

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 04/01/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>36609</p> <p>Based on observation, and review of resident clinical records, it was determined that the facility failed to ensure proper accommodation of needs for one of 32 residents reviewed regarding appropriate bed size and mattress (Resident R17).</p> <p>Findings include:</p> <p>Review of Resident R17 annual MDS (an assessment of resident needs) dated January 22, 2024, indicated the resident was cognitively intact, diagnosed with a history of a cerebrovascular accident (stroke), arthritis, and quadriplegia. The MDS indicated the resident was impaired on one side of his upper body, both sides of his lower body, and was completely dependent on staff for bed mobility and all activities of daily living (ADL). The MDS indicated the resident was on a scheduled pain management regimen and reported the pain would frequently affect his sleep, and frequently interfere with his day-to-day activities, including therapy. The resident rated the intensity of his pain, an 8 out of 10 (ten being the worst level of pain).</p> <p>Further review of Resident R17's clinical record revealed a plan of care for chronic pain related from his limited range of motion, and contractures in his upper and bilateral lower extremities. Interventions included staff facilitating passive and active movements to enhance the flexibility of the resident's joints, and the use of bilateral side rails for the resident's bed mobility, and repositioning. Interventions included assessing the bed for loose rails and contacting maintenance for repairs.</p> <p>On March 27, 2024, at approximately 12:00 p.m. the surveyor observed Licensed Practical Nurse (LPN) Employee E7 asked Resident R17 to turn to his left side. The resident was tall, and thin and had limited space in his bed for repositioning. Both legs were bent at the knees, and his feet were pressed against the bottom of the bed frame. The resident was unable to independently turn himself using the bed rails because of his awkward positioning and needed the LPN to turn him onto his side. The mattress was observed with an area bulging and not smooth. The resident stated the bed was uncomfortable and explained, 'Some man came this weekend to look at his bed and said, 'Well, this is what you get' and left. Immediately the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were called to the room. An attempt was made to reposition the resident by moving his body towards the top of the bed. Once repositioned, the feet no longer touched the bed frame, but the resident's head was approximately six inches past the head of the bed's mattress.</p> <p>28 Pa. Code 210.29(4) Resident rights.</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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>47973</p> <p>Based on observations, clinical record reviews, review of facility policy and interviews with residents and staff, it was determined that the facility failed to provide assistance with showers for three of five residents reviewed (Residents R96).</p> <p>Findings include:</p> <p>Review of facility policy, Refusal of Care, revised March 2024, indicated that the nurse will monitor for recurring refusals of medication, treatments, care and services. Further review revealed that the IDT team will meet with the resident/resident representative to ascertain the reasons why they are refusing care and services and will review and offer alternative interventions as appropriate.</p> <p>Interview with Resident R96's power of attorney on March 27, 2024, at approximately 2:00 p.m. revealed that Resident R96 was not provided assistance with showers.</p> <p>Review of physician orders for Resident R96 revealed that the resident was to receive showers on Mondays and Thursdays on the 7-3 shift.</p> <p>Review of Resident R96's current care plan, date-initiated September 7, 2023, revealed that the resident requires assist of 1 for showering or bathing. Further review failed to reveal a care plan regarding shower refusals and interventions for Resident R96.</p> <p>Further review of resident R96's clinical records revealed that the resident had not received a shower on the following dates marked as -97 (N/A), 31 (no), -98 (refused): January 4, 8, 11, 15, 18, 22, 25, 2024; February 1, 5, 8, 12, 15, 19, 22, 2024; and March 4, 14, 18, 2024.</p> <p>Interview with the Administrator, Employee E1, on April 1, 2024, at 1:11 p.m. confirmed that there was no documentation in the clinical records of the reason as to why Resident R96 was not provided assistance with showers on the days noted above. Further interview confirmed there was no evidence of meetings with the interdisciplinary team and resident representative to ascertain the reasons why the resident was refusing care; no alternative interventions were offered.