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

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to accurately complete the PASARR (Preadmission Screening and Resident Review) documentation for 4 of 6 residents reviewed for PASARR compliance. (Resident R20, Resident 51, Resident 4 and Resident R2) Findings include: Findings Include:PASRR (Preadmission Screening and Resident Review) is a federally mandated process in the United States designed to ensure that individuals being admitted to Medicaid-certified nursing facilities are appropriately placed and receive the services they need. It requires screening before admission to identify whether a person has a serious mental illness, intellectual disability, or developmental disability, and if so, whether they require specialized services or a different level of care. If the initial screening (Level I) indicates a possible condition, a more detailed evaluation (Level II) is completed to determine appropriate placement and services. PASRR also includes ongoing resident review after admission if a person's condition changes or if additional concerns arise. The purpose of the process is to prevent inappropriate institutionalization and ensure individuals receive care in the most suitable setting. Review of the facility's Mission Criteria policy (dated February 2026, last revised) indicates that all admissions are screened in accordance with the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility completes a Level I PASARR screening for all potential admissions, regardless of payer source, to determine whether an individual may have a mental disorder, intellectual disability, or related condition. If the Level I screening suggests a possible diagnosis, the individual is referred to the state PASARR representative for a Level II evaluation to determine eligibility and any need for specialized or rehabilitative services, as well as appropriate placement. The admitting nurse is responsible for notifying the Social Services Department when a resident may meet criteria, and the social worker completes the required referral to the state authority. The policy applies to all individuals without discrimination based on race, color, religion, national origin, age, sex, gender identity, sexual orientation, marital or veteran status, or payment source. The Administrator and Admissions Department are responsible for ensuring compliance with these procedures. A review of the Pennsylvania PASRR (Preadmission Screening and Resident Review) Level I identification form shows that the process applies to all nursing facility applicants regardless of payer source, and that required PASRR documentation must be completed prior to admission in accordance with federal regulation 42 CFR 483.106. This includes the Level I screening form and, if indicated, a Level II evaluation. Review of Resident R20's Minimum Data Set (MDS), a federally mandated assessment tool, dated July 14, 2025, revealed the resident was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required supervision or touching assistance with activities of daily living (ADLs) and had diagnoses including anxiety disorder (excessive worry or nervousness impacting daily functioning), depression (persistent low mood and loss of interest), and bipolar disorder (a mood disorder characterized by alternating episodes of depression and elevated or irritable mood). Review of the PASARR documentation for Resident R20 revealed discrepancies between the PASARR documentation and the resident's medical record. Specifically, Section III of the PASARR documentation identified only a diagnosis of (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression. Further review of the clinical record revealed diagnoses of anxiety disorder, bipolar disorder, and depression. The PASARR documentation did not include the resident's complete psychiatric history and reflected incomplete mental health diagnostic information. Review of Resident R51's Minimum Data Set (MDS), dated [DATE], revealed the resident was admitted on [DATE], with a BIMS score of 12, indicating moderately impaired cognition. The resident required supervision or touching assistance with activities of daily living (ADLs) and had diagnoses including bipolar disorder, unspecified (mood changes occur) anxiety disorder, unspecified (excessive worry occurs) and morbid (severe) obesity due to excess calories (severe excess weight). Further review of the clinical record on May 15, 2026, at 11:03am revealed only the diagnoses of anxiety disorder, and bipolar disorder. The PASARR documentation did not include the resident's complete psychiatric history and reflected incomplete mental health diagnostic information. Record review of May 15, 2026, at 10:54 am revealed Section IX of the form was signed and certified by a facility employee on June 25, 2025, for Resident R 20 and May 23, 2025, for Resident R51 confirming the accuracy of the information provided. An interview was conducted with the Social Worker (E9) on May 15, 2026, at 11:00 AM. The social worker stated that PASARR forms are normally completed upon admission by the admissions department. The social worker further stated she was new to completing PASARR documentation and is working closely with the PASARR nurse. further interview revealed, social worker E9 acknowledged that not all diagnoses had been transcribed onto the PASARR documentation for Residents R20 and R51 and Social Worker E9 confirmed that the forms were incomplete. Review of Resident R2's Minimum Data Set (MDS), dated [DATE], revealed the resident was admitted to the facility on [DATE]. The resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Diagnoses included anxiety, defined as a mental health disorder characterized by excessive worry, nervousness, or fear, and dementia, defined as a progressive decline in cognitive functioning affecting memory, thinking, reasoning, and the ability to perform daily activities. Further review of Resident R2's physician orders revealed an antipsychotic medication Risperidone prescribed for abnormal perception visual (Hallucinations). The review of the resident's PASRR form dated 6/19/2025 revealed that the resident was assessed as not having any mental disability. The PASRR form was signed and dated by staff on 6/19/2025. The resident's PASRR Level I form was completed on June 19, 2025, and is present in the record. Section III, which screens for serious mental illness or related conditions, was left blank, indicating no mental health conditions or diagnoses were identified or reported. The section regarding mental health conditions was not completed with any diagnoses, suggesting no evidence of mental illness was noted at the time of screening. Section IX of the form was signed and certified by a facility employee June 19, 2025, confirming the accuracy of the information provided. Review of the Resident R4's annual Minimum Data Set (MDS) dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia, a progressive decline in memory, cognition, and the ability to perform daily activities; Huntington's disease, a hereditary neurodegenerative disorder causing movement abnormalities, cognitive decline, and psychiatric symptoms; malnutrition, a condition resulting from inadequate nutritional intake or absorption; psychotic disorder, a mental health condition characterized by impaired thinking and perception that may include hallucinations or delusions; and recurrent falls, indicating repeated episodes of falling associated with impaired mobility, weakness, or cognitive deficits. The resident had a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment with significant deficits in memory, orientation, and recall abilities, with no behavioral symptoms noted. The resident received medications including antipsychotics, used to manage psychosis or severe behavioral symptoms; anxiolytics, prescribed to reduce anxiety; antidepressants, used to treat depressive symptoms; and antiplatelet. The resident's PASRR Level I form was completed on April 15, 2025, and is present in the record. Section III, which screens for serious mental illness or related conditions, was left blank, indicating no mental health conditions or diagnoses were identified or reported. The section regarding mental health conditions was not completed with any diagnoses, (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suggesting no evidence of mental illness was noted at the time of screening. Section IX of the form was signed and certified by a facility employee on April 15, 2025, confirming the accuracy of the information provided. Interview with [NAME] on May 15, 2026 revealed that she is new to the task of completing PASRRs and confirmed that the forms are incomplete. 28 Pa. Code 201.18 (a)(1)(2) Management 28 Pa. Code 201.24(f) admission 28 Pa. Code 211.15 (f)(v) Medical Records

