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	05/15/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews with resident and staff and review of clinical records, it was determined that the facility failed to provide care and services to maintain adequate grooming for one of 24 resident records reviewed (Resident R68). Findings include: Review of Resident R68's Quarterly MDS (an assessment of resident's needs) dated March 2026 revealed the resident was alert and oriented, admitted to the facility on [DATE], diagnosed with respiratory failure and fractures, status post motor vehicle accident prior to admission. Further review of the MDS assessment revealed the resident was dependent on staff for bathing. During an interview with Resident R68 on May 13, 2026 at approximately 11:30 a.m. indicated he had not been given a shower in at least three weeks. The resident said he was not sure why. He said he had only refused a shower one-time because it was late and he was ready to go to bed. Observation of the resident's hair during the interview appeared oily with flakes of skin around the ears. The resident stated his wife has tried washing his hair with a wet towel, but it does not work well. Review of the resident's clinical record revealed the resident received two showers in the past 30 days. The above was confirmed with the Director of Nursing on May 14, 2026, at 11:00 a.m. 28 Pa. Code 201.29(j) Resident rights28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) Nursing services

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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and interviews with resident and staff, it was determined that the facility did not ensure that physician orders for daily weights were followed for one of 24 residents reviewed (Resident R47).Findings include: Review of Resident R47 clinical record revealed an admission date of April 23, 2026, diagnosed with cardiac heart failure (the heart does not pump efficiently) with orders for daily weights (weight gain is a marker for heart failure) dated April 25, 2026. The order instructed to contact the physician if a weight gain is more than two pounds in one day or five pounds in one week. On April 29, 2026, Resident R47 was seen by the cardiologist on April 29, 2026 that noted to Monitor daily weights closely.Interview with Resident R47 on May 13, 2026, at 10:00 a.m. stated the staff started to weigh (him/her) daily but stopped. Review of Resident R47's clinical record revealed daily weights were not being obtained as ordered. No evidence of the resident's weights for April 25, 27 and 30, and May 1,2,5,6,7,8,10, and 11, 2026. The above was confirmed with the Director of Nursing on May 13, 2026, at 1:00 p.m.28 Pa. Code:201.18(a)(b)(1)(3) Management28 Pa. Code:211.12(d)(1)(5) Nursing services

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, review of clinical records, interviews with facility residents and staff and review of facility policy, it was determined that the facility failed to ensure a resident received the necessary services and treatment to prevent pressure ulcers and to promote healing for one of 24 resident records reviewed (Resident R47)Findings include: Review of facility policy titled, Pressure Injury Risk Assessment revised on March 2020 states, Develop the resident-centered care plan and interventions based upon on the risk factors identified in the assessment, and the resident's overall clinical condition. Review of Resident R47's clinical record revealed the resident was admitted on [DATE], diagnosed with cardiac heart disease, and impaired mobility. Interview with Resident R47 on May 15, 2026, at 10:00 a.m. indicated at times the resident's feet hurt if (he/she) is in bed too long. Observation conducted at the time of the interview, revealed a pair of heel boots near the bedside. The resident was asked if he elevated (his/her) heels when in bed. The resident pointed to the boots that were not in use and said sometimes I use them when the staff put them on me, it helps with the pain. Review of Resident R47's current care plan revealed intervention for the resident's impaired mobility that included keeping the residents' heels elevated in bed with the use of heel boots. Interview with the Unit Manager May 15, 2025, at 10:20 a.m. confirmed the heel boots should be in use at all times while in bed. 28 Pa. Code:211.12(d)(1)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 review of facility policies, clinical records, hospital records, care plans, fall investigations, observations, and interviews with staff and residents, it was determined that the facility failed to ensure residents received adequate assistants and interventions to prevent injury for three of 24 resident records reviewed. (Resident R2, Resident R47, Resident 101) Findings include:Review of the facility policy titled Falls Program, dated February 2017, revealed the facility utilizes assessments to identify residents at high risk for falls and implements interventions through the Falling Star Program. The policy further states that high-risk residents are to receive ongoing supervision, staff awareness, environmental safety