

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Willow Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE  One Penn Boulevard Philadelphia, PA 19144	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to ensure that residents were treated in a dignified manner for one of five residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy, Transmission Based Precautions dated revised April 6, 2024, revealed, Enhanced Barrier Precautions are designed to reduce the transmission of multidrug resistant organisms in facilities. Continued review revealed that Enhanced Barrier Precautions are indicated for residents with wounds and/or indwelling medical devices (such as central lines, foley catheters and feeding tubes). Further review revealed, Residents may share rooms with other residents who are not on Enhanced Barrier Precautions and residents may leave their rooms.</p> <p>Interview on September 11, 2024, at 10:00 a.m. Resident R1 stated that a few weeks ago she overheard staff outside of her room saying, I'm not going in there, I don't know what she's got. Resident R1 stated she needs assistance with toileting and wound care, and that staff have personal protective equipment (such as gowns and gloves) to wear if they want to protect themselves while assisting her with care. Resident R1 stated that staff tell her not to leave her room even though there are no restrictions with her leaving her room. Resident R1 stated that the statements made by staff made her feel embarrassed and undignified.</p> <p>Observation, at the time of the interview, Resident R1 had a wound to her buttocks area and a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in her right upper arm. Resident R1 stated that the PICC is used to administer intravenous antibiotics.</p> <p>Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated August 29, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including necrotizing fasciitis (serious bacterial infection that results in the death of the body's soft tissues).</p> <p>Review of Resident R1's care plan, dated initiated August 23, 2024, revealed that the resident has a wound infection, with interventions including to maintain enhanced barrier precautions. Continued review revealed that the resident receives intravenous antibiotics related to her wound infection.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes for Resident R1 revealed a note, dated August 25, 2024, at 2:40 p.m. which stated, Resident came out of room this shift and was redirected back to room in which she declined, insisting that she is no longer contagious, resident was educated on risk of her not abiding by isolation precautions but still left the floor to go collect food downstairs.</p> <p>Interview on September 11, 2024, at 3:38 p.m., the Nursing Home Administrator and Director of Nursing confirmed that Resident R1 did not have an infectious disease requiring isolation and only required Enhanced Barrier Precautions due to her wound and PICC line. Continued interview confirmed that all residents on Enhanced Barrier Precautions are not restricted to their rooms and are allowed to leave their rooms, move about in the facility and participate in activities.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to obtain and follow physician orders related to medications, wound care and dietary recommendations for three of five residents reviewed (Residents R1, R2 and R3).</p> <p>Findings include:</p> <p>Review of facility policy, Medication Management - Unavailable Meds dated April 22, 2024, revealed, If a medication shortage is noted during normal pharmacy hours, a licensed nurse notifies the pharmacy and speaks to a registered pharmacist to determine the status of the order . if the next available delivery results in a delay or missed dose in the customer's medication schedule, take the medication from the emergency stock supply to administer the dose. If ordered medication is not available in the emergency stock, notify pharmacist that an emergency delivery is required . if an emergency delivery is not feasible, a licensed nurse contacts the attending physician to obtain orders or directions which may include holding the dose, use of alternative medication from the emergency stock supply, and change in order.</p> <p>Interview on September 11, 2024, at 10:00 a.m. Resident R1 stated that she did not receive appropriate wound care when she was first admitted to the facility, that she had missed several doses of her medications, including intravenous antibiotics and insulin, and that she does not receive snacks. Resident R1 stated that she's been frequently having diarrhea and that she hasn't been receiving medications to treat it. Observation, at the time of the interview, Resident R1 had a wound to her buttocks area and a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in her right upper arm. Resident R1 stated that the PICC is used to administer intravenous antibiotics.</p> <p>Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated August 29, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including necrotizing fasciitis (serious bacterial infection that results in the death of the body's soft tissues), diabetes (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose), malnutrition (lack of sufficient nutrients in the body) and depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things).</p> <p>Review of Resident R1's progress notes revealed an admission note, dated August 22, 2024, at 4:02 p.m. which indicated that the resident was admitted to the facility with a diagnosis of wounds and to refer to the Admission Nursing Assessment.</p> <p>Review of Resident R1's Admission Nursing Assessment, dated August 22, 2024, revealed that the resident was admitted to the facility with wounds. Continued review revealed that there was no assessment of the resident's wounds noted on the assessment, such as the location, type of wound, or wound measurements.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R1's Treatment Administration Records for August 2024, revealed physician's orders, dated August 23, 2024, cleanse wound to buttocks with saline and apply Dakins (topical antiseptic used to treat wound infections) soaked kerlex (rolled gauze) and cover with clean dry dressing daily on day shift. Continued review of Resident R1's treatment record and progress notes revealed that there was no indication that the wound treatment was provided on August 23, 2024. Further review of Resident R1's clinical record revealed that the resident's wound was not assessed until August 25, 2024, which was three days after her admission to the facility.</p> <p>Review of Resident R1's Nutrition Assessment, dated August 26, 2024, revealed that the resident was at high risk for malnutrition with recommendations for afternoon snacks at 2:00 p.m.</p> <p>Review of physician orders, progress notes and food/meal/snack intake logs revealed no indication that the resident was offered or provided with 2:00 p.m. snacks as recommended by the dietician.</p> <p>Interview on September 11, 2024, at 11:50 a.m. Employee E3, Food Service Director, revealed that snacks are served at 2:00 p.m. and bedtime and are only prepared for residents who have physician orders for snacks.</p> <p>Review of Resident R1's Medication Administration Records (MARs) for August 2024 revealed a physician's order, dated August 23, 2024, for Unasyn (antibiotic medication) infuse nine grams intravenously every eight hours for wound infection. The MARs noted that administration times for the medication were scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. Continued review of MARs revealed that the August 23, 2024, dose for 2:00 p.m. was blank and that the August 24, 2024, dose for 6:00 a.m. was not administered and to See nurses note. Review of progress notes for Resident R1 revealed that was no indication as to why the medication was not initiated upon the resident's admission to the facility or why the scheduled dose on August 23, 2024, at 2:00 p.m. was not administered. Further review revealed an eMAR (electronic MAR note) note dated August 24, 2024, at 5:33 a.m. which stated that the medication was not administered due to waiting for delivery Review of the facility's emergency medication supply inventory revealed that Unasyn injectable vials were available for use at the facility.</p> <p>Continued review of Resident R1's MARs revealed a physician's order, dated August 23, 2024, for Micafungin (antibiotic medication) infuse 100 milligrams intravenously one time a day for wound infection. The MAR noted that the administration time for the medication was scheduled for 9:00 a.m. Continued review of MARs revealed that the August 23, 2024, dose for 9:00 a.m. was blank. Review of progress notes for Resident R1 revealed that was no indication as to why the scheduled dose on August 23, 2024, at 9:00 a.m. was not administered or that the physician was notified of the missed dose.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Continued review of Resident R1's MARs revealed a physician's order, dated August 23, 2024, for Novolin 70/30 (insulin medication used to lower blood sugar levels in people with diabetes), inject 30 units subcutaneously (under the skin) two times a day before meals. The MARs noted that administration times for the medication were scheduled for 8:00 a.m. and 5:00 p.m. Continued review of MARs revealed that the August 23, 2024, dose for 8:00 a.m. was blank and that on August 27, September 1 and September 2, 2024, the 8:00 a.m. doses were not administered due to not due. Review of progress notes for Resident R1 revealed that there were no notes as to why the medication was not administered on August 23, 2024. Continued review revealed an eMAR note, dated September 1, 2024, at 9:17 a.m. which stated that the Resident's blood sugar was 117 and that the medication was withheld. Continued review revealed an eMAR note, dated September 2, 2024, at 9:40 a.m. which stated that the Resident's blood sugar was 103 and that the medication was held. Further review revealed that no hold parameters were prescribed by the physician regarding withholding the medication and there were no notes to indicate that the physician was notified to obtain any hold parameters.</p> <p>Continued review of Resident R1's MARs revealed physicians orders, dated August 23, 2024, for cetirizine (allergy medication) one time a day, losartan (medication used to treat high blood pressure) one time a day, sertraline (medication used to treat depression) one time a day, and metformin (medication used to treat diabetes) twice per day. Continued review of MARs revealed that the August 23, 2024, dose for 9:00 a.m. for all the above medications was blank. Review of progress notes for Resident R1 revealed there was no indication as to why the scheduled doses on August 23, 2024, at 9:00 a.m. were not administered or that the physician was notified of the missed doses. Review of the facility's emergency medication supply inventory revealed that metformin was available for use at the facility.