

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  10/15/2025
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)
F 0600  Level of Harm - Actual harm  Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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 0600  Level of Harm - Actual harm  Residents Affected - Some	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, facility submitted documents, clinical records and staff interviews, it was determined that the facility failed to make certain each resident was free from neglect by not ensuring adequate supervision and assistance for transfers, which resulted in actual harm of a head contusion (bruise) for one of four residents (Resident R28), and actual harm of a skin tear for two of four residents (Residents R117 and R134), and failed to ensure that residents were free from neglect for an unknown skin condition injury for one of four residents reviewed (Resident R134). Findings include: Review of facility policy Skilled Nursing - Abuse dated August 2025, indicated neglect is defined as the failure of the community, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of facility policy Skilled Nursing - Lifting and Transferring Residents dated August 2025, indicated it is the policy to lift/transfer residents as safely as possible. All residents requiring assistance with transfer will be transferred and/or lifted using mechanical device unless otherwise indicated by a physician order, or unless the resident is able to bear weight on his/her own. Mechanical lifts are done by 2 nursing/therapy personnel. Review of the facility policy Unexplained Injuries dated August 2025, indicated an investigation of all unexplained injuries (including bruises, abrasions, and injuries of unknown source) will be conducted by an individual to ensure that the safety of our residents has not been jeopardized. Review of the facility policy Investigation of Incidents dated August 2025, indicated it is the policy of the facility to conduct a thorough and timely investigation of incidents and accidents. Review of facility Nurse Aide (NA) job description indicated the NA will follow each resident's/patient's plan of care to provide direct care to improve or maintain resident's/patient's abilities. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of Resident R28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/26/25, indicated diagnoses of high blood pressure, glaucoma (a group of eye conditions that can cause blindness), and anemia (too little iron in the blood). Review of facility submitted document dated 12/7/24, indicated the following: Administration was made aware on 12/9/24, that on 12/7/24 at 1930, the CNA (Certified Nurse Aide) was assisting the resident in the bathroom and bumped heads with the resident causing the resident to sustain a contusion (a bruise) to the left side of her head. The area was raised and bruised. It was 3 cm (centimeters) x 2 cm. There was no bleeding or laceration (a tear or cut in the skin). Upon investigation, it was noted that the CNA transferred the resident independently instead of a Sara lift (a mechanical lift). The aide stated that she wanted to hurry up and transfer the resident off of the toilet. Review of a witness statement dated 12/11/24, completed by NA Employee E9 stated, On 12/7/24 I was providing care from 3 pm - 7 pm on the 3rd floor. Prior to providing care for any patients I grabbed a day planner that correlated with my given assignment for that evening. Around 6:40 p.m. I provided care for Resident R28. When I went to transfer her, I transferred as a one assist no one was around to help, and the nurse also did not help with the transfer, so I transferred as a one assist. As I was transferring Resident R28 we had collided heads, she did not hit the floor, I was trying to prevent that, and that's when we collided heads. I got her in bed provided my care for her. When I was done with care, I noticed she had a knot forming on her head and that I was starting to swell and gain a headache as well. I got the nurse immediately to let her know what happened. We provided an ice pack for Resident R28, and I wrote my statement. I also asked one of the supervisors for medication because at that point I had a severe migraine. Review of a physician order dated 7/14/23, indicated Resident R28 transferred with Sara lift and assist x 2 at the time of the incident on 12/7/24. Review of the clinical record indicated Resident R117 was admitted to the facility on [DATE]. Review of Resident R117's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a facility submitted document dated 4/1/25, indicated the following: It was brought to administration's attention that on 4/2/25, Resident R117 sustained a skin tear to her right lower extremity following a transfer into her wheelchair and assistance was needed with first aid. The RN (Registered Nurse) immediately went to assess the resident and there was a 3 cm skin tear noted to Resident R117's right skin that was actively bleeding. Resident R117 stated, her CNA was transferring her from the toilet onto the chair and resident stood up and went to turn around and sit in her chair, then her CNA stated that she is bleeding. Resident R117 said I did not know how or what happened until CNA said I was bleeding she did not feel anything. Upon investigation, although Resident</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)		

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Review of facility submitted document dated 12/7/24, indicated the following: Administration was made aware on 12/9/24, that on 12/7/24 at 1930, the CNA (Certified Nurse Aide) was assisting the resident in the bathroom and bumped heads with the resident causing the resident to sustain a contusion (a bruise) to the left side of her head. The area was raised and bruised. It was 3 cm (centimeters) x 2 cm. There was no bleeding or laceration (a tear or cut in the skin). Upon investigation, it was noted that the CNA transferred the resident independently instead of a Sara lift (a mechanical lift). The aide stated that she wanted to hurry up and transfer the resident off of the toilet. Review of a witness statement dated 12/11/24, completed by NA Employee E9 stated, On 12/7/24 I was providing care from 3 pm - 7 pm on the 3rd floor. Prior to providing care for any patients I grabbed a day planner that correlated with my given assignment for that evening. Around 6:40 p.m. I provided care for Resident R28. When I went to transfer her, I transferred as a one assist no one was around to help, and the nurse also did not help with the transfer so I transferred as a one assist. As I was transferring Resident R28 we had collided heads, she did not hit the floor, I was trying to prevent that, and that's when we collided heads. I got her in bed provided my care for her. When I was done with care, I noticed she had a knot forming on her head and that I was starting to swell and gain a headache as well. I got the nurse immediately to let her know what happened. We provided an ice pack for Resident R28, and I wrote my statement. I also asked one of the supervisors for medication because at that point I had a severe migraine. Review of a physician order dated 7/14/23, indicated Resident R28 transferred with Sara lift and assist x 2 at the time of the incident on 12/7/24. Review of the clinical record indicated Resident R117 was admitted to the facility on [DATE]. Review of Resident R117's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a facility submitted document dated 4/1/25, indicated the following: It was brought to administration's attention that on 4/2/25, Resident R117 sustained a skin tear to her right lower extremity following a transfer into her wheelchair and assistance was needed with first aid. The RN (Registered Nurse) immediately went to assess the resident and there was a 3 cm skin tear noted to Resident R117's right skin that was actively bleeding. Resident R117 stated, her CNA was transferring her from the toilet onto the chair and resident stood up and went to turn around and sit in her chair, then her CNA stated that she is bleeding. Resident R117 said I did not know how or what happened until CNA said I was bleeding she did not feel anything. Upon investigation, although Resident R117 is a transfer assist x 2, the CNA assigned to her did confirm that she transferred her by herself. Review of a witness statement dated 4/4/25, completed by NA Employee E10 stated, On Monday March 31, 2025. It was the beginning of my shift 3 pm - 11 pm. I went to my section to check on my residents as I always do. I can't remember if Resident R117 put her call light on or if was in her room already, but she said she needed to go to the bathroom. I said let me see where my aide is or find someone else to help, but everyone was busy with their residents. My hall aide still hasn't arrived yet. So, I went back to Resident R117's room to let her know I'm still looking for help. That's when Resident R117 said I really need to go can we just go in and I can stand and turn. I told her we need help. Resident R117 said I really need to go. I said I'll be back so I went to look for help again but everyone was</p>		