STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395713	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Presbyterian Senior	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on a review of facility policies, documents and staff interviews it was determined that the facility failed to report to the State agency an allegation of misappropriation of resident property as required. (Allegation of misappropriation of resident property). Findings include: A review of facility Skilled Nursing - Abuse policy dated 8/24, revealed that the purpose of the policy is to comply with the seven step approach to abuse and neglect detection and prevention. Abuse is defined to include misappropriation of resident property. Step seven of the approach includes reporting the allegation to the proper agencies. During a review of facility documents submitted to the state agency it was revealed that the facility failed to notify the state agency of allegations of facility staff improperly destroying medications no longer prescribed for the resident as required. During a staff interview on 5/21/25 at 9:00 am the Nursing Home Administrator and Director of Nursing revealed that they were aware of allegations of staff members inappropriately destroying resident medications. The facility began an investigation into the allegation and developed new procedures for the destruction of medications no longer prescribed for the resident but failed to report the investigation to the state agency. During a staff interview on 5/21/25, at 9:00 am the Director of Nursing confirmed that the facility failed to notify the state agency of allegations and an investigation of the allegation for improper destruction of resident medications (misappropriation of resident property) as required. Pa Code: 201.14(a)(c) Responsibility of licensee Pa Code 201.20(b) Staff development

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to make certain exit seeking/wandering residents had a person-centered care plan individualized to each specific resident's needs for eight of 35 residents identified as high risk for wandering/elopement (Residents R1, R2, R3, R4, R5, R6, R7, and R8). Findings included: Review of the facility policy Skilled Nursing-Comprehensive Care Plans dated August 2024, indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. Review of the facility Elopement Process dated August 2024, indicated an elopement device should be placed if the resident scores a one or above on the elopement evaluation and are an elopement risk. Review of the admission Record indicated Resident R1 was admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), atrial fibrillation (irregular heart rhythm), and history of falling. Review of Resident R1's Elopement Evaluation Form dated 5/13/25, at 11:08 a.m. indicated resident wanders aimlessly or non-goal directed: Yes. Is the Resident's wandering behavior likely to affect the safety or well-being of self/others: Yes. Wandering behavior likely to affect the privacy of others: Yes. Elopement score of five. Review of the admission Record indicated Resident R2 was admitted to the facility on [DATE], with the diagnoses of dementia, repeated falls, and depression. Review of Resident R2's Elopement Evaluation Form dated 5/20/25, indicated resident wanders aimlessly or non-goal directed: Yes. Wandering behavior likely to affect the privacy of others: Yes. Elopement score of two. Review of the admission Record indicated Resident R3 was admitted to the facility on [DATE], with diagnoses of dementia, high blood pressure, and insomnia (a sleep disorder where individuals experience difficulty falling asleep, staying asleep or both, leading to daytime impairment). Review of Resident R3's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/10/25, indicated the diagnoses remain current. Review of Resident R3's Elopement Evaluation Form dated 4/22/25, indicated Does the resident have a history of elopement or an attempted elopement while at home: Yes. Does the resident have a history of elopement or attempted leaving the facility without informing staff: Yes. Does the resident wander: Yes. Elopement score of three. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Record indicated Resident R4 was admitted to the facility on [DATE], with diagnoses of high blood pressure, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R4's MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R4's Elopement Evaluation Form dated 4/1/25, indicated Does the resident have a history of elopement or an attempted elopement while at home: Yes. Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Elopement score of two. Review of the admission Record indicated Resident R5 was admitted to the facility on [DATE], with diagnoses of anemia (the blood doesn't have enough healthy red blood cells), hyperlipidemia (high levels of fat in the blood), and depression. Review of Resident R5's MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R5's Elopement Evaluation Form dated 4/3/25, indicated Does the resident have a history of elopement or attempted leaving the facility without informing staff: Yes. Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Does the resident wander: Yes. Does the resident wander aimlessly or non-goal-directed (i.e. confused, moves with purpose, may enter others' rooms and explore others' belongings): Yes. Elopement score of four. Review of the admission Record indicated Resident R6 was admitted to the facility on [DATE], with diagnoses of heart failure (heart doesn't pump blood as well as it should), insomnia, and hyperlipidemia. Review of Resident R6's Elopement Evaluation Form dated 5/12/25, indicated Does the resident wander: Yes. Elopement score of one. Review of the admission Record indicated Resident R7 was admitted to the facility on [DATE], with diagnoses of coronary artery disease (narrow arteries decreasing blood flow to heart), high blood pressure, and heart failure. Review of Resident R7's MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R7's Elopement Evaluation Form dated 4/26/25, indicated Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Does the resident wander: Yes. Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.): Yes. Elopement score of three. Review of the admission Record indicated Resident R8 was admitted to the facility on [DATE], with diagnoses of anemia, high blood pressure, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Resident R8's MDS dated [DATE], indicated the diagnoses remain current. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R8's Elopement Evaluation Form dated 3/3/25, indicated Does the resident have a history of elopement or attempted leaving the facility without informing staff: Yes. Does the resident wander: Yes. Does the resident wander aimlessly or non-goal-directed (i.e. confused, moves with purpose, may enter others' rooms and explore others' belongings): Yes. Elopement score of three. Review of eight of eight exit seeking/wandering resident care plans mimicked each other and did not identify any resident person-centered interventions and/or goals specific to each resident. -Resident R1's care plan dated 5/13/25. -Resident R2's care plan dated 5/20/25. -Resident R3's care plan dated 5/21/25. -Resident R4's care plan dated 4/2/25. -Resident R5's care plan dated 4/3/25. -Resident R6's care plan dated 5/15/25. -Resident R7's care plan dated 5/21/25. -Resident R8's care plan dated 5/14/25. Eight of eight resident care plans had almost identical goals of the following: -The resident's safety will be maintained through the review date. -The resident will demonstrate happiness with daily routine through the review date. -The resident will not leave facility unattended through the review date. Eight of eight resident care plan interventions had almost identical interventions of the following: -Assess for fall risk -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book resident prefers: -Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. -Monitor for fatigue and weight loss. -Provide structured activities; toileting walking inside and outside, reorientation strategies including signs, pictures and memory boxes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/23/25, at 11:30 a.m. the Director of Nursing confirmed the facility failed to make certain exit seeking/wandering residents had a person-centered care plan individualized to each specific resident's needs for eight of 35 residents identified as high risk for wandering/elopement (Residents R1, R2, R3, R4, R5, R6, R7, and R8). 28 Pa. Code 201.24(e)(1)-(5) Admissions Policy 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). This failure created an immediate jeopardy situation for one of 35 residents (Resident R1) identified as high risk for wandering. Findings include: Review of the facility policy Elopement Process dated August 2024, indicated an elopement assessment is completed upon admission, quarterly, annually, and if a resident actively attempts to elope. If they score a one or above on the elopement risk assessment an elopement device (alarm to alert staff of a resident going beyond a safe area), should be placed. Review of the facility policy Skilled Nursing- Elopement dated August 2024, indicated staff shall investigate and report all cases of missing residents. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. Review of the admission Record indicated Resident R1 was admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), atrial fibrillation (irregular heart rhythm), and history of falling. Review of the clinical admission V-19 form dated 5/10/25, at 10:17 p.m. indicated level of cognitive impairment as mild impairment (some confusion). Review of Elopement Evaluation Form dated 5/10/25, at 10:42 p.m. indicated that Resident R1 had an elopement score of zero. Not at risk. Review of Resident R1's progress note 5/12/25, at 3:09 p.m. indicated resident up ambulating (walking) with walker going into other resident rooms. Opening stairwell door. Redirected multiple times. EPD (elopement protection device) placed for safety. Review of Elopement Evaluation Form dated 5/13/25, at 11:08 a.m. indicated resident wanders aimlessly or non-goal directed: Yes. Wandering behavior likely to affect the safety or well-being of self/others: Yes. Wandering behavior likely to affect the privacy of others: Yes. Elopement score 5. Review of physician orders dated 5/13/25, indicated wander guard (EPD) check function every day and placement every shift. Review of Resident R1's care plan dated 5/13/25, indicated resident is an elopement risk/wanderer. EPD applied to left upper extremity. Disoriented to place, impaired safety awareness, wanders aimlessly, significantly intrudes on the privacy or activities of others. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident R1's progress notes indicated the following: -5/13/25, at 8:32 p.m. thinking orientation: Person. Mental status: pleasant. Smiling delusions (misconceptions or beliefs that are firmly held, contrary to reality) Wandering. Ambulates with front wheeled walker and assist of one. Assist of one for all activities of daily living. Wanders aimlessly, exit seeking at times, in other resident's rooms. EPD in place. -5/14/25, at 9:36 a.m. thinking orientation: Person. Mental status: pleasant smiling delusions wandering. Wanders aimlessly, exit seeking at times, in other resident's rooms. EPD in place. -5/15/25, at 9:34 a.m. Thinking orientation: Person. Mental status: pleasant smiling delusions wandering. Wanders aimlessly, exit seeking at times, in other resident's rooms. EPD in place. -5/15/25, at 7:10 p.m. called to front lobby by Licensed Practical Nurse (LPN) Employee E1 who reports Resident R1 was found in parking lot walking with wheeled walker. When resident was found, EPD alarm was going off and the front door was pushed open. Resident was assessed, no injuries apparent. Weather at the time of occurrence was 72 degrees and sunny. Resident had no complaints of pain or discomfort. Appeared at baseline. On Call supervisor notified, physician ordered immediate transfer of resident to the fourth-floor dementia unit (a secure unit). -5/15/25, at 9:59 p.m. resident was seen in the parking lot of facility by a staff member about 7:00 p.m. with her front wheeled walker. She was redirected into the building. Elopement device intact and active at the time. Resident transferred to the lock down unit afterwards for safety. Resident's Son notified. Review of facility provided documentation dated 5/15/25, indicated Resident R1 was found in the front parking lot with her walker. Upon investigation the resident had an EPD on. The front entrance sliding doors where she exited were alarming and ajar as resident forced them open and off the hinges. The community's EPD system prevents the sliding doors from opening if the alarm sounds, but as they are also fire doors, they are able to be pushed open with force in case of emergencies. Entrance doors were pushed open and off hinges which showed this occurred. Resident was last seen by NA Employee E2 at 6:45 p.m. Further review of Resident R1's care plan dated 5/16/25, indicated the resident has impaired cognitive dementia, low safety awareness, has attempted to elope, wanders, need for locked memory unit. Review of Nurse Aide (NA) Employee E2's undated witness statement indicated he took Resident R1 back to her room at 6:45 p.m. while cleaning up after dinner. Placed her call bell, pinned to her shirt, in her room watching TV. Then, NA Employee E2 went on to care for other residents. Review of LPN Employee E1's witness statement dated 5/16/25, at 8:49 a.m. indicated at approximately 7:10 p.m. the front door was alarming. She turned off the alarm and noticed one of the sliding doors was pushed open. She looked outside and observed a resident walking in the parking lot and noticed an EPD on resident's walker. She redirected resident back inside the facility. When asked her name, the resident indicated an incorrect last name. Supervisor notified of both lobby and patio sliding doors being pushed open. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephonic interview on 5/22/25, at 11:10 a.m. LPN Employee E1 indicated she was coming down off the elevator, heading towards the lobby. When she turned the corner, she could hear the alarm and proceeded to the front door where she saw Resident R1 outside with a EPD device. She indicated she did not hear the alarm until she turned the corner. When asked if she could hear the alarm at the nursing unit, she indicated no. Interview on 5/22/25, at 11:30 a.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide adequate supervision for one resident resulting in elopement and the failure created an immediate jeopardy situation for one of 35 residents (Resident R1) identified as high risk for wandering. On 5/22/25, at 11:40 a.m., the Nursing Home Administrator was made aware that Immediate Jeopardy (IJ) existed and was provided the IJ Template at that time and a corrective action plan was requested. On 5/22/25, at 3:40 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: Resident R1 was moved immediately to the fourth-floor secured neighborhood after incident occurred on 5/15/25. Resident R1 was assessed for any injuries or psychosocial effects from incident, there were none. Physician and family were notified, care plan was reviewed and person-centered interventions were put into place. Administrator and Director of Nursing (DON) met with family the following day to review plan of care and interventions in place to reduce likelihood of reoccurrence. Residents: All residents in the facility will be assessed by the nursing team for elopement risk using the elopement evaluation tool within the electronic health record by 5/23/25. After all residents are assessed for elopement risk, their care plans will be audited by the nursing team or designee to ensure measurable, person-centered goals and interventions are implemented to prevent residents from eloping by 5/23/25. Root cause of elopement - due to team's lack of supervision, Resident R1 was able to elope outside of front entrance. On 5/16/25, vendor who oversees EPD system came in to ensure system functioned appropriately. Vendor installed four kiosks (One iPad kiosk in the neighborhood and three larger screens mounted on wall in each hallway) on each