

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Willows of Presbyterian Senior		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Hulton Road Oakmont, PA 15139	

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 0689</p> <p>Level of Harm - 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>Based on review of facility policy and documents, clinical record, and staff interviews, it was determined the facility failed to ensure that residents received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a patella (knee) fracture, for one of two residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy, Skilled Nursing - Investigation of incidents update August 2024, indicated the purpose is to establish guidelines for investigations of incidents and accidents to determine the root cause of the event and to identify systemic changes and measures needed to prevent future incidents. The facility will conduct a thorough and timely investigation of incidents and accidents. If the accident/incident is related to resident care, in order to decide whether or not to substantiate abuse/neglect, begin by establishing the facts of the situation.</p> <p>Review of the clinical record indicated Resident R1 was admitted to facility 4/7/2020.</p> <p>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/4/25, included diagnoses epilepsy (brain condition that causes reoccurring seizures), history of falls, and muscle weakness. Section C0500 the Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact. Resident 1's score of 15.</p> <p>Review of Resident R1's clinical record progress note date 4/7/25, at 1:55 p.m., indicated CNA (nurse aide) came to this nurse due to resident complaining of pain. Resident stated that the driver was transferring her off the van and her left leg fell off the footrest and her left leg dragged under the wheelchair, and she told him to stop, and he keep pushing her in the wheelchair and she then came back to the facility and keep feeling the pain in her left leg. This nurse contacted CRNP (certified registered nurse practitioner) to obtain x-ray on the left leg tib (tibia), fib (fibula), knee.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility submitted information dated 4/8/25, indicated, Resident R1 was complaining of left leg pain. Resident R1 stated her leg fell off the leg rest and got caught under the wheelchair during transport from her audiology appointment earlier in the day. The driver accidentally dragged her foot under the wheelchair causing her to say, ouch, stop. The knee was painful to touch and slightly swollen. CRNP was notified and ordered imaging. Imaging showed a patella fracture to left leg. Order obtained to send Resident R1 to the hospital for evaluation. The driver stated, her leg fell off the footrest and he didn't notice. He also stated that he did not realize she was hurt so he did not notify anyone.</p> <p>Review of facility provided document dated 4/7/25, indicated that Van Driver (VD) Employee E1 was transporting Resident R1 back to the facility from an appointment. He (Employee E1) took her (Resident R1) down the lift with no issue. After getting into building, Resident R1 said Ouch, which alerted Employee E1 to stop and see what the issue was; he noticed that the footrest had fallen off and that her (Resident R1) left leg was caught under the wheelchair. He (Employee E1) pulled the wheelchair backwards to get her leg free. He picked up the footrest, placed it back on the wheelchair, and put her (Resident R1) foot back on the footrest.</p> <p>Review of an employee statement written by Receptionist Employee E2 dated 4/17/25, indicated that Resident R1 was coming from an appointment. As the driver was pushing her through the first set of sliding doors, a scream of pain was heard. The second set of doors opened, and a bystander stopped them and put her foot back on the footrest; it was bent under the footrest. Resident R1 told him (VD Employee E1) that she was okay, and they went to the elevator.</p> <p>Review of facility provided document dated 4/7/25, indicated a diagnostic X-ray (medical imaging used to capture pictures of the inside of the body, particularly the bones) was completed of the left knee revealing a mid-patella fracture.</p> <p>Review of emergency room documentation dated 4/8/25, indicated that Resident R1 was treated for acute nondisplaced transverse fracture inferior patella of the left leg.</p> <p>Review of Resident R1's clinical progress note dated 4/8/25, at 4:28 a.m., indicated resident returned from hospital. Left leg in locking brace. Discharge instructions reviewed and approved by physician services.</p> <p>During an interview on 5/8/25, at 2:30 p.m., the Nursing Home Administrator (NHA) and the Director of Nursing (DON) confirmed that the facility failed to ensure that residents received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a patella fracture, for one of two residents reviewed (Resident R1).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p>		