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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

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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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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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and staff and facility documentation determined that the facility failed to ensure safe and operable equipment were available for use relating to blood pressure cuffs, and two mobility assistance devises, (Hoyer and Sit-to-Stand lifts) for two of 24 residents reviewed. Resident R68 and R20)Findings include: Review of the Resident R20's Minimum Data Set (MDS- a federal mandated assessment tool for all residents), dated July 14, 2025, revealed the resident was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required supervision or touching assistance with activities of daily living (ADLs) and had diagnoses including anxiety disorder (excessive worry and feelings of fear), bipolar II disorder (episodes of mood changes including depression and hypomania), and depression, unspecified (persistent feelings of sadness and loss of interest). On May 11, 2026 at 9:30 a.m., an interview with Resident R20 revealed concerns with use of a mechanical Hoyer lift. (A mechanical lifting device used to safely move a person who cannot stand or bear weight on their own, such as moving from a bed to a wheelchair.) Resident R 20 stated that during a transfer the prior week, the lift stopped working and staff required a key to remove her from the lift and return her to bed. Resident further stated that lift batteries are frequently not charged. Review of the Resident R51's Minimum Data Set (MDS- a federal mandated assessment tool for all residents), dated June 13, 2025, revealed the resident was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired The resident required supervision or touching assistance with activities of daily living (ADLs) and had diagnoses including bipolar disorder, unspecified (a mental health condition characterized by mood swings including depression and elevated mood), neuromuscular dysfunction of bladder (impaired nerve control of bladder function), and morbid obesity (severe excess body weight that increases health risks On May 11 ,2026 at 9:41 am interview with Resident R51 revealed that on several occasions the sit-to-stand lift (a mechanical assist device used to help a resident who can bear some weight transfer safely from one surface to another, such as from a bed to a chair) was inoperable or staff stated the batteries were charging. Resident further stated that nursing aides typically informed him they would return once the equipment was charged to assist him out of bed. On May 11, 2026 at 9:50 am, observation revealed a Hoyer lift stored in the 2nd floor hallway against the wall. At 9:55 am, Unit manager, Employee E5 attempted to power on and operate the Hoyer lift. Initial attempt was unsuccessful. Unit manager, Employee E5 retrieved three separate batteries from the charging station behind the nursing station; each battery was attempted without success. The lift remained inoperable. Interview on May 11, 2026, at 10:11 am, Unit manager, Employee E5 confirmed the Hoyer lift was not functioning and stated it may be a connection issue and a work order would be placed. Unit manager further stated there was no designated staff responsible for ensuring equipment is charged or operational prior to use. 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 vehicle accident prior to admission. Further review of the MDS assessment revealed the resident was dependent on staff for transfers, and bathing. Interview with Resident R68 on May 13, 2026, at approximately 11:30 a.m. with the second-floor unit manager voiced concerns with the nursing staff using blood pressure cuffs that were too small for his bariatric sized arm. They use the blue cuff because the larger sized cuff is never available, they will instead put the blue cuff on my forearm and it is too tight and too small and gives an inaccurate reading. During the same interview Resident R68 stated that two aides attempted to transfer him using the sit to stand but instead of using the correct sized belt that is used with the sit to stand the aides wanted to use the body sling used with the Hoyer lift. They had the Hoyer sling around my waist trying to use it as the belt. I saw the Director of Therapy in the hallway and came to help me. Immediately after the (continued on next page)

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview, the Director of Therapy confirmed that he witnessed the staff attempting to incorrectly use the wrong sized sling for the resident when they were using the sit to stand. Review of the facility's investigation/documentation revealed on May 12, 2026, two aides attempted to utilize the incorrect sling/belt during the mechanical transfer with Resident R68. Review of the nurse aides' witness statements revealed one aide sat with the resident while the other aide went to the laundry room looking for the correct sized sling. The aide stated, I could not find the larger grey pad for the sit to stand. Instead, the aide took a larger hoyer pad even though the aide stated she knew it was the wrong and the resident was getting upset. The other aide went to the laundry room to look for the sling while the one stayed with the resident. Laundry told the aide it must be in the wash. The aide came back from the laundry room and said the resident was upset, looking for the therapist. Review of the facility's Competency Assessment Lifting Machine, Using a Mechanical, skill check list given to the nursing staff indicates, Make sure the battery is charged and Make sure that all necessary equipment (sling, hooks, chains, straps and supports) is on hand and in good condition. 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(3)(5)(e)(1) Management