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	03/17/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews with staff, review of hospital records and review of policy and procedure, it was determined that the facility failed to ensure that each resident maintained acceptable parameters of nutritional status for usual body weight or desirable body weight for one of twelve residents reviewed. (Resident R1)Findings include: A review of the facility policy and procedures titled nutritional assessment dated 2001 revealed that the physician, dietitian and nursing staff were responsible for the nutritional assessment and care of each resident. The policy indicated that a nutritional assessment was required when a resident experienced a change in condition. The policy indicated that the interdisciplinary team would use data gathered throughout the resident's stay to provide important interventions to meet the nutritional needs of each resident. The nutritional assessment was to identify a description of the resident's usual intake and appetite, advanced directives, usual meal and snack patterns, preferred portion size of food and current clinical conditions and events that affect each resident's nutritional status. The policy indicated that the dietitian was to assess and monitor each resident's nutritional intake and determine if it was adequate to meet his or her nutritional needs. The Dietitian was responsible for identifying increased need for calories and or protein due to onset or exacerbation of disease or conditions that result in a hypermetabolic state and increased demand for calories and protein. Clinical record review for Resident R1 revealed a quarterly MDS (Minimum Data Set- assessment of resident needs) dated October 11, 2025, that indicated Resident R1 had diagnoses of urinary tract infection and malnutrition (deficiencies or imbalances in a person's intake of energy or nutrients). The MDS assessment also indicated that Resident R1 was 66 inches in height and weighed 130 pounds. This assessment said that Resident R1 was on a physician prescribed weight gain regimen. Continued review of Resident R1's quarterly assessment dated [DATE], indicated Resident R1 had a pressure ulcer on the skin, a diagnosis of malnutrition and was 66 inches in height and weighed 122 pounds. The assessment indicated that Resident R1 was eating 25% or less of total calories provided. Review of a wound care assessment dated [DATE], revealed that Resident R1 developed a right lateral ankle-deep tissue injury measuring 4.8 centimeters (cm) by 4.1 cm by .1 cm depth. The physician ordered a treatment of cleansing the wound with a cleanser and applying betadine daily, leave open to air. The physician also ordered a nutritional supplement of active liquid protein for 30 grams protein and 140 calories on January 27, 2026. Review of nursing note dated February 11, 2026, indicated that the resident was identified with a right lateral leg wound. The nursing documentation also indicated that the physician had ordered that a treatment be applied to Resident R1's right lateral leg. The treatment documented by the nurse was cleansing the right lateral leg with wound cleanser and applying xeroform and dry dressing daily. Review of the wound consultant assessment dated [DATE], revealed that the resident was assessed with a Stage IV (ulcer involving loss of skin layers, exposing muscle) on the right lateral calf, measuring 12.7 cm by 3.9 cm by .1cm with tendon exposed. The treatment was a wound cleanser, apply Medi honey, ABD pad and Kling daily. The wound report also indicated that the right later ankle was continuing as an unstageable wound measuring 2.3 cm by 2.1 cm with no depth. The treatment ordered for the right lateral ankle pressure injury was wound cleanser and apply betadine (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	daily. Interview with the director of nursing, Employee E2 at 10:30 a.m., on March 17, 2026, confirmed the wound care assessment dated [DATE], whereby Resident R1 had a stage IV pressure injury of the right lateral calf and an unstageable wound located on the right lateral ankle. Review of the Registered Dietitian evaluation dated October 8, 2025, indicated that Resident R1 had a height of 66 inches and an ideal body weight of 142 pounds. The resident's actual weight was 129.6 pounds on October 8, 2025. The nutrition care planned was for Resident R1 to gain weight to ideal body weight of 142 pounds. Review of the Registered Dietitian's progress note dated November 6, 2025, indicated that Resident R1 experienced a significant weight loss that was recorded at 122 pounds. On December 31, 2025, the Dietitian indicated that Resident R1 was 122 pounds, not 215.8 pounds as documented by the nursing staff on December 31, 2025. Interview with the director of nursing, Employee E2 at 10:35 a.m., on March 17, 2026, confirmed the weight recorded for Resident R1 on