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records, interviews with staff and review of facility policy, it was determined that the facility failed to ensure a resident who required respiratory care received the necessary care and services in accordance with professional standards of practice, and resident's plan of care for one of 32 resident records reviewed (Resident R96)</p> <p>Findings included:</p> <p>Review of the facility's policy titled, BIPAP CPAP revised May 2021 states, BIPAP and CPAP is administered by Licensed Nurses with a Physician's order . prescribed for some residents to augment resident breathing when they have difficulty maintaining adequate ventilation due to obstructive sleep apnea, central sleep apnea and complex sleep apnea.</p> <p>Review of Resident R96's clinical record revealed that the resident was admitted to the facility on [DATE], diagnosed with Obstructive Sleep Apnea (intermittent airflow blockage during sleep). Review of physician orders dated June 1, 2023, instructed to use the C-pap machine at bedtime and remove in the morning to aide with breathing related to the resident's shortness of breath. Further review of the resident's record revealed on March 6, 2024, the resident was transferred to the hospital and returned on March 8, 2024. There was no documented evidence of an order to continue the use of a C-pap machine or that the physician was contacted related to the use of a C-pap machine.</p> <p>Interview with Resident R96's Power of Attorney on March 27, 2024, at approximately 2:00 p.m. revealed that Resident R96 was escorted to the ophthalmologist appointment on March 6, 2024, without an oxygen tank, which resulted in Resident R96's admission to the hospital for shortness of breath.</p> <p>Review of physician orders for Resident R96 revealed an order dated August 17, 2023, which stated, Oxygen at 2 L/min for Pulse Ox <90%, shortness of breath, or dyspnea; as needed.</p> <p>Review of Resident R96's clinical record, Oxygen Saturation Summary, dated February 5, 2024, through March 5, 2024, revealed that Resident R96 was utilizing Oxygen via Nasal cannula 28 times during the 30-day lookback period, leading up to her appointment on March 6, 2024. Further review revealed that on March 4, 2024, through March 5, 2024, Resident R96 was on oxygen via nasal cannula continuously, two days prior to the appointment.</p> <p>Review of Resident R96's care plan, date-initiated August 17, 2024, failed to reveal a care plan for oxygen use and respiratory care.</p> <p>Interview with nurse aide, Employee E8, who escorted Resident R96 to the ophthalmologist appointment on March 6, 2024, confirmed that the resident did not have an oxygen tank present at the appointment. Further interview revealed that the resident began to experience shortness of breath at the appointment and was admitted to the hospital.</p> <p>Review of hospital documentation dates March 6, 2024, confirmed that Resident R96 was admitted to the Hospital on March 6, 2024, for shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing, Employee E2, on April 1, 2024, at approximately 1:00 p.m. confirmed the above-mentioned findings. Further interview confirmed that Resident R96 was not assessed for oxygen saturation levels prior to leaving to the appointment and that there was no documented evidence of Resident R96 being cleared by the physician to proceed to the appointment without a portable oxygen tank. Employee E2 confirmed that Resident R96's oxygen levels needed to be assessed prior to being escorted to the Ophthalmology appointment on March 6, 2024.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on the review of clinical records and interviews with staff, it was determined that the facility failed to ensure each resident received the necessary behavioral health services in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for two of 32 resident records reviewed (Resident 18 and R61).</p> <p>Findings include:</p> <p>Review of Resident R18 clinical record revealed the resident was initially admitted to the facility on [DATE] diagnosis included Traumatic Brain Injury, Major Depressive Disorder, recurrent, severe with psychotic symptoms, Unspecified Dementia, unspecified severity, with other behavioral disturbances, Vascular Dementia, unspecified severity, with other behavioral disturbance, Schizoaffective disorder, unspecified, Mood Disorder due to unknown physiological condition with depressive features, and unspecified Symbolic Dysfunctions,</p> <p>Review of Resident R18 psychiatric consultation dated August 9, 2023, indicated the physician recommendations were to monitor behaviors for agitation and/or psychoses, adverse effects of his medication and to follow-up with an appointment in three months. Further review of the clinical record revealed the facility failed to reschedule the appointment in the recommended time frame. The following psychiatric consultation was not until February 21, 2024, when the resident complained of increased anxiety with rapid breathing, pounding in his chest, and difficulty sleeping.</p> <p>The delay in rescheduling Resident R18's psychiatric consultation was confirmed with the Nursing Home Administrator on March 27, 2024, at 5:54 p.m. when no other documentation for review was found.</p> <p>Review of Resident R61's clinical record revealed the resident was initially admitted to the facility September 17, 2020, diagnosis included, Unspecified Dementia, Anxiety disorder, Major Depressive disorder, and insomnia.</p> <p>Review of Resident R61's psychiatric consultation dated November 29, 2023, revealed the reason for the follow up visit was due to reports of nightmares, with yelling in his sleep. Resident reported dreams of people chasing him that occurs once a month. The nurses indicated it happens about twice a week. Otherwise, he is feeling pretty good considering the circumstances. Expresses hopelessness about not being able to leave here. The consult recommended following up in three months.</p> <p>Further review of Resident R61's clinical record revealed the facility failed to reschedule the appointment in the recommended time frame and no further appointments had been scheduled.</p> <p>The delay in rescheduling Resident R61's psychiatric consultation was confirmed with the Nursing Home Administrator on March 27, 2024, at 5:54 p.m. when no other documentation for review was found.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>36609</p> <p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on review of clinical records and interview with staff and review of facility policy, it was determined that the facility failed to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of a resident by failing to assist in community placement options until completion for one of 32 resident records reviewed (Resident R61).</p> <p>Findings include:</p> <p>Review of facility policy titled, Discharge Planning Process dated March 2021, last reviewed April 2023 stated, The policy is to ensure that the resident has a planned program of post-discharge continuing care that takes his/her needs into account for a safe discharge. Discharge planning is interdisciplinary and is initiated preadmission, admission and continues through continuum of care.</p> <p>Review of Resident R61's clinical record revealed the resident was initially admitted to the facility September 17, 2020, diagnosis included, Unspecified Dementia, Anxiety disorder, Major Depressive disorder, and insomnia.</p> <p>Review of Resident R61's Social Service note dated June 29, 2023, revealed Social Services met with Resident R61 to introduce him to housing opportunities. The person offering these services took the resident's background information and informed him of housing options he was able to offer. The resident stated he was interested in learning more about the housing options and was told the person would return to the facility with additional information.</p> <p>Review of Resident R61's Social Services note dated July 14, 2023, revealed the resident attended a housing meeting to gather more information and the Social Worker indicated more housing options would be provided.</p> <p>Social Services note dated August 14, 2023, revealed Resident R61 wanted to move in with his son and the son was able to give 24-hour supervision.</p> <p>Social Services note dated August 23, 2023, informed the resident a care conference discharge meeting would be scheduled.</p> <p>Social Services note dated September 6, 2023, attempted to contact son and left message.</p> <p>Review of Resident R61's September 6, 2023, psychiatric consultation noted the resident's frustration over still being here and is requesting assistance to find a place to go. The psychiatric stated, the resident's capacity for discharge to another place is generally intact, but due to some mild short term memory impairment, he will need a place where his medications are dispensed. Ask social worker to work with patient to attempt to find a discharge plan.</p> <p>Continue review of Resident R61's Social Service notes indicated the resident's son was contacted in October, November, and December 2023 to schedule the care conference discharge meeting and each time the son had to cancel due to car troubles.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The last documented Social Service note was dated December 12, 2023, indicated the resident's son was still experiencing transportation issues and needed to reschedule the meeting for January 12, 2024. No other correspondence was found regarding Resident R61's discharge.</p> <p>On March 29, 2024, at 11:24 a.m. during an interview with the Director of Social Services stated that was how it was left, the son had car problems and confirmed that there was no documented evidence that further attempts were made finding outside housing for Resident R61.