

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: 395713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
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 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. Based on observations and staff interviews it was determined that the facility failed to maintain sanitary conditions in the Main Kitchen which created the potential for cross contamination. (Main Kitchen) Findings include: During an observation on 9/22/25, at 9:30 a.m. it was revealed the ice machines in the main kitchen contained a brown substance inside the machine. During an interview on 9/22/25, at 9:50 am the Dietary Director E8 confirmed the brown substance in the ice machine and could not verify the last time it was sanitized creating the potential for cross contamination. 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information for five of seven residents (Resident R38, R43, R44, R98, and R159), and failed to maintain the confidentiality of residents' medical information on one of nine medication carts (Third Floor West/Northwest Medication Cart). Findings include: Review of facility policy HIPAA (Health Insurance Portability and Accountability Act) - Privacy dated August 2025, indicated facility is dedicated to protecting the privacy of personal health information and is committed to maintaining confidentiality. During a tour and observation on 9/29/25, at 10:19 a.m. with Licensed Practical Nurse (LPN) Employee E4 the following sign was observed hanging on the wall in Resident R44's room:- Please help resident with her meals- My showers are Monday and Fridays 7-3- Hoyer lift at all times until further notice During a tour and observation on 9/29/25, at 10:27 a.m. with LPN Employee E4 the following signs were observed hanging on the wall in Resident R98's room:- Right upper extremity passive range of motion with stretch to all joints, prior to putting on palm guard. - Resident to wear right palm guard for four hours daily, not during care.- Caregiver to perform skin integrity check pre and post wear and report any changes to nursing.- Gentle, slow, prolonged stretch to right wrist and knuckle joints when applying right palm guard- Palm guard -on in AM, off at dinner time to right hand. Complete skin checks and remove if irritation occurs- Positioning in wheelchair, Apply right half lap tray with pillow to elevate arm. If leaning left, apply rolled bath towel or personal pillow. During a tour and observation on 9/29/25, at 11:26 a.m. with LPN Employee E5 the following signs were observed hanging on the wall outside her room and above the bed in Resident R43's room:- Bilateral leg rests on except during meals- Resident fully to back of wheelchair- Resident midline in wheelchair- Towel roll between bilateral lower extremities at all times when up in wheelchair- Soft collar off at start of dinner, not to wear during meals- Maintain midline neck position During a tour and observation on 9/29/25, at 11:27 a.m. with LPN Employee E5 the following sign was observed hanging on the wall in Resident R159's room:- Please do not transfer with right arm- Please no pink cream on at all During a tour and observation on 9/29/25, at 12:32 p.m. with Unit Manager LPN Employee E6 the following sign was observed hanging on the wall in Resident R38's room:- Resident up in wheelchair daily- Dycem (a nonslip material used to secure wheelchair cushions) on top of cushion- Resident to seat fully back in chair- Body midline- Armrest on left side During an interview on 9/29/25, at 2:40 p.m. the Director of Nursing confirmed the above observations and that the facility failed to maintain the confidentiality of residents' medical information for five of seven resident rooms (Resident R38, R43, R44, R98, and R159). During an observation on 10/1/25, at 10:23 a.m. the Third Floor West/Northwest Medication Cart at the nurses station was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 10/1/25, at 10:25 a.m. Registered Nurse Employee E2 confirmed the above observation and that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. code: 211.5(b) Medical records. 28 Pa. Code: 211.12(d)(1)(3) Nursing services.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, observations, and staff interviews, it was determined that the facility failed to identify the placement of a bed against the wall as a possible restraint, the use of bolsters (a long, thick cushion) on a bed as a possible restraint, failed to obtain a physicians order, failed to develop a person-centered plan of care for the use of physical restraints, and failed to provide ongoing re-evaluation of the need for physical restraints for three of three residents reviewed (Residents R6, R9, and R18). Findings include: Review of facility policy Physical Restraints dated August 2025, indicated physical restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include but are not limited to placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed, and placing a resident on a concave mattress so that the resident cannot independently get out of bed. Review of facility policy Bed Rail dated August 2025, indicated bed rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). The use of bed rails as an assistive device will be addressed in the resident care plan. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/22/25, indicated diagnoses of gastroesophageal reflux disease (GERD - when stomach acid flows back into the esophagus, causing symptoms like heartburn), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and hemiplegia (paralysis on one side of the body). During an observation on 9/29/25, at 9:30 a.m. Resident R6 was observed lying in bed and the left side of the bed was pushed against the wall. Review of a physician order dated 9/30/24, indicated move bed against wall requested by family for better visitation and mobility. Review of Resident R6's comprehensive care plan failed to reveal goals and interventions related to placing the resident's bed against the wall. Review of Resident R6's clinical record failed to identify any assessments or ongoing evaluations for the placement of the resident's bed against the wall. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of aphasia (language disorder that affects communication), epilepsy (disorder of the brain characterized by repeated seizures), and anemia (too little iron in the blood). During an observation on 9/29/25, at 9:33 a.m. Resident R9 was observed lying in bed and the mattress had bilateral (on both sides) raised edges on top and bottom portions. During an observation on 10/1/25, at 10:40 a.m. Resident R9's mattress was observed with bilateral raised edges on the top and bottom portions. During an interview on 10/1/25, at 10:46 a.m. Registered Nurse Employee E2 confirmed Resident R9's mattress had bilateral raised edges on the top and bottom portions, but was unsure if the raised edges were from bolsters or a concave mattress. During an interview on 10/1/25, at 1:04 p.m. Director of Rehab Services Employee E22 stated she was unsure if Resident R9 had bolsters applied to their bed or a concave mattress. Review of Resident R9's active physician orders on 9/29/25, failed to include an order for bolsters or a concave mattress. Review of Resident R9's comprehensive care plan on 9/29/25, failed to reveal goals and interventions related to the usage bolsters or a concave mattress. Review of Resident R9's clinical record failed to identify any assessments or ongoing evaluations for the usage of bolsters or a concave mattress. Review of a physician order dated 10/1/25, indicated to install LAL (low air loss) mattress with bolsters for prevention of skin injury. Review of a physician order dated 10/1/25, indicated nurse will check LAL mattress with bolster for proper function every shift. Review of the clinical record indicated Resident R18 was admitted to the facility on [DATE]. Review of (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R18's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and obesity. Section GG- Functional Abilities, Question GG0170A was coded 1, indicating Resident R18 was dependent upon staff to roll left and right. Section P - Restraints and Alarms, Question P0100 was coded 1, indicating Resident R18 used bed rails less than daily as a restraint. During an observation on 9/29/25, at 9:35 a.m. Resident R18 was observed lying in bed with bilateral side rails applied to the resident's bed. Review of a physician order dated 6/11/24, indicated bilateral side rails on bari-bed. Review of Resident R18's comprehensive care plan failed to include goals and interventions related to the usage of bilateral side rails. During an interview on 10/14/25, at 10:27 a.m. the Director of Nursing 2 confirmed that the facility failed to identify the placement of a bed against the wall as a possible restraint, the use of bolsters (a long, thick cushion) on a bed as a possible restraint, failed to obtain a physician's order, failed to develop a person-centered plan of care for the use of physical restraints, and failed to provide ongoing re-evaluation of the need for physical restraints for three of three residents reviewed (Residents R6, R9, and R18). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Residents R7, R9, R10, R14 and R17).Findings include:Review of the facilities Transfer and Discharge policy dated August 2025, indicated each resident to remain in the community and not transfer or discharge the resident except in limited situations. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].Review of Resident R7's Minimum Data Set (MDS - periodic assessment of care needs)dated 8/14/25, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hyperlipidemia (high levels of fats in the blood).Review of the clinical record indicated Resident R7 was transferred to the hospital on 8/5/25, and returned to the facility on 8/9/25.Review of Resident R7's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].Review of Resident R9's MDS dated [DATE], indicated diagnoses of aphasia (language disorder that affects communication), epilepsy (disorder of the brain characterized by repeated seizures), and anemia (too little iron in the blood).Review of the clinical record indicated Resident R9 was transferred to the hospital on 6/21/25, and returned to the facility on 6/28/25.Review of Resident R9's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE].Review of Resident R10's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and chronic obstructive pulmonary disorder (COPD, a group of progressive lung disorders characterized by increasing breathlessness).Review of the clinical record indicated Resident R10 was transferred to the hospital on 7/24/25, and returned to the facility on 7/29/25.Review of Resident R10's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE].Review of Resident R14's MDS dated [DATE], indicated diagnoses of