapist noted that Nurse aide, Employee E8 put the resident on the bedpan at end of the session. Immediately after, a nursing progress note indicated the resident was in bed using the bed pan at that time and fell out of the bed, onto the floor. During an interview on January 5, 2026, at 10:00 a.m. with Employee E8 explained that when the therapist told the Nurse aide, Employee E8 the resident needed to go to the bathroom, to the Nurse aide, Employee E8, it appeared to be an emergency, so she said she went to get the bedpan. The NA said by the time she came back with the bedpan the therapist had already left. Surveyor asked the NA if the resident normally uses the bedpan when toileted. NA replied, No, and it confused me because she is incontinent. I would normally just change her after she soiled her brief. I put her on the bedpan by myself. She was crying out in pain when I was trying to sit her upright on the bedpan. Every little movement normally hurts the resident, and she moans a lot in pain. I left her for 5-10 minutes with the call bell on her stomach. She was still making moaning sounds like she was uncomfortable on the bedpan when I left. After 5-10 minutes I came back and heard she was on the floor. January 5, 2026, at 10:30 a.m. during an interview with Resident R24's son stated he went to see the resident immediately after the fall. He told the surveyor she wasn't hurt but she repeatedly said to him, 'Bedpan hurt, bedpan hurt.' Interview with the Director of Nursing (DON) on January 5, 2026, at 11:00 a.m. indicated he was one of the first staff members in Resident R24's room after the fall. The DON stated the resident was attempting to get off the bedpan herself. The resident told the DON she could not find the call bell, but the DON did notice it was hanging off the bed after the fall. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa code 211.12.(d)(1)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records and interviews with staff, it was determined that the facility failed to ensure care and treatment were provided in accordance with physician orders for one of 12 residents reviewed. (Resident R3) Findings Include: Review of resident R3's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including fractures, foot drop (inability lifting the front part of the foot). The resident was assessed with a BIMS (Brief Interview of Mental Status) score of nine, indicating moderate cognitive impairment. Continued review of Resident R3's clinical records revealed a physician order dated December 1, 2025, for multipodus boots to left foot drop (orthopedic positioning boots used to protect and properly align the foot and ankle). The physician order failed to indicate parameters for use, including duration, timing, and conditions for use of the multipodus boots. Interview conducted on December 30, 2025, at 11:20 a.m. with registered Nurse, Employee E6, revealed that the resident was not wearing the ordered boots because she doesn't like them, and the nurse was unfamiliar with specific order details or when the boots were to be applied. Observations conducted on December 30, 2025, revealed the resident at bedside wearing a sneaker and leg brace, with no multipodus boots present in the room or readily available. Interview with the Physical Therapy Manager, Employee E7, conducted on January 5, 2026, at 9:51 a.m. revealed the resident was using a leg brace and sneaker as part of a therapy trial; however, Employee E7 was unsure of the specific physician order requirements related to the multipodus boots. Follow-up interview with Physical Therapy Manager, Employee E5 via electronic communication, confirmed that the multipodus boots were intended to be worn at night, according to the physician. Further review of clinical record failed to reveal documentation that the resident was provided or wore the multipodus boot at any time. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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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. Based on review of facility policy, review of clinical records, and staff interview, it was revealed that the facility failed to assess and implement interventions to ensure acceptable parameters of nutritional status for one of 2 residents reviewed for nutrition (Resident R16). Findings include: Review of facility policy, Height and Weight Protocol dated January 1, 2025, revealed that upon admission, residents' weight and height will be recorded and residents with a weekly weight gain or weight loss of five pounds will be re-weighed. Review of Resident R16's clinical records revealed that on December 12, 2025, the resident's admission weight was documented as 94 pounds. A follow-up interview conducted on January 2, 2026, at 11:20 a.m. with Registered Dietitian (RD), Employee E3, revealed that the admission weight of 94 pounds was not transcribed into the system and was therefore not referenced by the nutrition services team when assessing Resident R16's weight changes. Continued record review revealed that on December 17, 2025, Resident R16's weight was documented as 104.7 pounds, representing an 11.38% (or 10.7 pound) weight gain in five days when compared to the admission weight. Despite this significant weight gain, continued review of the medical record and interview with the RD, Employee E3, conducted on January 2, 2026, at 11:25 a.m. confirmed that no reweight was completed after December 12, 2025, to validate the accuracy of the weight, and the significant weight change was not addressed or evaluated by the nutrition services team. Continued review of clinical records for Resident R16 failed to reveal evidence of reconciliation of the significant weight gain or confirmation of accurate baseline weights. Follow-up interviews with Registered Dietitians, Employee E3 and RD Employee E4, conducted on January 5, 2026, at 11:30 a.m. confirmed failure to identify and investigate the significant conflicting weight change, and to ensure accurate weights were used to guide nutritional assessment and interventions for Resident R16. 28 Pa. Code 211.5 (f) Clinical records 28 Pa. Code 211.6 (d) Dietary services 28 Pa. Code 211.12 (c)(5) Nursing Services		