December 31, 2025, was 122 pounds. The director of nursing, Employee E2 also confirmed a weight of 122 pounds recorded by the nursing staff on February 26, 2026. Clinical record review for Resident R1 revealed poor evening meal consumption of food and fluids for 12 of 28 days reviewed for the month of February 2026. Further review revealed poor evening snack consumption for 21 of 28 days for the month of February 2026. Interview with the director of nursing, Employee E2 at 10:45 a.m., on March 17, 2026, confirmed the poor food and fluid intake during evening meals for twelve of twenty-eight days reviewed for the month of February 2026 as documented by the nursing staff. Further interview with the director of nursing, Employee E2 confirmed poor evening snack consumption for twenty-one of twenty-eight days during the month of February 2026, as recorded by the nursing staff. Clinical record review for Resident R1 revealed poor intake of foods and fluids at meals for March 1 through March 4, 2026. Further review revealed poor intake of the evening snack of foods and fluids for March 1 through March 4, 2026. Interview with the director of nursing, Employee E2, at 10:50 a.m., on March 17, 2026, confirmed the poor food and fluid intake at breakfast and dinner on March 2, 2026, for Resident R1, no documented food consumption of food or fluid intake during the noon meal on March 3, 2026, and the poor amount eaten at the dinner meal on March 4, 2026. There was no documentation to indicate that a nutritional assessment, was completed by the Registered Dietitian for the months of February or March 2026 for Resident R1. The Dietitian failed to evaluate Resident R1 despite a diagnosis of malnutrition, having no evidence of weight gain, or poor consumption of foods and fluids during the months of February and March 2026. There were no nutritional care planning changes or updates to Resident R1's diet for February or March 2026. The resident remained on a regular pureed diet with house shake 4 ounces twice a day and protein liquid twice a day. Interview with the Administrator, Employee E1 at 1:00 p.m., on March 17, 2026, confirmed the lack of documented assessment, monitoring and nutrition care plan revision and implementation of nutritional approaches and measures to ensure Resident R1 maintained acceptable parameters of nutritional status. Hospital record review for Resident R1 revealed that this resident was admitted to the hospital on [DATE]. The physician indicated that Resident R1 assessed with osteomyelitis (severe infection of the bone) of the right leg to include the tibia (shin bone), fibula (leg bone) and ankle. 28 PA. Code 211.10 (c) Resident care policies28 PA. Code 211.12(d)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff, and clinical record reviews, it was determined that the facility failed to ensure that clinical records were accurately documented for one of twelve residents reviewed. (Resident R1)Findings include: A review of the facility policy and procedures titled nutritional assessment dated 2001 revealed that the physician, dietitian and nursing staff were responsible for the nutritional assessment and care of each resident. The policy indicated that a nutritional assessment was required when a resident experienced a change in condition. The interdisciplinary team would use data gathered throughout the resident's stay to provide important interventions to meet the nutritional needs of each resident. The nutritional assessment was to identify a description of the resident's usual intake and appetite, advanced directives, usual meal and snack patterns, preferred portion size of food and current clinical conditions and events that affect each resident's nutritional status. The policy indicated that the dietitian was to assess and monitor each resident's nutritional intake and determine if it was adequate to meet his or her nutritional needs. The Dietitian was responsible for identifying increased need for calories and or protein due to onset or exacerbation of disease or conditions that result in a hypermetabolic state and increased demand for calories and protein. Clinical record review for Resident R1 revealed a quarterly Minimum Data Set (MDS- assessment of resident care needs) assessment dated [DATE], that indicated Resident R1 was 66 inches in height and weighed 215 pounds. Clinical record review revealed a Dietitian's progress note dated December 31, 2025, noted that Resident R1 was 122 pounds, not 215.8 pounds as documented by the nursing staff on December 31, 2025. Interview with the director of nursing, Employee E2 at 10:35 a.m., on March 17, 2026, confirmed the weight recorded by the nursing staff for Resident R1 on December 31, 2025, was 122 pounds. The director of nursing, Employee E2 also confirmed a weight of 122 pounds that was recorded by the nursing staff on February 26, 2026, for Resident R1. 28 PA. Code 211.10 (d) Resident care policies