hyperlipidemia, arthritis (inflammation of one or more joints, causing pain and stiffness), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).Review of the clinical record indicated Resident R14 was transferred to the hospital on 5/8/25, and returned to the facility on 5/13/25.Review of Resident R14's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.Review of Resident R17's admission record indicated the resident was admitted to (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility on [DATE].Review of Resident R17's MDS dated [DATE], included diagnoses of depression, cancer (a disease characterized by abnormal cell growth and division), and low back pain. Review of the clinical record indicated Resident R17 was transferred to the hospital on 9/14/25, and returned to the facility on 9/19/25.Review of Resident R17's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.During an interview on 10/14/25, at 10:04 a.m. the Director of Nursing 2 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Residents R7, R9, R10, R14 and R17).28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for four of seven residents (Residents R16, R18, R47, and R80). Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 calendar days following admission (admission date plus 13 calendar days), and an annual MDS assessment was to be completed no later than the Assessment Reference Date (ARD) plus 14 calendar days. Resident R16 had an admission date of 8/27/25, with an MDS completion date of 9/9/25. The MDS was signed off as completed 9/10/25, one day after the due date. Resident R18 had an annual ARD of 6/6/26, and was due to be completed 6/20/25. The MDS was signed off as completed 6/22/25, two days after the due date. Resident R47 had an annual ARD of 5/27/25, and was due to be completed 6/10/25. The MDS was signed off as completed 6/11/25, one day after the due date. Resident R80 had an admission date of 7/7/25, with an MDS completion date of 7/20/25. The MDS was signed off as completed 7/21/25, one day after the due date. During an interview on 10/14/25 at 1:48 p.m. Registered Nurse Assessment Coordinator Employee E11 confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for four of seven residents (Residents R16, R18, R47, and R80) 28 Pa. Code 211.5(f) Medical records.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that quarterly Minimum Data Set assessments were completed within the required time frame for three of seven residents (Residents R19, R77, and R137). Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that quarterly MDS assessments were to be completed no later than 14 calendar days after the Assessment Reference Date (ARD). Resident R19 had a quarterly ARD of 6/28/25, and was due to be completed 7/12/25. The MDS was signed as completed on 7/15/25, three days after the due date. Resident R77 had a quarterly ARD of 6/24/25, and was due to be completed 7/8/25. The MDS was signed as completed on 7/10/25, two days after the due date. Resident R137 had a quarterly ARD of 6/3/25, and was due to be completed 6/17/25. The MDS was signed as completed on 6/19/25, two days after the due date. During an interview on 10/14/25 at 1:48 p.m. Registered Nurse Assessment Coordinator Employee E11 confirmed that the facility failed to make certain that quarterly Minimum Data Set assessments were completed in the required time frame for three of seven residents (Residents R19, R77, and R137). 28 Pa. Code 211.5(f) Medical records.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for five of five residents (Residents R1, R10, R98, R126, and R134). Findings include: Review of facility policy Oxygen Administration dated August 2025, indicated to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty or weekly. Keep delivery devices covered in plastic bag when not in use. Change nebulizer (a machine that delivers respiratory medication to person) tubing every week or as needed if they become contaminated. Keep delivery devices covered in plastic bag when not in use. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/13/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). MDS Section O-Special treatments, procedures and program C1 is marked, indicating oxygen therapy. Review of Resident R1's physician's orders dated 8/10/25, indicated oxygen two to four liters per minute via NC (nasal cannula - a lightweight tube that deliver oxygen through the nostrils) for chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Oxygen tubing and Humidifier change every night shift, every Sunday. Review of Resident R1's physician's orders dated 9/2/25, indicated to administer Ipratropium-Albuterol Inhalation Solution (a medication used to treat COPD) 3milligrams/3milliliters four times a day. During an observation on 9/29/25, at 10:00 a.m. Resident R1 was lying in her bed receiving two liters per minute of oxygen via NC. The oxygen tubing failed to have a date on it and the humidification bottle was dated 9/3/25. During an observation on 9/29/25, at 10:05 a.m. a nebulizer machine was sitting on Resident R1's counter. The nebulizer tubing failed to have a date on it and failed to be stored in a bag, when not in use. During an interview on 9/29/25, at 11:07 a.m. Licensed Practical Nurse (LPN) Employee E5 confirmed the missing dates on the humidification bottle, missing dates on the oxygen and nebulizer tubing, and the nebulizer not stored in a bag for Resident R1. Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), high blood pressure, and chronic obstructive pulmonary disorder. Review of a physician order dated 7/29/25, indicated to administer oxygen at 2 liters per NC. Review of a physician order dated 7/29/25, indicated to apply BiPAP (noninvasive ventilation therapy used to assist with breathing) at bedtime for sleep apnea. Review of a physician order dated 9/11/25, indicated to change oxygen tubing and humidifier ever Wednesday night shift. During an observation on 9/29/25, at 9:26 a.m. Resident R10 was observed receiving oxygen at 2 liters per nasal cannula. The date on the humidification bottle was 9/18. During an observation on 9/29/25, at 9:28 a.m. Resident R10's BiPAP machine and mask were observed on the resident's dresser with the mask being stored on the dresser and not in a bag while not in use. During an observation on 10/1/25, at 10:38 a.m. Resident R10 was observed receiving oxygen at 2 liters per nasal cannula. The date on the humidification bottle was 9/18 and the bottle was empty. During this observation, Resident R10's BiPAP machine and mask were observed on the resident's dresser with the mask being stored on the dresser and not in a bag while not in use. During an interview on 10/1/25, at 10:48 a.m. Registered Nurse (RN) Employee E2 confirmed Resident R10's humidification bottle was empty and out of date and that Resident R10's BiPAP mask was not stored in a bag while not in use. During this interview, RN Employee E2 confirmed that the facility failed to provide appropriate respiratory care for Resident R10. Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of heart failure, (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS Section O-Special treatments, procedures and program C1 is marked, indicating oxygen therapy. Review of Resident R98's physician's orders dated 1/11/25, indicated oxygen two liters per minute via nasal cannula every shift. Oxygen tubing and Humidifier change every night shift, every Wednesday. During an observation on 9/29/25, at 10:10 a.m. Resident R98 was lying in her bed resting with oxygen on. Observation of a portable oxygen tank (used when resident leaves room), sitting in the room, failed to have a date on the tubing and was not stored in a bag, when not in use. During an interview on 9/29/25, at 10:27 a.m. LPN Employee E4 confirmed the missing date on the portable oxygen tubing and was not stored in a bag, when not in use for Resident R98. Review of the clinical record indicated Resident R126 was admitted to the facility on [DATE]. Review of Resident R126's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). MDS Section O-Special treatments, procedures and program C1 is marked, indicating oxygen therapy. Review of Resident R126's physician's orders dated 6/16/25, indicated oxygen at two liters per minute. Oxygen tubing and humidification change every week on Tuesday. During an observation on 9/29/25, at 10:27 a.m. Resident R126 was lying in her bed resting. The oxygen tubing was not hooked to the oxygen machine, and the nasal cannula was lying on the bed, not in Resident R126's nostrils. The oxygen tubing and humidification failed to have a date on them. During an interview on 9/29/25, at 10:29 a.m. the LPN Employee E4 confirmed the missing date on the oxygen tubing and the missing date on the humidification bottle for Resident R126. Review of the clinical record indicated Resident R134 was admitted to the facility on [DATE]. Review of Resident R134's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure, and osteoporosis (condition when the bones become brittle and fragile). MDS Section O-Special treatments, procedures and program C1 is marked, indicating oxygen therapy. Review of Resident R134's physician orders dated 9/30/25, indicated oxygen at two liters per minute via nasal cannula every eight hours as needed. Oxygen tubing and humidification change every week on Wednesday. Review of Resident R134's physician orders dated 11/25/24, indicated Albuterol Sulfate Inhalation Nebulization Solution (medication used for respiratory conditions) three milliliters inhale orally via nebulizer every six hours as needed. During an observation on 9/29/25, at 11:00 a.m. Resident R134 was lying in her bed watching tv. The oxygen tubing was not dated. The nebulizer tubing was not dated and was not stored in a bag, when not in use. During an interview on 9/29/25, at 11:19 a.m. LPN Employee E5 confirmed the missing date on the oxygen tubing and the nebulizer tubing and was not stored in a bag for Resident R134. During an interview on 9/29/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for Residents R1, R98, R126, and R134. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Willows of Presbyterian Senior		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Hulton Road Oakmont, PA 15139	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for six of seven residents (Resident R43, R44, R57, R144, R150, and R159), and failed to maintain proper infection control practices related to the care of indwelling urinary catheters (tube inserted in the bladder to drain urine) for one of three residents (Resident R8). Findings include: Review of facility policy Infection Control - Infection Prevention and Control Program, most recently reviewed August 2025, indicated that this community has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our team member on infectious diseases, resident room placement, implementing isolation precautions, team member and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. All team members are responsible for following all policies and procedures related to the program. Review of facility policy Refrigerators and Freezers dated August 2025, indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperature and will include time, temperature, initials, and action taken. During an observation on 9/29/25, at 10:19 a.m. Resident R44 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R44's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an observation on 9/29/25, at 10:20 a.m. Resident R144 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R144's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an observation on 9/29/25, at 10:21 a.m. Resident R57 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R57's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an observation on 9/29/25, at 10:22 a.m. Resident R150 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R150's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an observation on 9/29/25, at 11:26 a.m. Resident R43 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R43's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an observation on 9/29/25, at 11:27 a.m. Resident R159 had a small personal refrigerator on a counter in the room. The refrigerator failed to have a temperature log that included daily monitoring for Resident R159's personal refrigerator and failed to have a thermometer to determine acceptable temperature ranges. During an interview on 9/30/25, at 1:03 p.m. the Director of Nursing-1 (DON-1) stated the facility ordered thermometers for all the personal refrigerators and confirmed that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for Residents R43, R44, R57, R144, R150, and R159). Review of the clinical record indicated Resident R8 was originally admitted to the facility 5/16/25, recently readmitted [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/1/25, indicated diagnoses of diverticulitis (inflammation of bulging pouches in the wall of the large intestine), atrial fibrillation (irregular heart rhythm), and bullous pemphigoid (rare autoimmune skin condition characterized by the formation of large, fluid-filled blisters). Section H0100 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated that Resident R8 had an indwelling catheter. During a tour of the facility on 10/1/25, at 12:38 p.m., included Enhanced Barrier Precaution (EBP-a type of isolation), signage on Resident R8's door [with Personal Protective Equipment (PPE) stored in a bin prior to entering residents room.] Review of Resident R8's care plan revised on 9/29/25, indicated the resident has an indwelling urinary catheter related to skin breakdown and has the need for EBP related to potential for infectious disease as evidenced by indwelling foley catheter and multiple wounds. Review of Resident R8's current physician orders indicated EBP for multiple wounds. Additional current physician order indicated Urinary Catheter: 16 F (French), 5-10 cc (cubic centimeter) bulb. During an observation on 10/1/25, at 12:40 p.m., Resident R8's catheter draining bag was observed lying directly on the floor beside the bed. During an interview on 10/1/25, at 12:43 p.m., the Assistant Director of Nursing/Infection Preventionist (ADON/IP) Employee E3 confirmed observation that Resident R8's catheter draining bag was observed lying directly on the floor beside the bed, and that the facility failed to maintain proper infection control practices related to the care of indwelling urinary catheters for one of three residents (Resident R8). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations and staff interview, it was determined that the facility failed to determine it was safe to self-administer medications for two of seven residents (Resident R45 and R166). Findings include: Review of the facility policy Self-Administration of Medications dated August 2025, indicated residents in the facility who wish to self-administer their medications may do so if the interdisciplinary team has determined that this practice is clinically appropriate. The staff and practitioner will document residents who are potentially capable of self-administering medications. The resident is asked to complete a bedside record indication of administration of the medication. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Review of the clinical record indicated Resident R45 was admitted to the facility on [DATE]. Review of resident R45's Minimum Data Set (MDS-a periodic assessment of care needs) dated 7/24/25, indicated the diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and hyperlipidemia (a condition characterized by high levels of lipids (fats) in the blood). During an observation on 9/29/25, at 11:30 a.m. of Resident R45's room indicated a tube of Voltaren gel (a topical cream used to treat a specific area to reduce pain), a bottle of Miralax (used to treat constipation), and Systane eye drops was lying on the counter in residents' room unsecured. Review of Resident R45's physician orders failed to include an order for self-administration of medications. Review of Resident R45's care plan failed to address self-administration of medications. Review of the clinical record indicated Resident R166 was admitted to the facility on [DATE]. Review of R166's MDS dated [DATE], indicated the diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). During an observation on 9/29/25, at 10:00 a.m. of Resident R166's room indicated a bottle of Venlafaxine (a medication used to treat depression) ER 150 mg (milligram) pills, a bottle of liquid pain reliever, a bottle of Emetrol (a medication used for upset stomach), and tube of Voltaren gel was lying on the counter in residents' room unsecured. Review of Resident R166's physician orders failed to include an order for self-administration of medications. Review of Resident R166's care plan failed to address self-administration of medications. During a tour and interview on 9/29/25, at 11:30 a.m. with Licensed Practical Nurse Employee E5 confirmed the unsecured medications at bedside and confirmed the absence of a physician order or care plan to self-administer medications for Residents R45 and R166. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R19). Findings include: Review of the clinical record indicated Resident R19 was admitted to the facility on [DATE]. Review of Resident R19's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/19/25, indicated diagnoses of high blood pressure, arthritis (inflammation of one or more joints, causing pain and stiffness), and osteoporosis (condition when the bones become brittle and fragile). During an observation on 9/29/25, at 9:43 a.m. Resident R19 was sitting in a recliner in their room. The call bell was placed on Resident R19's bed, under the linens, out of the resident's reach. During an interview on 9/29/25, at 9:50 a.m. Registered Nurse Employee E1 confirmed Resident R19's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R19's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 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 review of clinical records and staff interview, it was determined that the facility failed to obtain a physician order for a wound vac for one of one resident (Resident R189). Findings include: A review of the clinical record indicated Resident R189 was admitted to the facility on [DATE], with diagnoses that included infection and inflammatory reaction due to internal right knee prosthesis, bacteremia (presence of bacteria in the bloodstream) and congestive heart failure (heart can't pump blood well enough to give your body a normal supply). A review of Resident R189's admission MDS (minimum data assessment) assessment- (periodic assessment of resident care needs) dated 9/29/25, indicated the diagnosis remained current. During an interview with Resident R189 on 9/29/25 at 10:30 a.m., R189 had a wound vac attached to the left hand side of her wheel chair. R189 stated it was for her knee. A review of Resident R189's physician orders dated 9/24/25 indicated no order for the wound vac. During an interview on 9/29/25, at 1:30 p.m. the Director of Nursing (DON)-1 confirmed the above findings and the facility failed to obtain an order for Resident R189's wound vac as required. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive resident-specific plan of care for a resident with limited mobility requiring equipment and assistance to maintain or improve mobility for one of three residents (Resident R6). Findings include: Review of facility policy Splinting dated August 2025, indicated there must be a physician's order for splinting. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/22/25, indicated diagnoses of gastroesophageal reflux disease (GERD - when stomach acid flows back into the esophagus, causing symptoms like heartburn), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and hemiplegia (paralysis on one side of the body). During an observation on 9/29/25, at 12:11 p.m. Resident R6 was observed wearing bilateral (both sides) palm guards (a brace used to prevent finger contractures and skin break down in the palm). During an interview on 9/29/25, at 12:12 a.m. Nurse Aide Employee E20 confirmed Resident R6 was wearing bilateral palm guards. During an observation on 10/1/25, at 10:32 a.m. Resident R6 was observed wearing bilateral palm guards. During an interview on 10/1/25, at 10:36 a.m. Registered Nurse Employee E2 confirmed Resident R6 was wearing bilateral palm guards and stated, Residents will have an order for splints and braces and it will be in their care plan. Review of Resident R6's active physician orders on 10/1/25, failed to include an order for bilateral palm guards. Review of Resident R6's comprehensive care plan on 10/1/25, failed to include the development of goals and interventions related to the resident's bilateral palm guard usage. During an interview on 10/14/25, at 12:52 p.m. the Nursing Home Administrator confirmed that the facility failed to develop a comprehensive resident-specific plan of a care for a resident with limited mobility requiring equipment and assistance to maintain or improve mobility for one of three residents (Resident R6). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to provide adequate treatment and care for a peripheral inserted central catheter (PICC - a thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) in accordance with professional standards of practice for one of two residents (Resident R17). Findings include: Review of Resident R17's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - periodic assessment of care needs) dated 8/29/25, included diagnoses of depression, cancer (a disease characterized by abnormal cell growth and division), and low back pain. During an observation on 9/29/25, at 9:24 a.m. Resident R17 was lying in her bed and a double lumen PICC line was observed in right upper arm. Resident R17 stated it was used for getting fluids once a week and for her chemotherapy medication. During a review of physician orders dated 9/24/25, indicated Sodium Chloride Solution 0.9% (a supplement of fluid used for hydration), give one liter every Wednesday. During a review of current physician orders on 10/1/25, failed to include any orders related to a PICC line, including the care of and maintenance. During an interview on 10/1/25, at 11:20 a.m. with Certified Registered Nurse Practitioner Employee E7 stated, She's been in and out of the hospital, so the orders probably just fell off her chart. I will put new orders in . During an interview on 10/1/25, at 11:26 a.m. Unit Manager Licensed Practical Nurse Employee E6 stated, I will reach out to the hospital to get the length of the PICC line for our records and confirmed that Resident R17's was missing orders for her PICC line. During an interview on 10/1/25, at 2:40 p.m. the Director of Nursing (DON)-1 confirmed that the facility failed to provide adequate treatment and care for a PICC line in accordance with professional standards of practice for one of two residents (Resident R17). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy, observation, and staff interviews, it was determined the facility failed to dispose of or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (Fourth Floor Medication Room). Findings: Review of facility Medication Disposal-Non-controlled Medications policy dated August 2025, indicated discontinued medications and medications left in the facility after a resident's discharge or death should be disposed of in a timely manner. Any non-controlled medication product that is discontinued should be appropriately documented on a Medication Reconciliation form. During a medication room review on 9/30/25, at 10:18 a.m. a plastic bin over filled with medication was observed sitting in the corner of the medication room, unsecured and unaccounted for. The medications observed were:- Tylenol (used for fever or pain) - 28 pills- Lovenox injections (used to prevent blood clots) - Two injections- Omeprazole (used to treat acid reflux) - Three pills- Gas Relief - Two bottle- Immodium (used to treat diarrhea) - 30 pills- Lactated ringers (used to replace fluid loss) - Three liters- Zebeta (used to treat high blood pressure) - Two pills- Atenolol (used to treat high blood pressure) - One pill- Namenda (used to treat dementia- a group of symptoms that affects memory, thinking and interferes with daily life) - Two pills- Heparin (used to treat or prevent blood clots) - Nine vials- Scopolamine (used to treat nausea) - 35 patches- Zofran (used to treat nausea)- 20 pills- Tylenol suppositories - 93 suppositories- Zoloft (used to treat depression) - Three pills- Mucinex (used to treat congestion) - Two bottles- Latanoprost eye drops - One bottle- Zyprexa (used to treat mental disorders) - One vial and one pill- Seroquel (used to treat mental disorders) - Two pills. During an interview on 9/30/25, at 10:45 a.m. When asked, What do you do with discontinued medication? Licensed Practical Nurse Employee E21 responded, Overnight writes all the medication up. We have a reconciliation form to complete. Usually, they are medications that were discontinued or if resident is discharged, then they go back to pharmacy. The pharmacy delivers every day. During an interview on 9/30/25, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to dispose of or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (Fourth Floor Medication Room). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to properly store medical supplies in one of two medication rooms (Fourth Floor Medication Room), and failed to properly secure a medication cart while not in use for one of nine medication carts (Third Floor West/Northwest Medication Cart). Findings include: Review of facility policy Skilled Nursing - Medication Storage dated [DATE], indicated during a medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart. All drugs and biologicals will be stored in locked compartments under proper temperature controls. Facility will ensure all medications housed on our premises will be stored in medication rooms according to recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. During a medication storage room review on [DATE], at 10:02 a.m. the following were observed:- Three 27 gauge needles expired on [DATE].- Twelve 23 gauge needles expired on [DATE].- Eleven 23 gauge needles expired on [DATE].- Three ESwab (used to detect viruses or bacteria through a laboratory) expired.- Tuberculosis vial (a medication used to detect the presence of respiratory disease) was opened and failed to have an expiration date. During an interview on [DATE], at 10:18 a.m. Licensed Practical Nurse (LPN) Employee E21 confirmed the above findings. During an interview on [DATE], at 2:45 p.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies in one of two medication rooms (Fourth Floor Medication Room). During an observation on [DATE], at 10:23 a.m. the Third Floor West/Northwest Medication Cart at the nurses station was left unlocked and unattended. During an interview on [DATE], at 10:25 a.m. Registered Nurse Employee E2 confirmed the above observation and that the facility failed to properly secure a medication cart while not in use. 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		