STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396017	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Grove Post Acute	3485 Davisville Road Hatboro, PA 19040

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and review of clinical record, it was determined that the facility failed to ensure timely and accurate medication administration for two of five residents reviewed (Resident R1, and Resident R6)Review of facility policy 'Administering medications,' revised April 2019, indicates that medications are to be administered in a safe and timely manner as prescribed. Further review of policy indicates that medications are administered in accordance with prescriber orders, including any required time frames. Review of Resident R1's electronic medication administration report (e-MAR), dated September 21, 2025, revealed an order for Carbidopa Levodopa, extended release 70-280 milligrams (mg), scheduled to be administered at 9:00 am for Parkinson's disease (progressive disease of the central nervous system). Further review of the e-MAR revealed that the medication was not administered until 3:49 pm. Continued review of the e-MAR revealed the medication Keppra, 500 mg, was scheduled to be administered at 9:00 am for seizure disorder, but was not administered until 6:59 pm. Further review of audit e-MAR indicated that Escitalopram, 20 mg, was scheduled to be given at 9:00 am. Further review of the e-MAR revealed that the medication was not administered until 3:48 pm. Continued review of the e-MAR, indicated Medline active liquid protein, 30 mls, was scheduled to be given at 8:00 am. Further review of the e-MAR revealed that the medication was not administered until 3:46 pm. Review of Resident R6's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnosis: Congestive Heart Failure (a chronic condition where the heart can't pump enough blood to meet the body's needs, causing fluid to back up (congest) in the lungs, legs, and other areas, leading to symptoms like shortness of breath, fatigue, and swelling), Hypertension (high blood pressure), Depression (sadness and loss on interest), Atrial Fibrillation (type of irregular heartbeat (arrhythmia), where the heart's upper chambers quiver chaotically) Observation and interview held with Resident R6 on December 31, 2025 at 10:13 a.m. Resident R6 had not received their medications at the time of interview on December 31, 2025. Review of facility medication administration times revealed medication are administered at 8AM or 9AM with an hour window given before or after. Observation on December 30. 2025 of the second-floor nursing unit revealed licensed nurse Employee E3 was observed at 10:21 a.m. at the medication cart crushing medications. Once the surveyor passed Resident R5's room, Employee E3 was observed leaving the medication cart and going into Resident R5's room empty handed and walking out with a medication cup in hand containing several pills. When asked the licensed nurse Employee E3 stated that she went to crush Resident R5's roommate (Resident 4's) medication while she was waiting for Resident R5 to take her medication. The medication cart was located two rooms down from Resident R5's room on the opposite side of the hallway. When asked if this was standard practice to leave medications beside with a resident, the nurse stated that it was not. When asked how many residents the licensed nurse had today Employee E3 counted the census sheet and was assigned 31 residents for day shift and stated at the time she was still completing morning medication pass. Review of the facility grievance log revealed a grievance for Resident R9 dated November 10, 2025 stated, Grievance Details- Patient's sister complained he did not receive his meds on time. Further review of the grievance form revealed that, Summary of findings- There was a delay in medication administration. Resolved Note- Education will be provided to the nurse regarding the importance of administering medications in a timely and consistent manner. Per patient's sister request, this nurse will no longer be assigned to the patient's room. No further concerns at this time. Review of facility grievance log revealed a grievance for Resident R10 dated September 21, 2025 stated, Grievance Details-Patient complained her medication was late. Further review of the grievance form revealed that, Summary of findings- The Nurse was covering another nurse that day. She indicated that medications were late, but she then got to administer the medications as soon as she could. Resolved Note- Nurse will be verbally educated on giving residents medications in a timely manner. 28 Pa Code 211.12(d)(1) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews with staff, and review of facility policies it was determined that the facility failed to ensure prevention of accidents and hazards related to unattended medication carts and medications for two of two nursing units reviewed. (First floor and Second floor)Findings Include: Review of facility policy titled, Administering Medications dated April 2019. Review of policy states, Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Further review of facility policy revealed Policy Interpretation and Implementation- .20. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Observation on the second floor on December 31, 2025 revealed a licensed nurse Employee E4 not observed around the medication cart assigned to them at 9:41 a.m. The medication cart had the narcotic book out and open, the medication cart was unlocked, resident information was up on the computer screen including the photograph. A second cart was observed at 9:44 a.m. to the right of the first nursing cart also unlocked with just a cellphone on top of the cart. At 9:46 a.m. the medication cart that was unlocked was identified a licensed nurse Employee E4 stated, the resident a few rooms down was having pain so I went to them to administer the pain medication. When asked the licensed nurse Employee E4 stated, they don't move the carts here from room to room, but I can if you want me to I can. The licensed nurse stated that she got moved units so there was confusion on what residents she had. When asked how many residents the licensed nurse was assigned to they stated 29 after counting the census sheet. At 10:25 a.m. licensed nurse Employee E4 asked the surveyor if a cellphone left on the second medication was hers and she stated no. The licensed nurse Employee E4 confirmed that the other cart was also left unlocked and that it was her cart as well. Further observation on the second hall on the second-floor nursing unit revealed licensed nurse Employee E3 was seen observed at 10:21 a.m. at the medication cart. Once the surveyor passed Resident R5's room, Employee E3 was observed leaving the medication cart and going into Resident R5's room empty handed and walking out with a medication cup in hand containing several pills. When asked the licensed nurse Employee E3 stated that she went to crush R5's roommate Resident 4's medication while she was waiting for Resident R5 to take her medication. The medication cart was located two rooms down from Resident R5's room on the opposite side of the hallway. When asked if this was standard practice the nurse stated that it was not. When asked how many residents the licensed nurse had today Employee E3 counted the census sheet and was assigned 31 residents for day shift and at the time was still completing morning medication pass. Observation of the first-floor nursing unit at 11:01 a.m. revealed a medication cart which was left unlocked with the resident information up on the computer. At 11:03 a.m. licensed nurse R5 came to the medication cart to lock it and close the screen on the computer. When asked if it was normal practice to leave the cart unlocked and screen visible the licensed nurse Employee E5 stated it is not. 28 Pa. Code 201.14(a) Responsibility of licensee28 PA. Code 211. 12(d)(1)(5) Nursing services