</p> <p>Continued review of Resident R1's MARs revealed a physician's order, dated August 23, 2024, for floranax (lactobacillus, a probiotic medication used to treat diarrhea) give one packet three times for day. The medication was scheduled to be administered at 9:00 a.m., 1:00 p.m. and 5:00 p.m. Continued review of MARs revealed that the scheduled doses for August 23, 2024, at 9:00 and 1:00 p.m were blank. Further review revealed that the following doses were not administered and to See nurses note: August 24 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; August 25 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; August 26 at 9:00 a.m. and 1:00 p.m.; August 27 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; August 28 at 9:00 a.m. and 1:00 p.m.; August 29 at 9:00 a.m. and 1:00 p.m.; August 30 at 9:00 a.m. and 1:00 p.m.; August 31 at 5:00 p.m.; September 1 at 5:00 p.m.; September 3 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; September 4 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.; September 5 at 1:00 p.m. and 5:00 p.m.; and September 6 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. Review of corresponding eMAR notes revealed that the medication was not administered due to not on hand or waiting for delivery. Further review revealed that there was no indication in the clinical record that the physician was notified of the missed doses or that the medication was unavailable.</p> <p>Review of Resident R2's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (bone infection) of left ankle and foot and ventricular tachycardia (irregular heart rate).</p> <p>Review of progress notes for Resident R2 revealed an Admission note, dated May 24, 02024, at 9:12 p.m. which indicated that the resident was admitted to the facility and to refer to the Admission Nursing Assessment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R2's Admission Nursing Assessment, dated May 24, 2024, revealed that the resident had wounds on her left thigh, left ankle and left foot.</p> <p>Review of Treatment Administration Records for May 2024 for Resident R2 revealed a physician's order, dated May 26, 2024, to cleanse the left lower leg with normal saline, apply oil emulsion dressing and rolled gauze every day shift. Continued review revealed that on May 27, 2024, there was no indication that the treatment was completed.</p> <p>Continued review of Treatment Administration Records for Resident R2 revealed physicians orders, dated May 30, 2024, to apply wound cleanser and betadine to the resident's left heel and lateral (side) heel and to apply wound cleanser, topical antibiotic ointment and foam dressing to the resident's left posterior (back) thigh.</p> <p>Further review of Resident R2's clinical record revealed no indication as to why any of the above wound treatments were not implemented upon the resident's admission to the facility.</p> <p>Review of Resident R2's MARs for May 2024 revealed a physician's order, dated May 25, 2024, for Meropenem (antibiotic medication) infuse 2000 milligrams intravenously every eight hours. The MAR indicated that the medication was scheduled to be administered at 6:00 a.m., 2:00 p.m. and 10:00 p.m. Continued review revealed that the medication was not prescribed to begin until May 25, 2024, at 2:00 p.m. Further review revealed that the doses scheduled for May 25, 2024, at 2:00 p.m. and 10:00 were not administered and to See nurses note. Review of corresponding eMAR notes revealed that the medication was not administered due to pending delivery. Further review of progress notes for Resident R2 revealed that was no indication as to why the medication was not initiated upon the resident's admission to the facility or that the physician was notified of the missed doses.</p> <p>Continued review of Resident R2's MARs revealed physicians orders, dated May 25, 2024, for amiodarone (medication used to treat irregular heart rate) one time a day, ezetimibe (medication used to treat high cholesterol) one time a day, and rosuvastatin (medication used to treat high cholesterol) one time a day. Continued review of MARs revealed that the May 25, 2024, dose for 9:00 a.m. for all the above medications were noted as not administered and to See nurses note. Review of corresponding eMAR notes revealed that the medications were not administered due to not on hand/awaiting delivery. Further review revealed that there was no indication in the clinical record that the physician was notified of the missed doses or that the medication was unavailable. Review of the facility's emergency medication supply inventory revealed that amiodarone was available for use at the facility.</p> <p>Review of Resident R3's care plan, dated initiated September 7, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including diabetes. Interventions included to administer diabetes medication as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of MAR's for Resident R3 revealed a physician's order, dated September 7, 2024, for lispro insulin (rapid acting insulin) inject four units subcutaneously before meals. Continued review revealed that the following doses were not administered due to Hold/See nurses note: September 8 at 11:00 a.m., September 9 at 7:30 a.m. and September 10 at 11:00 a.m. Review of corresponding eMAR notes revealed that on September 8, 2024, the medication was held - blood sugar 100 and on September 9 and 10, 2024, that no rationale was provided as to why the medication was not administered. Further review revealed that no hold parameters were prescribed by the physician regarding withholding the medication and there were no notes to indicate that the physician was notified to obtain any hold parameters.</p> <p>Interview on September 11, 2024, at 3:38 p.m., the Nursing Home Administrator and Director of Nursing confirmed that medications should be obtained from the facility's emergency medication supply if they are unavailable. Continued interview revealed that they were unable to explain why the medications, wound treatments and dietary recommendations were not implemented in a timely manner for Residents R1, R2 and R3.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		