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>36609</p> <p>Based on review of facility policy, review of clinical records, and interview with staff, it was determined that the facility failed to provide pharmaceutical services to meet resident's needs including acquiring, receiving, and administering medications for two of 32 residents reviewed (Resident R17 and R96).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medication Storage/Unavailable Medications not dated, states when medications are not available the nurse will urgently initiate action. If delivery of the medication will be late or missed, take the medication from the emergency stock supply. If the medication is unavailable the nurse will call the physician for further orders. The policy further instructs to document missed doses on the EMAR (electronic medical record), document explanation for missed , See nurses notes for explanation. Document explanation of missed dose in the nurses note, describing the circumstance of medication shortage, notification of pharmacy and response and action(s) taken.</p> <p>Review of Resident R17 annual MDS (an assessment of resident needs) dated January 22, 2024, indicated the resident was cognitively intact, diagnosed with a history of a cerebrovascular accident (stroke), arthritis, and quadriplegia. The MDS indicated the resident had an impairment on one side of his upper body, both sides of his lower body, and was completely dependent on staff for bed mobility and all activities of daily living (ADL). The MDS indicated the resident was on a scheduled pain management regimen and reported the pain would frequently affect his sleep, and frequently interfere with his day-to-day activities, including therapy. The resident rated the intensity of his pain an 8 out of 10 (ten being the highest level of pain).</p> <p>Further review of Resident R17's clinical record revealed a plan of care for chronic pain related from his limited range of motion, and contractures in his upper and bilateral lower extremities. Interventions included administer analgesia as per orders, facilitating passive and active movement to enhance flexibility of his joints, and the resident's use of bilateral side rails for bed mobility.</p> <p>Review of Resident R17's medical record revealed an order for Tramadol HCl Oral Tablet 50 mg. for pain management active from December 22, 2023, to January 12, 2024, instructing to give 50 milligrams (mg) by mouth every 6 hours scheduled at 12:00 a.m., 6:00 a.m., 12:00 pm. and 6:00 p.m. The order was discontinued on January 12, 2024, and a new order, instructing to give 50 mg of Tramadol every eight hours, at 6:00a.m., 2:00 p.m., and 10 p.m. The order was discontinued on January 29, 2024, and a new order, instructing to administer 50 mg of Tramadol, four times a day, to be administered at 9:00 a.m., 1:00 p.m., 5:00 p.m. and 9:00 p.m. and is currently active.</p> <p>Review of Resident R17's electronic medical administration record (EMAR) and review of the nursing progress notes revealed the medication Tramadol was documented as not given, not available. pending delivery and/or back ordered for the following dates:</p> <p>On January 1, 2024, three dosages were not administered</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 2, 2024, two dosages were not administered</p> <p>On January 21, 2024, one dose was not administered</p> <p>On January 22, 2024, two dosages were not administered</p> <p>On January 26, 2024, two dosages were not administered</p> <p>On January 27, 2024, two dosages were not administered</p> <p>On February 9, 2024, two dosages were not administered</p> <p>On February 16, 2024, three dosages were not administered</p> <p>On February 26, 2024, one dose was not administered</p> <p>On March 11, 2024, one dose was not administered</p> <p>Continued review of Resident R17's clinical record revealed no documented evidence that the physician was made aware of the missed doses or that an alternate treatment was requested. Further review of the clinical record revealed no documented evidence the licensed nurse activated backup pharmacy process and procedures to obtain and administer the medication.</p> <p>Interview with Licensed Registered Nurse, Employee E7 on March 27, 2024, at 10:30 a.m. was not aware the emergency supply of medication included pain medication Tramadol.</p> <p>Review of Resident R96 clinical record revealed the resident was admitted with Chronic Systolic Congestive Heart Failure (the heart does not pump efficiently) Atrial Fibrillation (irregular heartbeat) and Obstructive Sleep Apnea on May 30, 2023.</p> <p>Resident R96 was ordered Carvedilol Oral Tablet 25 mg, instructed to give one tablet by mouth two times a day for hypertensive chronic kidney disease /end stage renal disease . On January 20, 2024, nursing progress note indicated the medication was not given due to the medication ordered.</p> <p>On March 5, 2024, Resident R96 was ordered Nitrofurantoin Macrocrystal oral capsule 100 mg, instructed to give one capsule by mouth two times a day for an urinary tract infection. Further review revealed the medication was not administered due to medication not available.</p> <p>Continued review of Resident R96's clinical record revealed no documented evidence that the physician was made aware of the missed doses or that an alternate treatment was requested. Further review of the clinical record revealed no documented evidence the licensed nurse activated backup pharmacy process and procedures to obtain and administer the medication.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy Services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47973</p> <p>Based on review of facility documentation, observations, and resident and staff interviews, it was determined that the facility failed to provide food that was palatable, attractive, and served at the proper temperature for one of five nursing units observed (third floor nursing unit)</p> <p>Findings include:</p> <p>Review of undated facility policy titled, Meal Tray Accuracy Audit Report Policy, indicated that for satisfactory result, all got items must be 135 degrees or higher and all cold items must be 45 degrees or below at point of service.</p> <p>Interview with Resident R119 on March 26, 2024, at 12:04 p.m. revealed that food is always cold and coffee is never hot.</p> <p>Observations during a test tray conducted with The Food Service Director, Employee E3, on March 27, 2024, at 12:58 p.m. revealed that the hot coffee registered at 133.7 degrees Fahrenheit (F); macaroni and cheese at 135.7 degrees F; green beans at 138.4 degrees F; mashed potato at 124.9 degrees F; milk at 56 degrees F; rice pudding at 62.8 degrees F; and cranberry juice at 61 degrees F.</p> <p>An interview with the FSD, on March 27, 2024, at 1:03 p.m. confirmed that the above-mentioned food items were below and above the acceptable temperatures and therefore not palatable.</p> <p>Observations during the lunch meal, in the third-floor dining room, on March 26, 2024, at 12:39 p.m. revealed Resident R39 received his lunch meal which, according to the meal slip consisted of puree peas, pureed rice, and pureed potatoes. Observations revealed the consistency of the foods appeared as liquid which spread throughout the whole plate. Interview with the FSD confirmed that Resident R39's meal was not the appropriate pureed consistency. Further interview revealed that the pureed foods needed one and a half packets of thickening powder added to make the pureed foods attractive, palatable, and the appropriate pureed consistency.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 211.6(f) Dietary services</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>47973</p> <p>Based on review of facility policy, review of clinical record, observations, and staff and resident interviews, it was determined that the facility failed provide food items consistent with the prescribed diet order for one of four residents reviewed for nutrition (Resident R149).</p> <p>Findings Include:</p> <p>Review of facility diet guide sheet revealed Tuesday lunch offerings on March 25, 2024, was Herb Rubbed Pork, Parley New Potatoes, Braised Cabbage, and Chilled Peas. Per the diet guide sheet, a resident on a mechanically soft diet (consisting of food that have been bended, mashed, pureed, or chopped, making them soft and easy to eat without biting or chewing), should receive ground herb rubbed pork, mashed potatoes, and pureed braised cabbage.</p> <p>Review of Resident R149's physician orders revealed the resident was ordered a Mechanically Soft Textured diet dated January 25, 2024.</p> <p>Dining observation conducted on March 26, 2024, at 1:16 p.m. revealed Resident R149's meal ticket confirmed that the resident was ordered a Mechanical Soft Diet. Further review of the meal ticket indicated the resident was to receive ground herb rubbed pork with gravy, mashed potatoes, and pureed braised cabbage. Further observations of Resident R149's lunch time meal tray revealed the resident was served a regular consistency diet which included whole slices of rubbed pork, cubed potatoes, and braised cabbage; Licensed Practical Nurse, Employee E6, confirmed this finding.</p> <p>Further observations with the Speech Therapist, Employee E5, revealed that the resident had pocketed the cabbage due to the inability to swallow. The resident proceeded to taking the cabbage out of his mouth for over a ten-minute span. Interview with Employee E5 confirmed that the meal that was served to Resident R149 during lunch was not appropriate and had placed the resident at risk for choking and aspiration hazard.</p> <p>28 Pa. Code 211.6 (a) Dietary Services</p>		

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 04/01/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47973</p> <p>Based on observations, interviews with staff, and a review of facility policies and documentation, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of facility policy titled, Uniform Policy, revised May 27, 2023, indicated that facial hair coverings will be worn to cover any and all facial hair.</p> <p>Review policy titled, Dating and Labeling Policy revised January 24, 2023, indicated that the kitchen will assure food safety by maintaining proper dated and labels to all goods and ready to eat food products .</p> <p>An initial tour of the main kitchen was conducted on March 25, 2024, at approximately 10:19 a.m. with the Food Service Director (FSD), Employee E3.</p> <p>Observations revealed that two kitchen staff were not wearing a facial hair covering.</p> <p>Observations in the reach in refrigerator in the main cooking area revealed that gravy and macaroni and cheese was unlabeled and undated; hashbrowns and peas were inappropriately dated with the month and year, 3/24.</p> <p>Observations in the main refrigerator revealed four uncooked poultry products (turkey) were stored on the highest rack in the refrigerator and were leaking pink liquid. Further observations revealed that breadcrumbs and egg wash (mix of beaten whole egg) were stored on the rack below the raw poultry.</p> <p>Interview with the FSD on March 25, 2024, at approximately 10:40 a.m. confirmed that safe refrigerator storage requires raw poultry to be stored on the lowest rack possible; and that eggs are to be stored below ready-to-eat/fully cooked foods and produce, above raw poultry. FSD confirmed that the raw turkey was leaking pink liquid.</p> <p>Interview with the FSD at 10:41 a.m. on March 25, 2024, confirmed the above findings.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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 04/01/2024
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 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>36609</p> <p>Based on interviews with residents and staff and review of clinical records, it was determined that the facility failed to ensure timely provision of professional services furnished by outside providers, for one of 32 residents reviewed (Residents R17).</p> <p>Findings include:</p> <p>Review of Resident R17 annual MDS (an assessment of resident needs) dated January 22, 2024, indicated the resident was cognitively intact, diagnosed with a history of a cerebrovascular accident (stroke), arthritis, and quadriplegia. The MDS indicated the resident had an impairment on one side of his upper body, both sides of his lower body, and was completely dependent on staff for bed mobility and all activities of daily living (ADL).</p> <p>During an interview on March 27, 2024, Resident R17 stated he had a cardiologist appointment in July but couldn't get a ride to his appointment, so the facility cancelled it but did not reschedule another visit.</p> <p>Review of the nursing progress notes dated July 17, 2023, stated, Cardiology appointment cancelled.</p> <p>This was confirmed on March 27, 2024, at 4:00 p.m. with the Nursing Home Administrator when no evidence of a rescheduled cardiologist appointment was found.</p> <p>28 Pa. Code 211.12 (d)(1) Nursing Services.</p>		

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 04/01/2024
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.			
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>47973</p> <p>Based on observations of the food and nutrition department, review of facility policy and interviews with staff, it was determined that the facility failed to maintain essential food service equipment in safe operating condition.</p> <p>Findings Include:</p> <p>Review of facility policy titled, Dish Machine Usage Policy, revised November 15, 2023, revealed that dishwasher staff will monitor and record dish machine temperatures to assure compliance for wash and rinse cycles . FSD (food service director) or Designee will monitor temperature log and PPM readings prior to each usage for compliance.</p> <p>An initial tour of the main kitchen was conducted on March 25, 2024, at approximately 10:19 a.m. with the Food Service Director (FSD), Employee E3.</p> <p>Observations of the dish room revealed Dietary Aide, Employee E4, was utilizing the dish machine. Further observations revealed that the dish machine thermometers were not operating; FSD confirmed that the dish machine was not functioning properly.</p> <p>Review of the dish machine temperature log titled, Dish Machine Ware Washing- Low Temperature, revealed missing wash temperatures, final rinse temperatures, and chlorine sanitizer PPM for breakfast, lunch, and dinner meals from March 22, 2024, through March 25, 2024.</p> <p>Interview with the foodservice director, Employee E3 at 10:21 a.m. revealed that staff are not trained to look at the thermometers, they just run the machine and that they do not fill out the temperature log.</p> <p>Review of documentation titled, Cleanslate Kitchen Service Report dated March 25, 2024, confirmed that the dish machine wash temperature and rinse temperature were out of compliance.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.6(d) Dietary services</p>		