interventions, and interdisciplinary review of fall risks. Review of the facility policy titled Assessing Falls and Their Causes, dated March 2018, revealed residents are to be routinely assessed for fall risk, with identified risk factors addressed promptly through implementation of safety interventions and monitoring. Review of Resident R47 clinical record revealed the resident was admitted on [DATE], diagnosed with cardiac heart disease, and impaired mobility. During an interview with Resident R47 on May 15, 2026, at 10:00 a.m. three medications revealed in a small cup sitting on the resident's overbed table. The resident was not aware what the medication was for. Observed Resident R47's nurse administering medication to other residents was asked about this medication left on the resident's table. Nurse unaware indicating the resident's medication for this morning was not dispensed and had never had this resident before today, stating, I don't know what kind of medication they are. Regional Registered Nurse Employee E12 observed medication and the RN and the Unit Manager Employee E13 confirmed medication should not be left at bedside. Continuing interview with resident revealed wounds on the resident's lower right leg, open to air with scabbing. The resident was asked about wound and stated, I have very thin skin, it's very fragile. If I bump it, it will bleed easily. I have told the nursing staff to please be careful when they move me. Last week an aide was putting the leg rests on my wheelchair while I was sitting in it. She was not careful and hit my leg. I was upset because it was one more thing I didn't need. Review of Resident R47's physician progress note date May 8, 2026, stated, Patient upset about right shin wound due to transfer to wheelchair - being dressed by nursing. Facility documentation related to the above incident indicated the nurse aide (NA) Employee E10 was not aware of the wound until Resident R47's nurse, Registered Nurse Employee E11 notified the nurse aide. The NA witness statement indicated awareness of the resident's frail skin and how it Cut's easily. Facility documentation indicated the NA was educated to be more mindful when placing equipment on and off wheelchair and of Resident R47's skin integrity. Resident R101 was admitted to the facility on [DATE], following hospitalization for a hip fracture requiring surgical repair after a fall. Review of the admission Minimum Data Set (MDS resident assessment of care needs) dated May 12, 2026, revealed diagnoses including dementia (a progressive neurocognitive disorder characterized by decline in memory, reasoning, judgment, communication, and the ability to safely perform activities of daily living); anxiety disorder, (a mental health condition involving excessive fear, nervousness, worry, or agitation that may interfere with daily functioning and safety awareness); and recent hip fracture status post-surgical repair. Continued review of the MDS revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment, and was assessed as rarely or never understanding others or able to express needs. Review of the admission fall assessment dated [DATE], revealed the resident scored 14, indicating moderate fall risk, the assessment identified the resident at moderate risk for falls. Review of the resident's care plan initiated May 9, 2026, identified the resident as being at risk for falls and included interventions such as maintaining the bed in the lowest position, ensuring the call light was within reach, maintaining a clutter-free environment, providing adequate lighting.Review of the physical therapy evaluation dated May 10, 2026, revealed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was totally dependent for transfers and mobility, unable to tolerate standing, unable to ambulate, and demonstrated poor balance, weakness, impaired safety awareness, impulsive behaviors, and high fall risk. Review of the fall incident report dated May 10, 2026, revealed the resident experienced an unwitnessed fall in the resident room and was found on the floor by staff. The walker was not within reach. Documentation further indicated the bed was placed in the lowest position only after the fall occurred. Observation conducted on May 11, 2026, at 10:00 am. revealed the resident's bed remained in a high position.Interview with Licensed Nurse, Employee E6 at the time of the above observation revealed she had just received report and was unaware of the resident's specific safety precautions. Employee E6 stated she was unsure what fall prevention or safety interventions should have been implemented for the resident at that time. Interview conducted with the Director of Nursing, Employee E2 on May 15, 2026 at 10:10 am revealed the resident was subsequently placed on low bed positioning and fall-risk precautions. Review of Resident R2's annual MDS dated [DATE], revealed diagnoses including dementia; Huntington's disease, (a hereditary progressive neurological disorder causing involuntary movements, impaired coordination, cognitive decline, behavioral disturbances, and poor safety awareness); psychotic disorder, (a mental health condition involving