neighborhood that will audibly alarm in the event that a resident with an EPD is within range. This range was also expanded at this time to alert much earlier before the resident can get to the front entrance. Previously, this did not exist, and the audible alarm would be heard at the front of the building only. Moving forward, kiosks on each neighborhood were changed to ensure that they will alarm in the event that a resident with an EPD device gets in range of the front entrances and exits. System Correction: For any resident exhibiting new wandering behaviors, they will be placed on 15-minute checks by nursing team or designee. This will be documented within the electronic health record by the nursing team by 5/23/25. Physicians will be notified of their residents who are at wandering/elopement risk to collaborate for further interventions by 5/23/25. Administration will review and update policies to identify residents who are at risk for eloping by 5/23/25. A system check was completed on 5/21/25, by maintenance and administration to ensure entrances and exits alarms are functioning as intended. Vendor was contacted to install delayed egress feature on remaining stairwell doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitoring: Whole house staff will be educated by the DON/designee on elopement risk and assessments, person-centered care plans, and supervision of residents before the start of their next shift. Ongoing audits will be completed to ensure residents are appropriately assessed for elopement risk, placed on proper safety checks, and person-centered care plan for elopement is implemented. This will be audited daily by DON/designee for seven days a week for two weeks, five days a week for two weeks and three days a week for two weeks. This incident will also be brought to Quality Assurance Performance Improvement meeting to review and prevent further incidents of this nature. Review of facility's Corrective Action Plan was verified and completed on 5/23/25, at 10:58 a.m. as follows: -Resident R1 was moved to the Fourth-floor secured neighborhood after elopement 5/15/25. -Resident R1 was assessed for injury and psychosocial effects with no new findings. -Physician and family were notified. -Care plan reviewed and person-centered interventions were put into place. Administrator and DON met with son to review the plan of care and interventions to reduce likelihood of recurrence. -All residents, 172 of 172, were re-assessed for elopement using the Elopement Evaluation within the electronic health record. Seven new wandering behavior residents were identified through this process. -Care plans for 172 of 172 residents were audited for measurable person-centered goals, and interventions were implemented to prevent residents from eloping. -Root cause of elopement was due to the team's lack of supervision. -Wander guard system was checked by the vendor to ensure functionality. Vendor installed four kiosks (one iPad in the neighborhood and three larger screens mounted on the wall in each hallway) that will audibly alarm in the event that a resident with a wanderguard was within range of the front entrance. -Prior to this installation, the audible alarm would only be heard if staff were in the front lobby. -All wandering/exit seeking residents' providers were updated 5/22/25, with a list of their respective residents who have been identified as wanders to ensure their collaboration is current. -Residents exhibiting new wandering behaviors will be placed on 15-minute checks by nursing team, moving forward. -New behaviors will be documented in the electronic health record by nursing upon discovery. -Physicians will be notified for further collaboration upon discovery. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Administrator reviewed and updated the policy to identify residents who are at risk for elopement on 5/22/25, to include adequate supervision will be provided to help prevent accidents or elopements. -Five of five wandering exit/seeking behavior residents were care planned with person centered specific interventions on the Hickory Haven unit. -Nine of nine wandering exit/seeking behavior residents were care planned with person centered specific interventions on the Cedar Heights unit. 28 of 28 wandering exit/seeking behavior residents were care planned with person centered specific interventions on the [NAME] Gardens unit. Seven new residents identified as wandering exit/seeking behaviors through this process. Total of 42 of 42 wandering exit/seeking behavior residents had care plans reviewed. 289 of 298 signatures of all facility staff receiving and understanding education. 88 of all facility staff in person interviews verified receiving and understanding education on elopement and exit seeking behaviors. The Nursing Home Administrator was informed the IJ was lifted on 5/23/25, at 10:58 a.m. Exit interview on 5/23/25, at 11:30 a.m. information was disseminated to the Nursing Home Administrator and the Director of Nursing that the facility failed to make certain each resident received adequate supervision and person-centered care plan interventions that resulted in an elopement. This failure created an immediate jeopardy situation for one of 35 residents (Resident R1) identified as high risk for wandering. 28 Pa. Code 201.14 Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29 Responsibility of Licensee. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies.