STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396129	A. BLDG: 00 B. WING:	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLOW TERRACE STATE LICENSE NUMBER: **072102**	**ONE PENN BLVD** **PHILADELPHIA, PA 19144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, and State Licensure Survey completed on January 31, 2025, it was determined that Willow Terrace was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0552 SS=D		F 0552		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0552 SS=D	Continued from page 1 483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 0552	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R142 and the responsible party were notified of medication recommendations and of the risks and benefits were explained to them. R139 and responsible party were notified of the medication recommendations and of the risks and benefits. R158 and responsible party were notified of the medication recommendations and of the risks and benefits. The psychiatrist documented the reason for changing the medication. An initial audit of the last 2 weeks of psychiatry recommendations was done to ensure if any medication	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0552 SS=D	Continued from page 2	F 0552	changes were done, the resident and responsible party were notified of the recommendations and of the risks and benefits as well as alternative treatment options. The DON/designee educated the psychiatrist and licensed staff to document reasons for psychoactive medication changes as well as informing residents and responsible party of medication changes and the risks and benefits associated with the change. Alternative treatment options will also be discussed and documented. The DON/designee will audit psychiatry consults to ensure reasons for medication changes are documented and that the resident and responsible party are informed of the medication change as well as the risk and benefits associated with the changes and alternative treatment options. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of	

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F 0552 SS=D	Continued from page 3	F 0552	these audits will be submitted to the quality assurance committee to determine if further action is needed.	

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F 0552 SS=D	Continued from page 4 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 September 27, 2023, 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).	F 0552		

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F 0552 SS=D	Continued from page 5 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.	F 0552		

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F 0552 SS=D	Continued from page 6 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. 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.	F 0552		

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F 0552 SS=D	Continued from page 7 Review of Resident R139's Annual MDS, dated August 9, 2024, revealed that the resident was admitted to the facility on August 4, 2023, 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	F 0552		

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F 0552 SS=D	Continued from page 8 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.	F 0552		

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F 0552 SS=D	Continued from page 9 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 November 21, 2024, revealed that the resident was admitted to the facility on November 15, 2024, 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. 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	F 0552		

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F 0552 SS=D	Continued from page 10 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	F 0552		

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F 0552 SS=D	Continued from page 11 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	F 0552		

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F 0552 SS=D	Continued from page 12	F 0552		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 13 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. Air temps were addressed immediately by Maintenance staff and were returned to range of 71-81 degrees. Maintenance staff were educated on the Temperature Extremes policy. The Maintenance Director or designee will audit air temperatures in affected unit/rooms that were out of range daily as well as an additional 5 rooms from every resident unit. Audits will be done daily x 4 weeks and monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0584 SS=E	Continued from page 14 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=E	Continued from page 15 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.	F 0584		

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F 0584 SS=E	Continued from page 16 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.	F 0584		

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WILLOW TERRACE STATE LICENSE NUMBER: **072102**	**ONE PENN BLVD PHILADELPHIA, PA 19144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=E	Continued from page 17 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. 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	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0585 SS=D		F 0585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0585 SS=D	Continued from page 19 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R110 A grievance form was completed with the resident and resolution reviewed with her. The last 2 weeks of grievances were reviewed to ensure prompt documentation of the grievance and timely follow up with the resident and or resident representative. The Director or Social Service/designee educated staff on the grievance process. The Director of Social Service/designee will audit grievances submitted to ensure timely documentation of the grievance as well as prompt follow up and communication to the resident and or resident	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0585 SS=D	Continued from page 20 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting 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; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	representative. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

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F 0585 SS=D	Continued from page 21 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 22 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	F 0585		

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F 0585 SS=D	Continued from page 23 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	F 0585		

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F 0585 SS=D	Continued from page 24 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,	F 0585		

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F 0585 SS=D	Continued from page 25 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. 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	F 0585		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 26 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The alleged violation was reported to the state agency. The DON/designee conducted a 2 week look back of incident reports and grievance reports to ensure any abuse allegations made were reported to the state survey agency as required. The DON/designee educated staff on the abuse policy. The DON/designee will audit incident reports and grievance reports to ensure any abuse allegations made are reported to the state survey agency as required. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0609 SS=D	Continued from page 27	F 0609	quality assurance committee to determine if further action is needed.	

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F 0609 SS=D	Continued from page 28 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	F 0609		

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F 0609 SS=D	Continued from page 29 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	F 0609		

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F 0609 SS=D	Continued from page 30 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. 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	F 0609		

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F 0609 SS=D	Continued from page 31 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	F 0609		

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F 0609 SS=D	Continued from page 32 15 out of 15 which place the resident as cognitively intact. Review of MDS dated December 12, 2024 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	F 0609		

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F 0609 SS=D	Continued from page 33 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. 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.	F 0609		

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F 0609 SS=D	Continued from page 34 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	F 0609		
F 0658 SS=D		F 0658		

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F 0658 SS=D	Continued from page 35 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R158 was seen by the psychiatrist. The reason for the medication change was documented in the Psychiatry progress note. The DON/designee audited the last 2 weeks of psychiatry recommendations to ensure if a medication change was made there is documentation indicating the reason for the medication change. The DON/designee educated the consultant psychiatrist on documenting reasons for medication changes on the consultant form. The DON/designee will audit psychiatry recommendations to ensure if a medication change was made there is documentation	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0658 SS=D	Continued from page 36	F 0658	indicating the reason for the medication change. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0658 SS=D	Continued from page 37 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 November 15, 2024, 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	F 0658		

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F 0658 SS=D	Continued from page 38 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	F 0658		

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F 0658 SS=D	Continued from page 39 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	F 0658		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 40 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R151 wound recommendations were addressed. The DON/designee audited the most recent wound report recommendations to ensure current recommendations are addressed and orders are in place. The DON/designee educated licensed staff on ensuring that the wound care practitioner recommendations are addressed and orders are in place. The DON/designee will audit the wound care practitioner recommendations to ensure recommendations are addressed and orders are in place. Audits will be done weekly x 4 weeks	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0684 SS=D	Continued from page 41	F 0684	and then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

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F 0684 SS=D	Continued from page 42 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 May 8, 2024. 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	F 0684		

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F 0684 SS=D	Continued from page 43 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.	F 0684		

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F 0684 SS=D	Continued from page 44 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.	F 0684		

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F 0684 SS=D	Continued from page 45 28 Pa Code 211.12(d)(3)(5) Nursing services	F 0684		
F 0685 SS=D		F 0685		

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F 0685 SS=D	Continued from page 46 483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 0685	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R138 has a vision exam scheduled. The DON/designee conducted an audit of residents last eye exam to ensure that residents with impaired vision have appropriate follow up. The DON/designee educated licensed staff on the importance of residents receiving proper treatment and assistive devices to maintain vision. The DON/designee will audit eye consults to ensure there is appropriate follow up. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of the audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0685 SS=D	Continued from page 47 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 October 19, 2024 that indicated this resident's preferred language was	F 0685		

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F 0685 SS=D	Continued from page 48 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	F 0685		

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F 0685 SS=D	Continued from page 49 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. Clinical record review for Resident R138 revealed	F 0685		

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F 0685 SS=D	Continued from page 50 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	F 0685		
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 51 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R271 wound treatment was corrected to the recommendations made by the wound consultant The DON/designee audited the most recent wound report recommendations to ensure current recommendations are addressed and orders are in place and prior orders are discontinued. The DON/designee educated licensed staff on ensuring that the wound care practitioner recommendations are addressed and orders are in place and prior orders are discontinued. The DON/designee will audit the wound care practitioner recommendations to ensure	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0686 SS=D	Continued from page 52	F 0686	recommendations are addressed and orders are in place as well as making sure prior orders are discontinued. Audits will be done weekly x 4 weeks and then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0686 SS=D	Continued from page 53 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 January 25, 2025. 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	F 0686		

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F 0686 SS=D	Continued from page 54 (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.	F 0686		

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F 0686 SS=D	Continued from page 55 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	F 0686		

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F 0686 SS=D	Continued from page 56 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	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 57 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R14 was re assessed and has an updated smoking assessment and care plan. The DON/designee conducted an audit of residents on the smoking list to ensure smoking assessments are accurate and that care plans are in place. The DON/designee educated licensed staff on ensuring that residents that smoke have an accurate smoking assessment and a care plan. The DON/designee will audit the smoking list to ensure any new smokers added to the list have an appropriate assessment and a care plan. Audits will be done weekly x 4	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0689 SS=D	Continued from page 58	F 0689	weeks and monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=D	Continued from page 59 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	F 0689		

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F 0689 SS=D	Continued from page 60 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 December 23, 2024 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	F 0689		

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F 0689 SS=D	Continued from page 61 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	F 0689		

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F 0689 SS=D	Continued from page 62	F 0689		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 63 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R65 the facility cannot go back retroactively to correct this issue. The Dietician/designee conducted an audit of residents with significant weight loss in the last 30 days to ensure timely assessment with interventions, as well as physician notification and documentation completed by the physician in response to the weight loss. The DON/designee educated the Dietician on timely follow up on residents with significant weight loss as well as physician notification of residents with significant weight loss The Dietician/designee will audit residents with significant weight	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0692 SS=D	Continued from page 64	F 0692	loss to ensure timely follow up as well as physician notification of the weight loss. Audits will be done weekly x 4 weeks then monthly thereafter. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 65 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 March 18, 2024, 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."	F 0692		

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F 0692 SS=D	Continued from page 66 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	F 0692		

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F 0692 SS=D	Continued from page 67 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. Review of clinical record for Resident R65 revealed	F 0692		

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F 0692 SS=D	Continued from page 68 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.	F 0692		

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F 0692 SS=D	Continued from page 69	F 0692		
F 0698 SS=D		F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLOW TERRACE STATE LICENSE NUMBER: **072102**	**ONE PENN BLVD PHILADELPHIA, PA 19144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0698 SS=D	Continued from page 70 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R47 The facility cannot go back retroactively to correct this issue The DON/designee conducted an audit of residents dialysis communication binders to ensure that communication pages have complete documentation on them from the facility and the dialysis unit. The DON/designee educated licensed staff on the dialysis policy which includes completing the documentation on the dialysis communication sheet prior to leaving to dialysis and upon returning from dialysis. The DON/designee will audit dialysis communication binders to ensure documentation is complete.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0698 SS=D	Continued from page 71	F 0698	Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

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F 0698 SS=D	Continued from page 72 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	F 0698		

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F 0698 SS=D	Continued from page 73 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:	F 0698		

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F 0698 SS=D	Continued from page 74 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. 28 Pa. Code 211.12(d)(1) Nursing Services 28 Pa. Code 211.12(d)(3) Nursing Services	F 0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0710 SS=D		F 0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0710 SS=D	Continued from page 76 483.30(a)(1)(2) Resident's Care Supervised by a Physician §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by:	F 0710	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R65 The facility cannot go back retroactively to correct this issue. The DON/designee conducted an audit of residents with significant weight loss in the last 30 days to ensure the residents physician was made aware of the weight loss and that documentation was completed by the physician in response to the weight loss. The DON/designee educated the residents physician that when a weight loss occurs the physician is expected to complete an assessment of the resident and document it on the clinical record. The DON/designee will audit residents with significant weight	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0710 SS=D	Continued from page 77	F 0710	loss to ensure physician notification of the weight loss and that documentation was completed by the physician in response to the weight loss. Audits will be done weekly x 4 weeks then monthly thereafter. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0710 SS=D	Continued from page 78 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 March 18, 2024, 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.	F 0710		

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F 0710 SS=D	Continued from page 79 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	F 0710		

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F 0710 SS=D	Continued from page 80 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.	F 0710		

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F 0710 SS=D	Continued from page 81 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.	F 0710		

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F 0710 SS=D	Continued from page 82 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	F 0710		
F 0726 SS=D		F 0726		

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F 0726 SS=D	Continued from page 83 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R132 physician was made aware of the residents insulin given after breakfast instead of before breakfast E8, E7, and E10 were trained on medication administration, narcotic management, and enhanced barrier precautions by the facility educator/designee. The facility educator/designee provided training on medication administration, narcotic management and enhanced barrier precautions to licensed agency staff currently coming to the facility. New agency staff will be educated on specific competencies and skill sets as it relates to medication administration, narcotic management and enhanced barrier precautions prior to working a shift at the facility.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0726 SS=D	Continued from page 84	F 0726	The DON/designee will audit new agency licensed nurse personnel files to ensure trainings/competencies have been completed as it relates to medication administration, narcotic management and enhanced barrier precautions. Audits will be done weekly x 4 weeks and monthly thereafter. The audits will be submitted to the quality assurance committee to determine if further action is required.	

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F 0726 SS=D	Continued from page 85 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,	F 0726		

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F 0726 SS=D	Continued from page 86 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	F 0726		

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F 0726 SS=D	Continued from page 87 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	F 0726		

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	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

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F 0726 SS=D	Continued from page 88 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. 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	F 0726		

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F 0726 SS=D	Continued from page 89 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	F 0726		
F 0740 SS=D		F 0740		

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F 0740 SS=D	Continued from page 90 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R17 was seen by the psychiatrist. The Director of social service/designee audited residents PASARR's to ensure that if a resident qualifies for specialized behavioral health services the resident is receiving specialized behavior health services. The Director of social service educated the social service department on making sure if a PASARR indicates that a resident qualifies for specialized behavioral health that the resident is receiving those services. The Director of social service will audit new admissions PASARR's to ensure if the resident qualifies for	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0740 SS=D	Continued from page 91	F 0740	specialized behavior health services the resident will be scheduled to see the psychiatrist. Audits will be done weekly x 4 weeks then monthly x 2 months.	

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F 0740 SS=D	Continued from page 92 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	F 0740		

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F 0740 SS=D	Continued from page 93 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 May 21, 2020 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	F 0740		

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F 0740 SS=D	Continued from page 94 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	F 0740		

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F 0740 SS=D	Continued from page 95 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. 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	F 0740		

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F 0740 SS=D	Continued from page 96 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	F 0740		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 97 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct the issue. The DON/designee conducted an audit of narcotic books to ensure shift to shift count is being completed and the index of the narcotic log book is complete and matches the individual resident count down record. The DON/designee will do a 2 week look back on documentation of meds not available to ensure appropriate follow up was done. The DON/designee will educate licensed including agency staff on narcotic management and the policy of what to do if a medication is not available.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0755 SS=D	Continued from page 98 This REQUIREMENT is not met as evidenced by:	F 0755	The DON/designee will audit narcotic books to ensure shift to shift count is being completed as well as complete documentation in the index portion of the log book. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed. The DON/designee will audit documentation of medications not available to ensure appropriate follow up was done Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	

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F 0755 SS=D	Continued from page 99 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	F 0755		

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F 0755 SS=D	Continued from page 100 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	F 0755		

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F 0755 SS=D	Continued from page 101 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. Observation of the morning medication pass on January 29, 2025, at 10:20 a.m. revealed Employee	F 0755		

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F 0755 SS=D	Continued from page 102 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	F 0755		

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F 0755 SS=D	Continued from page 103 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	F 0755		
F 0759 SS=D		F 0759		

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F 0759 SS=D	Continued from page 104 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R132 physician was made aware that the resident received insulin after breakfast and was made aware of the lidocaine patches that were not removed per order. The DON/designee educated licensed staff including agency licensed staff on the medication administration policy which includes timely administration of insulin and topical lidocaine patch removal per orders. The DON/designee will conduct random medication pass observations of 5 licensed staff focusing on residents with orders for insulin and topical lidocaine patches. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

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F 0759 SS=D	Continued from page 105	F 0759	these audits will be submitted to the quality assurance committee to determine if further action is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0759 SS=D	Continued from page 106 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	F 0759		

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F 0759 SS=D	Continued from page 107 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	F 0759		

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F 0759 SS=D	Continued from page 108 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)	F 0759		

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F 0759 SS=D	Continued from page 109 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 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	F 0759		

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F 0759 SS=D	Continued from page 110 after removing the old patches. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12 (d)(5) Nursing services	F 0759		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 111 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. R17 insulin pen was removed and replaced R132 insulin vial was removed and replaced R95 insulin vial was removed and replaced R83 insulin vial was removed and replaced The DON/designee audited the remining medication carts to ensure insulins were labeled and dated. Licensed staff were educated on the medication administration/disposition policy which includes dating a multi dose container with the date it was opened. The DON/designee will audit	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0761 SS=D	Continued from page 112	F 0761	medication carts to ensure insulins are labeled and dated per policy. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed,	

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F 0761 SS=D	Continued from page 113 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;	F 0761		

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F 0761 SS=D	Continued from page 114 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	F 0761		
F 0847 SS=D		F 0847		

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F 0847 SS=D	Continued from page 115 483.70(m)(1)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.	F 0847	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct the issue. The NHA/designee conducted a 30 day look back of new admissions to ensure residents that have signed the arbitration agreement have the capacity to understand the terms of a binding arbitration agreement. The NHA/designee educated the Admissions Director that if a resident lacks capacity the resident cannot sign an arbitration agreement. The NHA/designee will Audit new admissions arbitration agreements to ensure that the resident has the capacity to understand the agreement to sign it. Audits will be	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0847 SS=D	Continued from page 116 §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by:	F 0847	done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is required.	

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F 0847 SS=D	Continued from page 117 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 May 2, 2024, 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	F 0847		

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F 0847 SS=D	Continued from page 118 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 May 8, 2024, 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	F 0847		

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F 0847 SS=D	Continued from page 119 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	F 0847		

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F 0847 SS=D	Continued from page 120 and Resident R147 had communication and cognitive deficit and should not be provided with arbitration agreement. 28 Pa. Code 211.10 (d) Resident care policies	F 0847		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 121 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct the issue. E11 and E 10 were educated on Enhanced Barrier Precautions and location of PPE The DON/designee educated staff on Enhanced Barrier Precautions and location of PPE. The DON/designee will do Random observations of 5 staff members entering rooms requiring EBP to ensure appropriate PPE is worn. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further action is required.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0880 SS=D	Continued from page 122 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 123	F 0880		

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F 0880 SS=D	Continued from page 124 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."	F 0880		

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F 0880 SS=D	Continued from page 125 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.	F 0880		

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F 0880 SS=D	Continued from page 126 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	F 0880		

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P 4860	Medical records. (d) Records of discharged residents shall be completed within 30 days of discharge. Medical information pertaining to a resident ' s stay shall be centralized in the resident ' s record. This REGULATION is not met as evidenced by:	P 4860	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct the issue. The NHA/designee educated physicians on timely completion of discharge summaries. The Medical records director/designee will audit discharged residents charts to ensure a discharge summary is completed within 30 days of discharge by the physician. Audits will be done weekly x 4 weeks then monthly thereafter. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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

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P 4860	Continued from page 1 Based on a review of clinical records and interview with staff, it was determined that the facility failed to ensure that a physician's discharge summary was completed within 30 days of discharge for one of three closed records (Resident R167 and Resident R168). Findings include: Review of Resident 167's clinical record revealed that the resident was expired on December 12, 2024. There was no evidence that the discharge summary was completed by the physician within 30 days of discharge. Review of Resident 168's clinical record revealed that the resident was discharged home on November 19, 2024. There was no evidence that the discharge summary was completed by the physician within 30 days of	P 4860		

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P 4860	Continued from page 2 discharge. Interview with the Director of Nursing on January 31, 2025, at 12:30 p.m. confirmed that the discharge summary was not completed for Resident R167 and R168 within 30 days as required.	P 4860		
P 5280		P 5280		

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P 5280	Continued from page 3 Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retroactively to correct the issue. The DON/designee will audit the last 30 days of discharged residents to ensure timely documentation of medication disposition. Licensed staff were educated on the policy of Mediation administration/disposition. The DON/designee will audit discharged resident records to ensure that the medication disposition assessment is completed timely. Audits will be done weekly x 4 weeks then monthly x 2 months. Results of these audits will be submitted to the quality assurance committee to determine if further	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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P 5280	Continued from page 4	P 5280	action is required.	

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P 5280	Continued from page 5 Based on a review of facility policies and closed records, as well as interviews with staff, it was determined that the facility failed to document the timely disposition of medications and/or the quantity of drugs disposed for one of three closed clinical records reviewed (Resident 167). Findings include: The facility's policy Medication Administration/Disposition dated September 6, 2023 revealed that "Medications will be disposed of when applicable. Examples of procedures addressing the disposition of medications include: o Timely identification and removal (from current medication supply) of medications for disposition, i.e. medications discontinued, medications expired, medication dose change; o Identification of storage method for medications awaiting final disposition; medications will remain in the locked medication room until disposed; o Control and accountability of medications	P 5280		

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P 5280	Continued from page 6 awaiting final disposition consistent with standards of practice; o Documentation of actual disposition of medications to include: resident name, medication name, strength, prescription number (as applicable), quantity, date of disposition, and involved facility staff, consultant(s) or other applicable individuals; and o Method of disposition (including controlled medications) should prevent diversion and/or accidental exposure and is consistent with applicable state and federal requirements, local ordinances, and standards of practice." Further review of the facility policy did not reveal documented evidence of proper guidelines for "Timely and safe identification and removal of medications for disposition." as outlined in 28 Pa. Code:211.9(j) Pharmacy services for discharged residents. Review of Resident 167's clinical record revealed that the resident was expired on December 12,	P 5280		

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P 5280	Continued from page 7 2024 There was no documented evidence in Resident 167's clinical record to indicate that a disposition of medications was completed upon discharge from the facility prior to the start of the survey on January 28, 2025. Interview with the Director of Nursing on January 31, 2025, at 12:30 p.m. confirmed that there was no documented evidence that the medication disposition for Resident R167 was completed in a timely manner.	P 5280		
P 5520		P 5520		

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P 5520	Continued from page 8 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retro actively to correct this issue. The NHA, DON, and staffing coordinator were educated by the regional nurse on the CNA staffing ratios for dayshift, evening shift and nightshift. The NHA/designee will audit staffing rations daily as well as projected rations for the upcoming shifts using the PA DOH staffing grid to ensure the required CNA ratios are met. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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P 5520	Continued from page 9 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents during the evening shift and one nurse aide per 15 residents during the overnight shift, on seven of 14 days reviewed (December 29 and 31, 2024; January 24, 25, 26, 27 and 28, 2025). Findings include: Review of facility census data revealed that on December 29, 2024, the facility census was 164, which required 131.20 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 72.00 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on December 31, 2024, the facility census was 164, which required 131.20 hours of nurse aides during the day shift. Review of the nursing time schedules	P 5520		

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P 5520	Continued from page 10	P 5520		

and punch reports revealed 128.00 hours of nurse aide care was provided during the shift.

Review of facility census data revealed that on December 31, 2024, the facility census was 164, which required 87.47 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 80.00 hours of nurse aide care was provided during the shift.

Review of facility census data revealed that on January 24, 2025, the facility census was 163, which required 130.40 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 129.08 hours of nurse aide care was provided during the shift.

Review of facility census data revealed that on January 25, 2025, the facility census was 163, which required 130.40 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 83.59 hours of nurse aide care was provided during the shift.

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P 5520	Continued from page 11 Review of facility census data revealed that on January 25, 2025, the facility census was 163, which required 118.55 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 96.00 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on January 25, 2025, the facility census was 163, which required 86.93 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 65.20 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on January 26, 2025, the facility census was 162, which required 129.60 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 94.27 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on	P 5520		

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	396129	A. BLDG: __00_____ B. WING: _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLOW TERRACE STATE LICENSE NUMBER: **072102**	**ONE PENN BLVD PHILADELPHIA, PA 19144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 12 January 27, 2025, the facility census was 163, which required 130.40 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 120.00 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on January 27, 2025, the facility census was 163, which required 118.55 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 117.00 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on January 27, 2025, the facility census was 163, which required 86.93 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 72.00 hours of nurse aide care was provided during the shift. Review of facility census data revealed that on January 28, 2025, the facility census was 165, which required 88.00 hours of nurse aides during	P 5520		

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P 5520	Continued from page 13 the overnight shift. Review of the nursing time schedules and punch reports revealed 80.00 hours of nurse aide care was provided during the shift. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Director of Nursing on January 31, 2025, at 9:48 a.m. The Director of Nursing confirmed that the required staffing ratios for nurse aides were not met on the above dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 14 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retro actively to correct this issue. The NHA, DON, and staffing coordinator were educated by the regional nurse on the LPN staffing ratios on the evening shift and the nightshift. The NHA/designee will audit staffing ratios daily as well as projected ratios for the upcoming shifts using the PA DOH staffing grid to ensure the required LPN ratios are met. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 15 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one LPN (Licensed Practical Nurse) per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents during the overnight shift, on six of 21 days reviewed (January 24, 25, 26, 27, 28 and 29, 2025). Findings include: Review of facility census data revealed that on January 24, 2025, the facility census was 163, which required 34.64 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 34.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on January 25, 2025, the facility census was 163, which required 46.18 hours of LPNs during the evening shift. Review of the nursing time schedules	P 5530		

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P 5530	Continued from page 16 and punch reports revealed 25.50 hours of LPN care was provided during the shift. Review of facility census data revealed that on January 26, 2025, the facility census was 162, which required 34.43 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on January 27, 2025, the facility census was 163, which required 34.64 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 34.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on January 28, 2025, the facility census was 165, which required 35.06 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 34.00 hours of LPN care was provided during the shift.	P 5530		

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P 5530	Continued from page 17 Review of facility census data revealed that on January 29, 2025, the facility census was 165, which required 35.06 hours of LPNs during the overnight shift. Review of the nursing time schedules and punch reports revealed 34.00 hours of LPN care was provided during the shift. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Director of Nursing on January 31, 2025, at 9:48 a.m. The Director of Nursing confirmed that the required staffing ratios for LPNs were not met on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 18 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	This plan of correction is submitted to comply with federal regulations. This plan is not an admission of guilt, or wrong doing, nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. The facility cannot go back retro actively to correct this issue. The NHA, DON, and staffing coordinator were educated by the regional nurse on the state required PPD of 3.2 per patient day. The NHA/designee will audit the daily PPD as well as the projected PPD for the upcoming day using the PA DOH gird to ensure the required PPD is being met. Results of these audits will be submitted to the quality assurance committee to determine if further action is needed.	Completion Date: **03/22/2025** Status: **APPROVED** Date: **02/21/2025**

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P 5640	Continued from page 19 Based on review of nursing time schedules, punch reports and staff interviews, it was determined that the facility failed to provide a minimum of 3.20 hours of direct nursing care per resident on five of 14 days reviewed (December 29, 2024; January 24, 25, 26 and 27, 2025). Findings include: Review of facility census data, punch reports and nursing time schedules revealed that on December 29, 2024, the facility census was 164, and a total of 484.00 direct nursing staff hours were provided, which equaled 2.95 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on January 24, 2025, the facility census was 163, and a total of 514.50 direct nursing staff hours were provided, which equaled 3.16 hours of direct nursing care per resident.	P 5640		

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P 5640	Continued from page 20 Review of facility census data, punch reports and nursing time schedules revealed that on January 25, 2025, the facility census was 163, and a total of 385.85 direct nursing staff hours were provided, which equaled 2.37 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on January 26, 2025, the facility census was 162, and a total of 479.85 direct nursing staff hours were provided, which equaled 2.96 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on January 27, 2025, the facility census was 163, and a total of 496.50 direct nursing staff hours were provided, which equaled 3.05 hours of direct nursing care per resident. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Director of	P 5640		

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P 5640	Continued from page 21 Nursing on January 31, 2025, at 9:48 a.m. The Director of Nursing confirmed the required staffing minimum of 3.20 hours of direct nursing care per resident was not met on the above dates.	P 5640		

Certified End Page

WILLOW TERRACE

STATE LICENSE NUMBER: 072102

SURVEY EXIT DATE: 01/31/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY