STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396129	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Terrace	One Penn Boulevard Philadelphia, PA 19144

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that residents or their representatives were informed of treatment options, as well as the risks and benefits of the proposed care, for three of four residents reviewed for psychotropic medications (Residents R142, R139 and R158). Findings include: Review of Resident R142's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated November 14, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cerebrovascular accident (damage to the brain from interruption of its blood supply), dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things) and psychotic disorder (loss of contact with reality). Continued review revealed that the resident had a BIMS (Brief Interview for Mental Status) score of three, which indicated that the resident was severely cognitively impaired. Review of progress notes for Resident R142 revealed a nurses note, dated December 23, 2024, at 4:47 p.m. which indicated that the resident had an appointment with neurology (branch of medicine that specializes in disorders of the brain, spinal cord and nerves) and returned with a new order for risperidone (antipsychotic medication used to treat mood disorders) 1 m.g (milligram) twice per day. Review of Resident R142's neurology consultant note, dated December 23, 2024, revealed that the consultant recommended for the resident to receive risperidone 1 m.g twice per day. Review of Medication Administration Records (MARs) for Resident R142 revealed that the resident received risperidone on December 24, 25, and 26, 2024, for a total of four doses. Continued review of progress notes for Resident R142 revealed a nurses note, dated December 26, 2024, at 3:03 p.m. which indicated that the resident was seen by psychiatry (mental health) and discontinued the risperidone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R142's psychiatry note, dated December 26, 2024, noted that the resident was started on risperidone by neurology. The psychiatrist recommended to discontinue the risperidone because the resident was already on aripiprazole (antipsychotic medication) and that the resident should not be on two antipsychotic medications. The risperidone was subsequently discontinued on December 26, 2024. Further review of Resident R142's progress notes revealed no indication that the resident or her responsible party were notified of the medication recommendation, that the risks and benefits were explained or that the resident was offered alternative treatment options. Review of Resident R139's Annual MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including severe depression with psychotic symptoms (a mental disorder characterized low mood and disconnection from reality). Continued review revealed that the resident had a BIMS score of 9, which indicated that the resident was moderately cognitively impaired. Review of Resident R139's progress notes revealed a nurses note, dated September 5, 2024, at 9:47 a.m. which indicated that the resident was seen by psychiatry and recommended to discontinue risperidone and start aripiprazole solution. Review of Resident R139's psychiatry note, dated September 4, 2024, revealed that the resident had paranoid delusions (false beliefs in something that is untrue) and auditory hallucinations (hearing things that are not there). The psychiatrist noted to add paranoid schizophrenia (mental illness associated with loss of reality contact, delusions and hallucinations) to the resident's diagnosis list, discontinue risperidone and start aripiprazole solution added to orange juice or apple sauce. Review of MARs for Resident R139 revealed that the resident was started on aripiprazole on September 6, 2024, and that the medication was discontinued on September 27, 2024. Continued review revealed that the resident received a total of 10 doses and refused the medication for a total of 12 doses. Continued review of Resident R139's progress notes revealed a nurses note, dated September 27, 2024, at 2:02 p.m. which indicated that the resident was seen by psychiatry and recommended to discontinue aripiprazole due to patient refusal. Review of Resident R139's psychiatry note, dated September 25, 2034, revealed that the psychiatrist recommended to discontinue aripiprazole due to patient refusal. Further review of Resident R139's progress notes revealed no indication that the resident or her responsible party were notified of the medication recommendation, that the risks and benefits were explained or that the resident was offered alternative treatment options. Review of Resident R158's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including non-traumatic brain dysfunction, delirium (confusion) and encephalopathy (brain damage). Continued review revealed that the resident had a BIMS score of 6, which indicated that the resident was severely cognitively impaired. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medication administration records revealed physician's orders for olanzapine (antipsychotic medication used to treat certain mental health disorders, such as schizophrenia [loss of reality with delusions and hallucinations] and bipolar [severe high and low mood changes]) 7.5 m.g (milligrams) once per day at bedtime for delirium. The medication was administered November 15, 2024, through January 8, 2025. Review of Resident R158's progress notes revealed a nurses note, dated January 8, 2025, which indicated that the resident was seen by psychiatry, recommended to discontinue olanzapine and start Depakote 125 m. g every 12 hours (medication used to treat seizures and certain mental health disorders such as bipolar). Review of Resident R158's psychiatry note, dated January 8, 2025, revealed that the psychiatrist recommended to discontinue olanzapine and start Depakote. Continued review of the consultation note revealed that there was no documented clinical indication or rationale for why the consultant recommended the medication change. Continued review of medication administration records revealed that Resident R158 began receiving Depakote on January 9, 2025, as recommended by the psychiatry consultant. Further review of Resident R158's progress notes revealed no indication that the resident or her responsible party were notified of the medication recommendation, that the risks and benefits were explained or that the resident was offered alternative treatment options. Interview on January 30, 2025, at 1:21 p.m. Employee E4, Assistant Director of Nursing (ADON) confirmed that there was no documentation available for review at the time of the survey to indicate that Residents R142, R139 and R158 or their responsible parties were informed of their psychotropic medication changes, that the risks and benefits were explained or that they were offered alternative treatment options. 28 Pa Code 201.29(a) Resident rights 28 Pa code 211.2(d)(6) Medical Director

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41471 Based on observations, review of facility records, interviews with resident and staff, it was determined that the facility failed to ensure comfortable and safe temperature levels. Facilities failed to maintain a temperature range of 71 to 81 F for four of four resident rooms. (301, 302, 311, 328) Findings Include: Interview with Resident R169 on January 28, 2025, at 11:00 a.m. with Maintenance Director, Employee E9 stated the room temperature was too high, and she was suffocating in the room. She stated she had COPD and would like the room temperature at 72-degree Fahrenheit. Interview with Resident R134 on January 28, 2025, at 11:35 a.m. it was too hot for her, and she needed fan to make her comfortable. Resident stated it's been a month since the facility had the temperature issue. Interview with Resident R151 on January 28, 2025, at 11:34 a.m. stated it was very hot in the facility. He stated it was very hard for him to sleep at night due to the heat. Interview with Resident R169 on January 28, 2025, at 11:39 a.m. stated it was always hot in the facility. She showed the heater and there was a towel placed over the vent to prevent heat from getting in the room. Interview with Resident R14 on January 28, 2025, at 11:54 a.m. stated it was too hot in the facility. Interview with Resident R156 on January 28, 2025, at 11:57 a.m. stated it was too hot in the facility. Resident R156's family member stated its always hot in the facility whenever he visited. Interview with Resident R108 on January 28, 2025, at 12:30 p.m. stated it was always hot in the facility and she would like to be little cooler. Temperature check of resident rooms with the maintenance director using facility thermometer was performed on January 28, 2025, at 11:11 a.m. the following temperatures were recorded, 302-82.8-degree Fahrenheit. 301 82.2-degree Fahrenheit. 311 83.3-degree Fahrenheit. 328-83 -degree Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up room temperature was performed at 12:44 p.m. which revealed the following; 301-84-degree Fahrenheit. 311-82.9-degree Fahrenheit. Interview with the Maintenance Director, Employee E9 on January 28, 2025, at 1:00 p.m. confirmed that the temperatures recorded above 81 degrees Fahreheit 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41471 Based on the review of clinical records, facility documentation, facility policies, and interviews with resident and staff, it was determined that the facility failed to demonstrate evidence that a resident/resident representative grievance was promptly documented and resolved for one of 32 resident records reviewed. (Resident R110) Findings Include: Review of facility policy Grievance/Concern Form; Grievance/Concern Log revised October 28, 2021 revealed Our facility will assist residents, their representatives, family members or resident advocates in filing a grievance/concern form or completing a review on the customer service kiosk when concerns are expressed, which may not be able to be handled immediately by the facility staff, requires further investigation or requires consultation with other facility staff, the attending physicians or outside service providers. Any resident, his/her representative, family member or advocate may file a Grievance/Concern. Form or complete a review on the Customer service kiosk regarding treatment, facility services, Medical care, behavior of other residents or staff members, theft of property, missing items, Discrimination, etc. without fear of threat or reprisal in any form. Upon request, the facility will provide a copy of the grievance policy to the resident or resident/Representative. The facility will practice immediate reporting standards as required by state law of all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider. The resident and/or Resident Representative or person who presented the grievance will be Informed of the findings of the investigation and the actions that will be taken to resolve the issue or problem orally in person or phone and or in writing if requested. Interview with Resident R110 on January 28, 2025, at 11:42 a.m. stated a week ago a man came into my room and opened his pants and started masturbating right next to my bed. Resident stated she got terrified and screamed. Resident stated that was the man living across from her room. Resident pointed out Resident R34's room. Resident stated she reported this to a staff and completed a grievance form which was given by the staff. Resident stated she did not hear or see anything from the staff about the grievance or did not receive a copy of the grievance Resident stated she felt like she was harassed and would like to press charges against the resident. Review of facility investigation for Resident R110 dated January 24, 2025, revealed that the resident reported to the staff that another resident was showing his private parts in her room. Resident reported the incident to the staff. Staff provided a grievance form for the resident to fill out. Further review of the facility investigation revealed no evidence that the facility staff followed up with the resident or no information was available grievance. A copy of the grievance was requested to the Director of Nursing on January 29 and January 30, 2024. Interview with the Director of Nursing on January 31, 2025, at 11:00 a.m. stated there was no grievance available from the resident which the resident stated she filed on January 24, 2025. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker on January 31, 2025, at 11:30 a.m. confirmed that the resident filed the grievance, gave it to the staff but the facility was unable to locate the grievance. Facility also did not know the content of the grievance filed by the resident on January 24, 2025. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on interviews with facility staff and residents and review of facility documents, it was determined that the facility failed to report an incident of alleged sexual abuse to the State Agency and the Administrator as required for one of 32 residents reviewed (Resident R110). Findings include: Review of facility policy titled Abuse Investigation and Reporting dated September 8, 2022, indicated that The Facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation/exploitation of resident/patient property by anyone including staff, family, friends, visitors, etc. The Facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. The Administrator, Director of Nursing, and Risk Manager, if applicable are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect, and/or misappropriation/exploitation of policy standards and procedures: -Implementation -On-going monitoring -Reporting -Investigation -Tracking and trending When a facility has identified abuse, the facility must take all appropriate steps to remediate the Noncompliance and protect residents from additional abuse immediately. Facilities that take immediate Action to correct any issues can reduce the risk of further harm continuing or occurring to other Sexual abuse includes, but is not limited to: o Unwanted intimate touching of any kind especially of breasts or perineal area; o All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; o Forced observation of masturbation and/or pornography; and o Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g., posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents, The Facility will report abuse, neglect, misappropriation, and/or exploitation incidents timely and within The Federal/State requirements. o Notify the Shift Supervisor/Charge Nurse/Manager immediately if an allegation or suspected abuse, Neglect, mistreatment, misappropriation of property occurs, or injury of unknown source. This responsible Manager will then notify the Administer and Director of nursing immediately. o Report the incident to the Administrator, Director of Nursing, and the Risk Manager, if applicable. The Administrator and Director of Nursing or designee will report to the Regional Clinical Manager and RDO and immediately assist with the direct of the investigation. o Notify the designated State agency(s) within 2 hours after identification of the alleged/suspected abuse, neglect and/or misappropriation incident by electronic reporting system/fax/ and or telephone based on Agency specific requirement for reporting. Initiate process according to the Federal/State regulations for abuse investigation and reporting and the Elder Justice Act for any incidents involving suspicion of a Crime. Review of Resident R110's Minimum Data Set (MDS- assessment of resident care needs) dated January 1, 2025 identified the resident with a BIMS (Brief Interview of Mental Status) score of 15 out of 15 which place the resident as cognitively intact. Review of Resident R34's Minimum Data Set (MDS- assessment of resident care needs) dated December 7, 2024 identified the resident with a BIMS (Brief Interview of Mental Status) score of 15 out of 15 which place the resident as cognitively intact. Review of MDS dated [DATE] revealed that the resident had a BIMS score of 11 which indicated that the resident's cognitive status was moderately impaired. Interview with Resident R110 on January 28, 2025, at 11:42 a.m. stated a week ago a man came into my room and opened his pants and started masturbating right next to my bed. Resident stated she got terrified and screamed. Resident stated that was the man living across from her room. Resident pointed out Resident R34's room. Resident stated she reported this to a staff and completed a grievance form which was given by the staff. Resident stated she did not hear or see anything from the staff about the grievance or did not receive a copy of the grievance Resident stated she felt like she was harassed and would like to press charges against the resident. Review of clinical record for Resident R34 dated January 24, 2025, which was entered late on January 26, 2024 revealed that This nurse was made aware from the Nurse Aide that resident was displaying sexual behaviors to himself in front of the other resident. The other resident was interviewed and explained that he entered her room while she was sleeping and stood at the edge of her bed and began to pleasure himself. Review of facility investigation for Resident R110 dated January 24, 2025, revealed that the resident reported to the staff that another resident was showing his private parts in her room and was masturbating. Resident reported the incident to the staff. Staff provided a grievance form for the resident to fill out. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on January 31, 2025, at 11:00 a.m. stated that their staff did report that Resident R34 was in Resident R110's room however she was not aware of the details such as showing private parts or masturbating. Director of Nursing confirmed that the Administrator was not notified of the incident immediately as required. Director of Nursing also confirmed that the facility did not report the incident to state survey Agency as required, she stated after the allegation was reported by the surveyor the facility did report the allegation to appropriate agencies as required. 28 Pa Code 201.14. (c) Responsibility of licensee. 28 Pa. Code 211.12(d) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that psychotropic medication changes met professional standards of practice for one of four residents reviewed for psychotropic medications (Resident R158). Findings include: Review of Resident R158's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated November 21, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including non-traumatic brain dysfunction, delirium (confusion) and encephalopathy (brain damage). Review of medication administration records revealed physician's orders for olanzapine (antipsychotic medication used to treat certain mental health disorders, such as schizophrenia [loss of reality with delusions and hallucinations] and bipolar [severe high and low mood changes]) 7.5 m.g (milligrams) once per day at bedtime for delirium. The medication was administered November 15, 2024, through January 8, 2025. Clinical record review for Resident R158 revealed a psychiatric (mental health) evaluation, dated January 8, 2025. The evaluation noted that the resident was confused, not oriented and had poor memory with impaired judgment and insight. The consultant noted that the resident had a diagnosis of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) with behavioral disturbances and impulse control disorder. The consultant recommended to discontinue olanzapine and start Depakote (medication used to treat seizures and certain mental health disorders such as bipolar) 125 m.g every 12 hours. Further review of the consultation note revealed that there was no documented clinical indication or rationale for why the consultant recommended the medication change. Review of progress notes for Resident R158 revealed that there were no documented changes in behavior for the resident prior to evaluation by psychiatry on January 8, 2025. Continued review of medication administration records revealed that Resident R158 began receiving Depakote on January 9, 2025, as recommended by the psychiatry consultant. The medication records indicated that the resident needed the medication for cognitive communication deficit. Interview on January 30, 2025, at 1:21 p.m. Employee E4, Assistant Director of Nursing (ADON) confirmed that there was no documented rationale or clinical indication for why the psychiatry consultant recommended Resident R158's psychotropic medications. 28 Pa code 211.2(d)(3) Medical Director

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on observations, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that wound care practitioner recommendations were addressed appropriately for one of two residents reviewed for wounds (Residents R151). Findings include: Review of Resident R151's clinical record revealed that the resident was readmitted to the facility on [DATE]. Clinical record review for Resident R151 revealed a wound consultant report, dated January 22, 2025. The report indicated that the resident had a left shin wound with arterial etiology and a right distal shin wound with arterial etiology both wound was documented as full thickness wound. that was present on his readmission to the facility. The wound consultant recommended that the left shin wound be cleansed with 0.125% Dakin's solution (used to prevent and treat wound infections), treated with betadine (antimicrobial wound treatment) and leave it open to air. Further review of the wound consultant report recommended that the right distal shin wound be cleansed with wound cleanser, apply medical grade honey and cover with boarder gauze. Clinical record review for Resident R151 revealed a wound consultant report, dated January 29, 2025. The wound consultant recommended that the left shin wound be cleansed with 0.125% Dakin's, apply with betadine (antimicrobial wound treatment) as primary treatment and leave it open to air. Further review of the wound consultant report recommended that the right distal shin wound be cleansed with wound cleanser, apply medical grade honey and cover with boarder gauze. Review of clinical record for Resident R151 revealed no documented evidence that the wound care physician report was communicated to the attending physician. There was no documented evidence that the physician approved or disapproved the recommendation. Review of active physician's orders for Resident R151 revealed an order, dated January 9, 2025, to cleanse bilateral shin wound with Dakin's solution and apply betadine and leave it open to air. There was no evidence that the right shin wound treatment recommended by the wound care practitioner was followed or the resident received the recommended treatment. Review of Medication Administration Record for Resident R151 for the month of January 2025 revealed that the resident received the same treatment to right and left shin from January 10, 2025. The wound care practitioner recommendation for January 22, 2025, and January 29, 2025 was not followed by the staff. Interview on January 30, 2025, at 1:00 p.m. Employee E2, Director of Nursing (ADON) confirmed that Resident R151 wound care was consistent with the wound consultant's recommendations. 28 Pa Code 211.12(d)(3)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on observations of care and services, clinical record review, interviews with staff and residents and reviews of facility policies, it was determined that facility failed to ensure that each resident received proper treatment and assistive devices to maintain vision for one of two residents reviewed for communication needs. (Resident R138) Findings include: Review of the facility policy titled Clinical Manual, dated March 5, 2024 revealed that it was the responsiblility of the facility to make arrangements for each resident for needed vision services. The facility was also responsible to notify the resident's responsible party about the vision care and services that were needed. The policy also said that if the resident was in need of a vision consult that it would arrange for the consultation in a timely manner. Clinical record review for Resident R138 revealed a quarterly assessment dated [DATE] that indicated this resident's preferred language was Creole. The assessment also indicated that this resident needs an interpreter to communicate with the doctor or health care staff. The assessment indicated that Resident R138 had difficulty communication his needs. Observations of Resident R138 with Employee E17 at 9:30 a.m., on Janaury 29, 2025 revealed that the activities staff member provided Resident R138 with a news letter written in Creole on a weekly basis. The activities staff member confirmed she did not know if Resident R138 read the newspaper because she did not speak Creole and cannot ask the resident. Observations of the interactions with the Licensed nurse, Employee E15, who was also the interpreter for Resident R138 at 10:00 a.m., on January 31, 2025 revealed that Resident R138 was reporting that he cannot see to read the newspaper that the activities staff member was giving to him. The licensed nurse, Employee E15 reported that Resident R138 was able to read Creole and if he had glasses he could read and enjoy the newspaper. The licensed nurse reported that Resident R138 was not confused and that he has a language barrier with staff because he reads speaks and understands Creole.Llicensed nurse, Employee E15 reported that he does need an interpretor to facilitate his understanding with a doctor or healthcare staff member. Observations at 10:00 a.m., on January 31, 2025 with Licensed nurse, Employee E15 revealed that Resident R15 has a small printed picture board that he could not read; because his vision was impaired he seeing only large print not regular print in newspapers. Interview with Resident R138 at 10:15 a.m., on January 31, 2025 confirmed that the resident needs corrective lenses. The interpreter, Employee E15 reported that the resident was not sure if he had the money to pay for corrective lenses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident R138 revealed an eye examination dated July 24, 2024 that indicated that the physician had requested the vision examination for the resident's impaired vision. The specialist examining the resident said that the resident would not confirm yes or no answers during the examination. The vision specialist determined that the resident had vision impairment on July 24, 2024. 28 PA Code 211.12(d)(1)(2)(3)(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** 39344 Based on observations, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that wound care practitioner recommendations were addressed appropriately for one of two residents reviewed for wounds (Residents R271). Findings include: Review of Resident R271's Entry MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated January 25, 2025, revealed that the resident was readmitted to the facility on [DATE]. Clinical record review for Resident R271 revealed a wound consultant report, dated January 27, 2025. The report indicated that the resident had a sacral pressure ulcer that was present on his readmission to the facility. The wound consultant recommended that the wound be cleansed with 0.125% Dakin's solution (used to prevent and treat wound infections), treated with medical grade honey (antimicrobial wound treatment) and calcium alginate (absorbent wound dressing that promotes healing), then covered with a bordered foam dressing. Review of progress notes for Resident R271 revealed a wound consultant note, dated January 27, 2025, at 2:39 p.m. which indicated that the resident had new treatments listed in his wound plan and to reference the recommended orders for updated treatments. Continued review of progress notes for Resident R271 revealed an attending physician note, dated January 27, 2025, at 11:17 p.m. which indicated to provide wound care to the resident's sacrum as reported. Review of physician's orders for Resident R271 revealed an order, dated January 27, 2025, to cleanse sacral ulcer with Dakin's 0.125% daily, apply skin prep to wound perimeter, follow by medihoney and cover with border foam. Continued review of physician's orders for Resident R271 revealed another order, dated January 27, 2025, to clean the sacrum with Dakin's 0.125%, apply medihoney and cover with bordered gauze daily. Observation on January 29, 2025, at 11:31 a.m. revealed Employee E10, licensed nurse, perform wound care to Resident R271's sacrum. Employee E10, licensed nurse, removed the old dressing, cleansed the wound with Dakin's solution, applied medihoney and applied a clean bordered foam dressing. Interview on January 30, 2025, at 1:21 p.m. Employee E4, Assistant Director of Nursing (ADON) confirmed that Resident R271 had two active wound care orders for his sacrum that specified different treatments and confirmed that neither order was consistent with the wound consultant's recommendations. Employee E4, ADON, confirmed that the facility follows recommendations made by the wound consultant unless the attending physician specifies an alternative treatment. Employee E4, ADON, stated that she would need to clarify the treatment orders for Resident R271's sacral wound. 28 Pa Code 211.12(d)(3)(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** 41471 Based on review of clinical records, review of facility documentation, review of facility policies and interviews with staff, it was determined that the facility failed conduct smoking assessment to ensure the safety of a resident who smokes for one of 32 residents reviewed. (Resident R14) Findings include: Review of facility documentation revealed that the Resident R14 was a smoker, and the resident was included in the smoking list provided by the facility. Resident was added to smoking list with smoking privileges. Review of facility investigation for Resident R14 dated January 10, 2025, revealed that During this shift resident was observed on the floor sitting upright on his buttocks in front of the bathroom without his back brace or wheelchair in place. Resident was asked why he was on the floor at which the resident stated, I fell on the way back from the bathroom. Resident was then asked why he did not call for assistance to go to the bathroom at which he got out of bed to secretly smoked in the bathroom. Review of clinical records for Resident R14 did not reveal any evidence that facility conducted an evaluation to determine the ability of the resident to smoke safely with or without supervision at the time when resident admitted smoking in the room. Review of smoking assessment completed part of admission assessment dated [DATE] which was the only smoking assessment revealed that the resident was a non-smoker and no smoking care plan was created. Interview with the Activities Director, Employee E17 on January 31, 2025, at 1.00 p.m., confirmed that Resident R14 was a smoker, and he had the smoking privilege. She stated he smoked when he was first admitted , and the facility had his smoking supplies. Employee E17 also confirmed that the resident smoked in his room, and he was educated not to smoke in his room. Interview with the Director of Nursing, Employee E2 on January 31, 2025, at 12.30 p.m., confirmed that the facility should conduct a smoking safety assessment for all resident who wishes to smoke and should develop and smoking safety care plan with interventions. Employee E2 also confirmed that there was no smoking safety assessment available for Resident R14. 28 Pa Code 201.14(a) responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on the review of clinical records, review of facility policy, staff interviews, it was determined that the facility failed to maintain appropriate nutritional parameters for one of four residents reviewed. (Resident 65). Findings include: Review of facility policy Nutritional assessment dated [DATE], revealed The Facility will follow current professional standards of practice that recommend weighing the Resident on admission or readmission, the day following admission (to establish a baseline Weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help Identify and document trends such as slow and progressive weight loss. Weighing may also be Pertinent if there is a significant change in condition, food Intake has declined and persisted (e.g. For more than a week), or there is other evidence of altered nutritional status or fluid and Electrolyte imbalance. Review of physician orders for Resident R65 dated December 16, 2024, revealed an order to weigh resident weekly for four weeks until January 20, 2025. Review of care plan for Resident R65 dated December 20, 2024 revealed that resident was at risk for alteration in nutrition/ hydration related to impaired skin integrity, need for mechanically altered diet, need for therapeutic diet, low weight. Review of weight data for Resident R65 revealed that the resident weighed 114.4 pounds on December 16, 2024, and 103 pounds on December 23, 2024, which was 11.4 pounds weight loss (9.96% weight loss over 7 days) Review of weight data revealed no evidence that the facility obtained weight for Resident R65 on December 30, 2024, as ordered by the physician. Review of weight data for Resident R65 revealed that the resident weighed 101.5 pounds on January 6, 2025, which was 11.4 pounds weight loss (11.27 % weight loss over 30 days). Further review of the weight documentation revealed no evidence that the facility reweighed the resident or confirm the weight loss or any further weight check was completed as ordered by the physician. Review of clinical record revealed no evidence that the resident was assessed by the dietician when the resident had documented weight loss on December 23, 2024. Further review of the clinical record revealed that the resident was only assessed by the dietician on January 9, 2025 which was more than two weeks after the initial weight loss. Review of nutritional progress note dated January 9, 2025, revealed that the resident had an unplanned weight loss and was ordered to monitor weights and labs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of clinical record for Resident R65 revealed no evidence that the physician was notified of the weight loss and the physician conducted an assessment of the resident in response to the weight loss. Interview with Registered Dietician, Employee E14, on January31, 2025 confirmed that Resident R65 was at nutritional risk due to pressure ulcer and the resident was ordered for weekly weight on admission which was not completed as ordered. Employee E14 also confirmed that the resident was not assessed in a timely manner when the resident was observed with weight loss on December 23, 2024. Employee E14 stated there was no documented evidence in the clinical record that the physician was notified, and an assessment was completed by the physician in response to the weight loss. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46106 Based on review of clinical records, review of facility policy and staff interview, it was determined that the facility failed to ensure communication with the dialysis provider for one of two residents reviewed on renal dialysis (Resident R47) Findings include: Review of facility policy title Dialysis Management (Hemodialysis) dated March 28, 2024, revealed that the facility shall ensure that residents who require outpatient hemodialysis treatment have appropriate arrangements made by the facility with an outpatient treatment center to provide such service as directed by the physician. Further review of this policy reveals the facility to complete pre-dialysis information on the communication form and send with resident to dialysis on treatment days, to ensure communication of resident information and coordinate care between Dialysis Center and facility. Review of Resident R47 's record revealed Resident R47 entered the facility on June 9, 2022 with the diagnosis of end stage renal disease (a medical condition in which a person's kidney ceases functioning on a permanent basis leading to the need for regular course of long term dialysis or kidney transplant to maintain life), and dependent on dialysis (the process of removing waste products and excess fluid from the body dialysis is necessary when kidneys are not able to adequately filter the blood). Review of Resident R47's documented dialysis communication binder revealed that the daily documented pages included instructions to record both facility nurse to complete prior to leaving for dialysis and dialysis nurse to complete post dialysis. The daily pages also included any instructions, recommendations for care, any access problems, administered medications, lab work or any concerns before, during and after treatment. Review of treatment dates daily communication pages revealed incomplete communication: November 28, 2024, the documented page did not include Facility nurse to complete prior to leaving for dialysis. December 5, 2024, the documented page did not include Facility nurse to complete prior to leaving for dialysis. December 30, 2024, the documented page did not include Facility nurse to complete prior to leaving for dialysis. January 23, 2025, the documented page did not include Facility nurse to complete prior to leaving for dialysis. The above observation was confirmed by Licensed nurse, unit manager Employee E13 on January 31, 2025 at 10:49 am. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing Services 28 Pa. Code 211.12(d)(3) Nursing Services

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on clinical record review, facility policy and interviews with staff, it was determined that the facility did not ensure that a physician assessment was completed related to unplanned weight loss for one of 32 residents reviewed (Resident R65). Findings include: Review of facility policy Nutritional assessment dated [DATE], revealed The Facility will follow current professional standards of practice that recommend weighing the Resident on admission or readmission, the day following admission (to establish a baseline Weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help Identify and document trends such as slow and progressive weight loss. Weighing may also be Pertinent if there is a significant change in condition, food Intake has declined and persisted (e.g. For more than a week), or there is other evidence of altered nutritional status or fluid and Electrolyte imbalance. The facility may identify key individuals who could Participate in the assessment of nutritional status and related causes and consequences. For Example, nursing staff provide details about the resident's nutritional intake. Physicians and non-Physician practitioners help identify relevant diagnoses, identify causes of weight changes, and Monitor the continued relevance of those interventions. Qualified dietitians help identify Nutritional risk factors and recommend nutritional interventions, based on each resident's medical Condition, needs, preferences, and goals. Consultant pharmacists can help identify medications And medication interactions that may affect nutrition. Review of physician orders for Resident R65 dated December 16, 2024, revealed an order to weigh resident weekly for four weeks until January 20, 2025. Review of care plan for Resident R65 dated December 20, 2024 revealed that resident was at risk for alteration in nutrition/ hydration related to impaired skin integrity, need for mechanically altered diet, need for therapeutic diet, low weight. Review of weight data for Resident R65 revealed that the resident weighed 114.4 pounds on December 16, 2024, and 103 pounds on December 23, 2024, which was 11.4 pounds weight loss (9.96% weight loss over 7 days) Review of weight data revealed no evidence that the facility obtained weight for Resident R65 on December 30, 2024, as ordered by the physician. Review of weight data for Resident R65 revealed that the resident weighed 101.5 pounds on January 6, 2025, which was 11.4 pounds weight loss (11.27 % weight loss over 30 days). Review of nutritional progress note dated January 9, 2025, revealed that the resident had an unplanned weight loss and was ordered to monitor weights and labs. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of clinical record for Resident R65 revealed no evidence that the physician was notified of the weight loss and the physician conducted an assessment of the resident in response to the weight loss. Interview with Registered Dietician, Employee E14, on January31, 2025 confirmed that Resident R65 was at nutritional risk due to pressure ulcer and the resident was ordered for weekly weight on admission which was not completed as ordered. Employee E14 also confirmed that the resident was not assessed in a timely manner when the resident was observed with weight loss on December 23, 2024. Employee E14 stated there was no documented evidence in the clinical record that the physician was notified, and an assessment was completed by the physician in response to the weight loss. Dietician stated facility staff notifies the physician of the weight loss and the physician was expected to complete an assessment of the resident and document it on the clinical record. 28 Pa. Code:211.12(d)(5) Nursing services. 28 Pa. Code:211.2(a) Physician services. 28 Pa. Code 211.5(f) Clinical records

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39344 Based on observations, review of personnel files and interviews with staff, it was determined that the facility failed to ensure that agency licensed nurses had the specific competencies and skill sets necessary to care for residents' needs related to medication administration practices and infection control practices, for three of three agency staff reviewed (Employees E7, E8, and E10). Findings include: Observation of the morning medication pass on January 29, 2025, at 9:38 a.m. revealed that Employee E8, licensed nurse, prepared and administered medications for Resident R132. Employee E8, licensed nurse, administered two of the resident's insulin (medication used to lower blood sugar levels) doses after the breakfast meal, instead of before the meal. Employee E8, licensed nurse, also administered two lidocaine patches (medicated patch to relieve pain) without allowing sufficient time between doses. This resulted in four medication errors. Interview with Employee E8, licensed nurse, revealed that she was an agency nurse and only worked at the facility sporadically. Employee E8, licensed nurse, could not recall if she received any training regarding medication administration from the facility. Refer to F759. Observation on January 29, 2025, at 10:44 a.m. with Employee E7, licensed nurse, of the fourth floor south medication cart, revealed that there was no documentation in the narcotic log book that shift-to-shift counts were completed at any time. Continued observation revealed that the index in the narcotic log book was incomplete and did not match with the individual residents' countdown records. Employee E7, licensed nurse, stated that it was his first day at the facility as an agency nurse, that he did not receive any training by the facility regarding medication administration or controlled substances and that he did not complete a shift-to-shift count with the previous night shift nurse. Refer to F755. Observation on January 29, 2025, at 11:31 a.m. revealed that a sign was posted on Resident R271's door indicating that he required enhanced barrier precautions (reduces the risk of spreading infectious organisms). The sign instructed staff to wear a gown and gloves while providing high-contact care activities, such as wound care. Continued observation revealed Employee E10, licensed nurse, entered the room and performed wound care to Resident R271's sacrum, which included removing the old dressing, cleansing the wound and application of a new dressing. Employee E10, licensed nurse, was observed wearing only gloves while providing care. Employee E10, licensed nurse, stated that she was an agency nurse and that she had not received training regarding enhanced barrier precautions. Refer to F880. Review of Employee E8, agency licensed nurse, personnel file revealed that a medication competency review was conducted on January 20, 2025. Review of the competency evaluation revealed that there were no skills evaluations related to the administration of insulin or topical medication patches. Further review revealed that the evaluation form was not signed by the employee. Continued review of Employee E8, licensed nurse, personnel file revealed that there was no training related to controlled substances or enhanced barrier precautions available for review at the time of the survey. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Employee E7, agency licensed nurse, personnel file revealed that a medication competency review was not conducted until January 30, 2025, which is after Employee E7, licensed nurse, began working at the facility. Continued review of Employee E7, licensed nurse, personnel file revealed that there was no training related to controlled substances or enhanced barrier precautions available for review at the time of the survey. Review of Employee E10, agency licensed nurse, personnel file revealed that there was no competency evaluation or training related to medication administration, controlled substances or enhanced barrier precautions available for review at the time of the survey. Interview on January 31, 2025, at 9:38 a.m. the Director of Nursing confirmed that Employees E8, E7 and E10, agency licensed nurses, did not receive adequate trainings related to medication administration, controlled substances and enhanced barrier precautions. The Director of Nursing stated that the facility's orientation process for agency staff needed to be revised. 28 Pa Code 201.20(b) Staff development 28 Pa Code 211.12(c) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical record reviews, interviews with staff, reviews of policies and procedures and the Department of Human Services assessments, it was determined that the facility failed to provide the necessary behavioral health care and services to attain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and care plan for one of four residents reviewed with mental illness (Residents R17). Findings include: Reviews of the facility policy titled Behavioral-Mental Healthcare Substance Use dated May 7, 2024 revealed that the facility was to provide an interdisciplinary approach for the care of residents who have a diagnosis of mental health disorder and decreased social interaction. The policy also indicated that the facility must provide the necessary Behavioral Health care and services to attain or maintain the highest practicable physical, mental and psychosocial well -being of the residents in accordance with their assessment and care plan. This policy said that the facility was required to conduct a preadmission screening and resident review (PASARR) to determine if the resident was qualified for specialized Behavioral Health services. Review of Resident R17's annual comprehensive Minimun Data Set (MDS- assessment of care needs) dated October 14, 2024 revealed that the resident was mildly cognitiely impaired. Continued review of th assessment indicated that this resident wanted his family and close friend involved with discussions about his care. The assessment indicated that the resident had the following diagnoses: anxiety, depression, schizophrenia and tramatic brain injury. Clinical record review revealed an assessment dated [DATE] and revised on June 1, 2024 through December 23, 2024 that indicated the Department of Human Serives Office of Mental Health and Substance Abuse assessed Resident R17 and determined that this resident was eligible and did qualify for the provision of mental health services such as preparation of systematic plans which are designed to facilitate appropriate behavior, drug therapy and monitoring for effectiveness and side effects, structured social activities, the teaching of daily living skills to enhance self-determination and independence; individual, group or family therapy or personal support networks and formal behavior modification programs provided by qualified personnel. Interview with Resident R17 at 10:30 a.m., on January 28, 2025 revealed that this resident was reporting boredom. Doesn't have the activities that meet his interest and capabilities. Resident R17 reported that he could use a job. Interview with the social worker, Employee E18, at 9:30 a.m., on January 29, 2025 revealed that this social worker requested that the physician arrange for the specialized mental health services needs of Resident R17. The physician responded with yes saying that Resident R17 was eligible for specialized services based on his comprehensive assessment and (PASARR) preadmission screening and resident review document. The physician reported to the social worker on January 29, 2025 that the next physician scheduled visit was on February 7, 2025 at that time the physician decided to implement a care plan for Resident R17's mental illnesses and special needs. (continued on next page)

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Willow Terrace	One Penn Boulevard Philadelphia, PA 19144

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the director of nursing at 1:00 p.m., on January 31, 2025 confirmed that Resident R17 had not been offered behavioral health services: (preparation of systematic plans which are designed to facilitate appropriate behavior, structured social activities, the teaching of daily living skills to enhance self-determination and independence; individual, group or family therapy or personal support networks and formal behavior modification programs provided by qualified personnel) to meet his highest practicable well-being since April 21, 2021 and the most recent recertification evaluation conducted on June 1, 2024 to December 23, 2024; which indicated the continued eligibility of special services for Resident R17. 28 PA. Code 211.12(d)(3)(5) Nursing services 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 211.10(d) Resident care policies

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39344 Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for one of four medication carts reviewed (fourth floor south medication cart), and failed to ensure that medications were readily available for administration for three of 32 residents reviewed (Residents R132, R55, and R142). Findings include: Review of facility policy, Narcotic Management dated revised December 24, 2024, revealed, Control/Schedule II-V medication will be counted with two (2) professional nurses at the beginning and end of each shift. Documentation that a count was completed and accurate will be completed at the beginning and end of each shift. Control/Schedule II-V medications will be logged into a bound book or separate master index page once received from the pharmacy as well as individual countdown records. Observation on January 29, 2025, at 10:44 a.m. with Employee E7, licensed nurse, of the fourth floor south medication cart, revealed that there was no documentation in the narcotic log book that shift-to-shift counts were completed at any time. Continued observation revealed that the index in the narcotic log book was incomplete and did not match with the individual residents' countdown records. Interview, at the time of the observation, Employee E7, licensed nurse, confirmed the above findings. Employee E7, licensed nurse, stated that it was his first day at the facility as an agency nurse, that he did not receive any training by the facility regarding medication administration and that he did not complete a shift-to-shift count with the previous night shift nurse. Observation of the fourth floor south medication cart narcotic log book with Employee E9, unit manager, confirmed that the shift-to shift counts and index were not completed. Employee E9, unit manager, stated that staff need to be conducting these counts to prevent potential drug diversion. Observation of the morning medication pass on January 29, 2025, at 9:38 a.m. revealed Employee E8, licensed nurse, prepare medications for Resident R132. Review of physician orders for Resident R132 revealed an order, dated September 21, 2023, for amlodipine (medication used to treat high blood pressure) 10 m.g (milligrams) tabs, give one tab daily at 9:00 a.m. Employee E8, licensed nurse, was unable to administer Resident R132's amlodipine and stated that the medication was not available in the medication cart. Review of the facility's emergency pharmacy medication inventory list revealed that amlodipine 10 m.g tablets were available at the facility for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the morning medication pass on January 29, 2025, at 10:20 a.m. revealed Employee E7, licensed nurse, prepare medications for Resident R55. Review of physician orders for Resident R55 revealed an order, dated January 17, 2025, for potassium chloride (treats low potassium levels) oral packet 20 mEq (milliequivalent) give one packet daily. Employee E7, licensed nurse, was unable to administer Resident R55's potassium chloride and stated that the medication was not available in the medication cart. Review of medication administration records for Resident R142 for December 2024, revealed physician's orders for levetiracetam (medication used to treat seizures) give 750 m.g two times per day at 9:00 a.m. and 5:00 p.m. Continued review of the medication administration record revealed that the following doses were not administered: December 20, 2024, at 5:00 p.m.; December 21, 2024, at 9:00 a.m.; December 22, 2024, at 9:00 a.m.; December 23, 2024, at 5:00 p.m.; and December 25, 2024, at 9:00 a.m. Review of progress notes from December 20 through 25, 2024, revealed that the medication was not administered due to back order. Interview on January 30, 2025, at 1:21 p.m. Employee E4, Assistant Director of Nursing (ADON), revealed that if medications are not readily available in the medication cart that nurses should check the emergency supply to see if it is available. If the medication is not available, nurses are expected to call the physician. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.9(k) Pharmacy services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39344 Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that the medication error rate was less than five percent for one of three residents observed during medication administration (Resident R132). Findings include: The facility's medication error rate was 12.5% based on observation of 32 medication administration opportunities with four errors observed. Review of facility policy, Medication Administration/Disposition dated reviewed December 2024, revealed, Medications shall be administered in a safe and timely manner, and as prescribed by the physician. Facility staff involved in the administration of resident care will be knowledgeable of the policies and procedures regarding pharmacy services including medication administration. Medications, both prescription and non-prescription, shall be administered under the orders of the attending physician. Continued review revealed, Medications must be administered with one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of physician orders for Resident R132 revealed an order, dated September 21, 2023, for aspart (rapid acting) insulin (medication used to lower blood sugar levels), inject four units subcutaneously (under the skin) daily with breakfast. Continued review revealed order, dated September 20, 2023, for aspart insulin sliding scale (variable dosage based on blood sugar level), inject subcutaneously before meals and at bedtime. Both orders for aspart insulin were scheduled to be administered at 7:30 a.m. Observation of the morning medication pass on January 29, 2025, at 9:38 a.m. revealed Employee E8, licensed nurse, checked Resident R132's blood sugar level with a glucometer, and obtained a value of 258. Employee E8, licensed nurse, verified the physician orders for Resident R132; the sliding scale indicated that six units of insulin should be administered. Employee E8, licensed nurse, drew up a total of ten units of insulin (standing dose of four units plus six units of the sliding scale dose) and administered them to Resident R132. Both Resident R132 and Employee E8, licensed nurse, confirmed that the resident had already finished eating breakfast. Employee E8, licensed nurse, confirmed that Resident R132's insulin should have been administered before the breakfast meal. Continued review of physician orders for Resident R132 revealed an order, dated January 24, 2025, for lidocaine external 4% patch (medicated patch to relieve pain) apply to left knee at 9:00 a.m. and remove at 9:00 p.m. Further review of physician orders revealed an order, dated January 24, 2025, for lidocaine external 4% patch apply to right knee at 9:00 a.m. and remove at 9:00 p.m. Review of Medline (national library of medicines) drug information, available at https://medlineplus.gov/druginfo/ revealed that Nonprescription lidocaine transdermal comes as a 4% patch to apply to the skin. It is applied up to 3 times daily and for no more than 8 hours per application. If you wear too many lidocaine transdermal patches or topical systems or wear them for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation of the morning medication pass on January 29, 2025, at 10:05 a.m., Employee E8, licensed nurse, removed lidocaine patches from Resident R132's left and right knees; both patches had a date of January 28, 2025. Employee E8, licensed nurse, confirmed that the patches dated January 28, 2025, should have been removed on January 28, 2025, at 9:00 p.m. Further observation revealed that Employee E8, licensed nurse, administered new lidocaine patches to Resident R132's left and right knees immediately after removing the old patches. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39344 Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that insulin pens and vials were labeled in accordance with currently accepted professional principles for one of four medication carts reviewed (fourth floor north medication cart). Findings include: Review of facility policy, Medication Administration/Disposition dated reviewed December 2024, revealed, When opening a multi-dose container, the date opened is recorded on the container. Observation on January 29, 2025, at 10:14 a.m. of the fourth floor north medication cart with Employee E8, licensed nurse, revealed the following: A lantus (long acting) insulin (medication used to lower blood sugar levels) pen for Resident R17 that was opened and undated; A lantus insulin vial for Resident R132 that was opened and undated; A lispro (rapid acting) insulin vial for Resident R95 that was opened and undated; and An admelog (rapid acting) insulin vial for Resident R83 that was opened and undated. Interview, at the time of the observation, Employee E8, licensed nurse, confirmed the above findings. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.12(d)(5) Nursing services

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on the review of facility documents and resident clinical record and staff interviews, it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for two of three residents reviewed (Resident R147 and Resident R151). Findings Include: Review of Resident R147's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 6, 2024, revealed the resident was admitted to the facility on [DATE], and had a diagnosis of non-traumatic brain dysfunction and cognitive communication deficit. Further review of the MDS, Section C - Cognitive Patterns (items in this section are intended to determine the resident's attention, orientation, and ability to register and recall new information - these items are crucial factors in many care-planning decisions), indicated that Resident R147 scored a 12 on the Brief Interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. Review of Resident R151's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 14, 2024, revealed the resident was admitted to the facility on [DATE], and had a diagnosis of altered mental status. Further review of the MDS, Section C - Cognitive Patterns, indicated that Resident R151 scored a 2 on the Brief Interview for Mental Status (BIMS), which indicated the resident had severe cognitive impairment. Review of Resident R147's Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated the resident signed the document on May 3, 2024. Further review of the Binding Arbitration Agreement revealed it was also signed by facility employee, Admission Director, Employee E20. Review of Resident R151's Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated the resident signed the document on May 9, 2024. Further review of the Binding Arbitration Agreement revealed it was also signed by facility employee, Admission Director, Employee E20. Interview on January 31, 2025. with Employee E2, Director of Nursing confirmed that Resident R151 and Resident R147 had communication and cognitive deficit and should not be provided with arbitration agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (d) Resident care policies

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39344 Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to maintain enhanced barrier precautions during wound care for one of one observations of wound care performed (Resident R271). Findings include: Review of facility policy, Transmission Based Precautions dated revised July 11, 2024, revealed, Enhanced barrier precautions (EBP) are designed to reduce the transmission of multidrug-resistant organisms (MDRO) in facilities. Continued review revealed that, EBP consists of the use of gowns and gloves for high-contact care activities which include . changing briefs and wound care. Review of Resident R271's care plan, dated initiated January 29, 2025, revealed that the resident had a sacral wound and to maintain enhanced barrier precautions. Observation on January 29, 2025, at 11:31 a.m. revealed that a sign was posted on Resident R271's door indicating that he required EBP. The sign instructed staff to wear a gown and gloves while providing high-contact care activities, such as wound and continence care. Continued observation revealed that Employee E11, nurse aide, was in Resident R271's room providing continence care. Employee E11, nurse aide, was observed wearing only gloves while providing care. Further observation revealed Employee E10, licensed nurse, entered the room and performed wound care to Resident R271's sacrum, which included removing the old dressing, cleansing the wound and application of a new dressing. Employee E11, nurse aide, provided assistance to Employee E10, licensed nurse, while the wound care was being performed. Both employees were observed wearing only gloves while providing care. Interview on January 29, 2025, at 11:50 a.m. Employee E10, licensed nurse, revealed that there were no gowns readily available to wear. Employee E10, licensed nurse, stated that there might be some available in the treatment cart. Employee E10, licensed nurse, stated that she was an agency nurse and that she had not received training on enhanced barrier precautions. 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services