impaired thinking, altered perception, hallucinations, delusions, or disorganized behavior); malnutrition, (a condition resulting from inadequate nutritional intake or absorption leading to weight loss); and recurrent falls. The resident had a BIMS score of 1, indicating severe cognitive impairment.Review of the resident's current fall's care plan revealed interventions including floor mats on both sides of the bed, pillows for positioning support, maintaining the bed in the lowest position at all times except during care, medication reviews, and ongoing safety monitoring due to psychotropic medication use and Huntington's disease-related involuntary movements. Review of the resident's clinical record revealed repeated falls throughout January 2026, including falls on January 4, January 5 (three falls), January 10, January 11, January 20, and January 21, 2026. Review of the fall risk evaluation dated January 11, 2026, revealed the resident scored 22, identifying the resident as high risk for falls. Additional contributing factors included use of antipsychotic, antidepressant, anxiolytic, and antihypertensive medications, all of which may increase fall risk. Review of the hospital record dated January 21, 2026, revealed the resident was transferred to the hospital following an unwitnessed fall with head strike and head laceration while receiving anticoagulant therapy.Facility investigation findings revealed the resident was found on the floor beside the bed while the bed remained in an elevated position.Interview with the resident's son on May 12, 2026, at approximately 10:30 a.m. revealed he recalled the incident involving the resident's fall and confirmed he was present in the resident's room earlier that morning. The son stated he remembered lowering the resident's bed before leaving the facility and denied ever stating or suggesting that he may have left the bed in an elevated position. The son reported he left briefly to go to the store and returned to the facility after the fall had occurred. Upon his return, the roommate's visitor informed him that nursing staff had entered the room, obtained the resident's vital signs, and left the bed in an elevated position without lowering it afterward.Interview with the Director of Nursing, Employee E2 on May 15, 2026 at 10:10 am regarding falls revealed that families are expected to notify nursing staff when leaving the facility. The DON stated the family was frequently present in the facility and always lets someone know, but ultimately acknowledged facility staff remained responsible for resident supervision and safety monitoring. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review, it was determined that the facility failed to ensure that as needed antianxiety medication was discontinued in accordance with the physician for one of 24 records reviewed. Findings include: Review of facility policy titled Medication Regimen Review dated May 20, 2025, revealed the facility policy outlines that medication regimen reviews must be completed for all residents within 14 days of admission and at least every six months thereafter. Residents who are prescribed nine or more medications are subject to mandatory comprehensive review at least every six months. The purpose of the medication regimen review is to evaluate each resident's current medication profile, including prescription and over-the-counter medications. The review is intended to identify potential issues such as medications acting as chemical restraints, adverse drug reactions, medication interactions, and any medication errors occurring since admission. The pharmacist is responsible for conducting on-site reviews of healthcare practitioner prescriptions and resident records for applicable residents. The review must assess whether medications are being used without a valid current indication, whether there are undesired side effects or adverse reactions, and whether any medications are contributing to overuse or inappropriate dosing. Following the review, the pharmacist is required to make recommendations and forward them to the appropriate authorized prescriber for consideration and follow-up. Review of Resident R4's physician order dated October 2, 2025, for Lorazepam (Ativan) 0.5 milligrams, one tablet by mouth as needed (PRN) for anxiety and restlessness, twice daily as needed. The order was written with an indefinite end date. Review of pharmacy documentation dated April 14, 2026, indicated the PRN Lorazepam order remained active despite no documented administration in over 60 days. The consultant pharmacist recommended discontinuation of Lorazepam due to lack of recent use and regulatory concerns related to indefinite PRN psychotropic orders. The resident's physician subsequently agreed and discontinued the medication; however, the original order remained active since October 2, 2025, without a defined stop date or documented ongoing clinical justification.Interview with the Director of Nursing (Employee E2) on May 15, 2026, at 10:35 a.m. confirmed that the medication reviews were not completed correctly and acknowledged the discrepancies identified. 28 Pa. Code 211.10(c) Resident care policies