STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396129	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW TERRACE	**ONE PENN BOULEVARD PHILADELPHIA, PA 19144**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** Based on review of clinical records and facility policy and procedure and interviews with facility staff, it was determined that the facility failed to ensure that one resident was assessed for safe self- administration of medication for one of 33 residents reviewed (Resident R263). Finding ? Findings include: Review of the facility policy, Self-Administration of Medications - Resident, dated October, 2019, indicated, If the resident desires to self-medicate or is appropriate for self - administration teaching for discharge, an assessment will be completed by the nurse and reviewed by the IDT, (inter disciplinary team - different staff members assess one's ability to complete a task), prior to implementing. Secondly, Residents capability will be documented on the Medication Self - Administration Assessment. Third, Physician Orders are obtained for self- administration of medication. Lastly, The resident's care plan will be initiated or updated to reflect self - administration of medication. Clinical record review for Resident R263, revealed a physician's order dated November 1, 2019, which indicated the following diagnoses, diabetes mellitus, (DM - failure of the body to produce insulin to enable sugar to pass from the blood stream to cells for nourishment). Further review of Resident R263 clinical record, revealed a nursing note dated November 21, 2019, Resident R263, was educated and re-demonstrated with approval with Accu-check and Insulin administration. Reason leave of absence for Thursday November 28, 2019 till Friday, November 29, 2019, afternoon. Manager aware. An interview with the Assistant Director of Nursing on August 28, 2020, at noon. confirmed that Resident R263, was not properly assessed to self administer medication during leave of absence and no documentation was available for review related to Resident R263, self administration of medication, as indicated to be in the facility policy and procedure, related to Self - Administration of Medication. The facility failed to assess a resident for safe self-administration of medication. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(c)(e) Pharmacy services 28 Pa. Code: 211.10(c) Resident Care Policies 28 Pa. Code 211.12(d)(1) Nursing Services 28 Pa. Code 211.12(d)(2) Nursing Services 28 Pa. Code 211.12(d)(3) Nursing Services 28 Pa. Code 211.12(d)(5) Nursing Services
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility investigation report, and interview with facility staff, it was determined that the facility failed to notify the State agency of a fall incident requiring transfer to the hospital report for one of 33 residents reviewed. (Resident R113). Findings include: Review of the facility's Abuse Policy dated October 2017, revealed that the facility had designated and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse and neglect. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The facility's procedure for reporting included to report results of investigation to the proper authorities as required by state law. Review Resident R113's clinical record revealed the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of Resident R113's annual Minimum Data Set assessment completed January 29, 2020 revealed that the resident required extensive assistance of one person for bed mobility and transfers. Further review of the the MDS indicate that the resident had limitation in range of motion of the lower extremities. Review of Resident R113's clinical record revealed a nursing note dated February 20, 2020, which revealed the resident was turned to be repositioned in bed by a staff nurse assistant and the resident subsequentially fell out of his bed and fell on to the floor. Review of the facility's investigation date February 20, 2020 at 2:57 pm. revealed this nurse was notify by CNA (nursing assistant) 9:25 a.m. resident was lying on the floor mat beside bed. Manager also made aware, proceeded to resident room to find him in prone position leaving more to the left side of body with head lying on the left arm, screaming he fell trying to turn while getting morning care. The investigation further stated that one hematoma/red burn area, quarter size over left eye brow and burn mark/hematoma on the left knee 1cm (centimeter) x 0.5 Applied hand bed bars for grasping during care and transfer. Review of a witness statement from the nurse aide that provided care to the resident on the morning of February 20, 2020, which revealed that Today I was getting (Resident R113) ready for [MEDICAL TREATMENT] when I turned him on his side he fell out of the bed onto the floor. He did fall onto the floor mat. He also stated that he needed side rails for his bed. Further review of the facility's investigation included a typed note (not signed or dated) which revealed that the resident was transfer to the ER (hospital emergency room) for evaluation after family visited and were uncomfortable with the swelling and brusing. Review of Resident R113's clinical record revealed a nurse progress note dated February 23, 2020, which revealed the resident's left and right eyes were swollen and the resident's responsible party was made aware of the status change and requested for the resident to be transported to the hospital for evaluation. The Nurse Practitioner was made aware and the resident to be transported to the hospital for further evaluation. Review of the information submitted to the State Agency revealed no documented evidence that the facility notified the State Agency of Resident R113's fall incident which resulted transfer to the hospital, as required. 28 Pa. Code 201.14 (c) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to develop a comprehensive care plan regarding suicidal ideation for one of 33 residents reviewed. (Resident R314). Findings include: A review of the facility policy titled Suicide Prevention dated July 2016, revealed it is the policy of this facility to ensure that residents/patients who voice and /or display suicidal ideation actions receive services and interventions to help them manage feeling and maintain their psychosocial well being. A review of Resident R314's clinical record revealed that the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. A review of the resident's admission Minimum Data Set (MDS- periodic review of the residents needs) dated February 18, 2020 revealed that the resident was independent in decision making skills. The resident used a wheelchair but was able to walk with an unsteady gait. A review of nurse's noted dated March 31, 2020, revealed the resident stated after the smoke break if you take me to the 5th floor, I am going to kill myself. Asked if he had a plan, the resident stated no. A Psychology consult was ordered. Further review of nurse's note dated May 1, 2020, revealed the resident had several attempts to elope. The resident came to the nurse's station and stated I just want to die, I can make it happen. A review of the resident's care plan revealed no evidence that the facility developed a comprehensive care plan with interventions to address the resident [MEDICAL CONDITION]. An interview with the Nursing Home Administrator and the Director of Nursing on August 28, 2020, at 10:00 a.m. confirmed there

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

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was no comprehensive care plan developed for the resident's [MEDICAL CONDITION]. 28 Pa. Code: 211.12 (d)(5) Nursing services.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation and staff interviews, it was determined that the facility failed to ensure that assistive devices to prevent accidents were provided to prevent falls for one of 33 residents reviewed (Resident R113). Findings include: Review Resident R113's clinical record revealed the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of Resident R113's annual Minimum Data Set assessment completed January 29, 2020 revealed that the resident required extensive assistance of one person for bed mobility and transfers. Further review of the the MDS indicate that the resident had limitation in range of motion of the lower extremities. Review of the resident's care plan dated June 16, 2019 revealed that a care plan was developed related to resident recent right [MEDICAL CONDITION]. Review of Resident R113's clinical record revealed a nursing note dated February 20, 2020, which revealed the resident was turned to be repositioned in bed by a staff nurse assistant and the resident subsequentially fell out of his bed and fell on to the floor. Review of the facility's investigation date February 20, 2020 at 2:57 p.m. revealed this nurse was notify by CNA (nursing assistant) 9:25 am resident was lying on the floor mat beside bed. Manager also made aware, proceeded to resident room to find him in prone position leaving more to the left side of body with head lying on the left arm, screaming he fell trying to turn while getting morning care. The investigation further stated that one hematoma/red burn ara, quarter size over left eye brow and burn mark/hematoma on the left knee 1cm (centimeter) x 0.5 Applied hand bed bars for grasping during care and transfer. Review of a witness statement from the nurse aide that provided care to the resident on the morning of February 20, 2020, which revealed that Today I was getting (Resident R113) ready for [MEDICAL TREATMENT] when I turned him on his side he fell out of the bed onto the floor. He did fall onto the floor mat. He also stated that he needed side rails for his bed. Review of Resident R113's clinical record revealed a nurse progress note dated February 23, 2020, which revealed the resident's left and right eyes were swollen and the resident's responsible party was made aware of the status change and requested for the resident to be transported to the hospital for evaluation. The Nurse Practitioner was made aware and the resident to be transported to the hospital for further evaluation. The facility failed to ensure that Resident R113 with a [DIAGNOSES REDACTED]. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that non-pharmacological interventions were intimated prior to the administration of an antianxiety medication for one of 33 residents reviewed (Resident R36). Findings include: Review of Resident R36's clinical record revealed that the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Continued review of the clinical record for Resident R36 revealed a significant change Minimum Data Set (MDS- a periodic review of the resident needs) dated June 12, 2020, which indicated that the resident was independent in decision making skills. A review of physician orders [REDACTED]. A review of Resident 36's August 2020 Medication Administration Record [REDACTED]. An interview with the Nursing Home Administrator and the Director of Nursing on August 28, 2020, at 10:00 a.m. confirmed that non-pharmacological interventions were initiated prior to the antianxiety medication [MEDICATION NAME] being administered to Resident R36. 28 Pa. Code: 211.12 (d)(5) Nursing services.
F 0807 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and procedure and staff interview, it was determined that the facility failed to ensure that residents received a fresh cup of water on every shift, for two of four nursing units (5th and 6th floor nursing units). Findings include: Review of facility policy and procedure titled, Water Cup Pass, revised 1/2020, indicated, Styrofoam cups will be replaced nightly on the 11-7 shift. Second, Cups should be labeled with date of placement. Additionally, Styrofoam cups with ice and fresh water placing them at bedside. Lastly, Water will be provided/passed every shift unless contraindicated by their [DIAGNOSES REDACTED]. During the interview with Resident R38, it was revealed that no water cup was available to R38. Further observation of Resident R38 on August 25, 2020, at 10:15 a.m., revealed no water cup was available for resident use. Further observation on the 6th floor nursing unit and interviews with Residents R263, R56, R49, R154, R22, and R138, on August 25, 2020, between 9:40 a.m. and noon, revealed these six residents did not have water cups available at their bedside. Interview with Employee E7, nurse aide, on August 25, 2020, at 12:05 p.m. confirmed that all six residents listed above were able to drink water but had not been provided with water cups at their bedsides. Observation of the fifth floor nursing unit, North side on August 25, 2020, from 1:00 - 2:30 p.m., revealed the following residents (R36, R4, R12, R81 and R44) were observed without water cups readily available at bedside. Interview with Employee E8, licensed nurse, on August 25, 2020, at 2:40 p.m., during an additional observation of each residents' room with Employee E8 confirmed that each of these resident's was not provided with a water cup at the bedside table. Observation of the 5th floor nursing unit, South side, with Employee E9, nurse aide, on August 25, 2020, at 1:45 p.m. revealed that 21 of 21 residents observed on the nursing unit, did not have a water cup available in their rooms. Interview with Employee E9, at the the end of the observation, revealed that all 21 of the residents would be able to have water cups at bed side. Interview with the Assistant Director of Nursing, on August 25, 2020, confirmed that all 21 of 21 residents on the South side of the 5th floor nursing unit, should have been provided with a fresh cup of water, during the previous 11-7, shift and the assigned nurse aide and licensed nurse, should have ensured that all residents were provided with a water cup within their room. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Dispose of garbage and refuse properly.** Based on observation of the Food and Nutrition Department and staff interviews, it was determined that the facility failed to ensure that the facility was disposing of garbage and refuse properly. Findings include: Observation of the main kitchen on August 25, 2020 at 9:30 a.m., with Employee E6, the Director of Food and Nutrition Services, revealed that the trash and garbage for the food and nutrition department was held and stored for pick-up by an outside agency. Four large mobile containers were placed on the loading/receiving dock located in the rear of the facility. The mobile containers once filled were transported by housekeeping staff to the dumpster unit and held there for pick-up, by the contracted trash removal service. Observation of the doors that lead directly out of the building onto the loading/receiving dock on August 25, 2020 at 10:00 a.m., revealed that the doors' threshold at the bottom of the doors was not flush with the building construction and lacked a tight seal upon closing. The lack of these tight seals provided easy access (one inch gap) for common household pests (flies, mice) to enter the building. Observation of the garbage and refuse storage area on August 25, 2020 at 10:00 a.m., revealed that the large plastic garbage storage containers were not cleaned of food spillage and debris. Three of the four trash containers did not have lids. The presence of flies was noted. Interview with Employee E1, Nursing Home Administrator, on August 26, 2020 at 9:00 a.m. revealed that the housekeeping staff and maintenance staff were responsible for the cleaning and making repairs of equipment for the facility's garbage and refuse area. 28 Pa. Code 207.2(a) Administrator's responsibility
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and procedures and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to wound care for one of two residents, (Resident R36) and did not maintain effective infection control program related to hand hygiene, for one of four nursing units (5th floor nursing unit). Finding include: A review of facility policy, non-sterile dressing change, dated created August 2016,

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) revealed that staff shall prepare a clean, dry work area at the bedside. The policy did not mention a protective barrier. A review of Resident R36's clinical record revealed that the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Further review of Resident R36's clinical record revealed a significant change Minimum Data Set (MDS- periodic assessment of the resident's needs) dated June 12, 2020, which indicated that the resident was independent in decision making skills. A review of the wound care tracking dated August 21, 2020, revealed that Resident R36 was being treated for [REDACTED]. The wound measured 0.2 centimeters by 0.3 centimeters by 0.1 centimeters. Physician orders [REDACTED]. Observation of a wound treatment to Resident R36's right heel on August 27, 2020, at 11:20 a.m. revealed the resident sitting in his wheelchair with bare feet. Employee E3, nurse, cleansed the residents' right heel and then the resident put his right heel on the bare floor for several seconds. There was no protective barrier present between the residents' foot and the floor. An interview with the fifth floor nursing unit manager on August 27, 2020, at 11:30 a.m. confirmed that a protective barrier should have been placed between the floor and the residents' foot. During the observation in Resident R36's room on August 27, 2020, at 11:20 a.m. it was further noted that a fly was present in the room by the surveyor, nurse and the resident. Resident R36 stated that, he does see flies in his room often. A review of the pest control log for the months of June, July and August 2020, revealed no documention of flies just roaches. A review of Resident R42's clinical record revealed that the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. This tissue makes it hard to stretch the area and prevents normal movement.) A review of Resident R42's significant change Minimum Data Set (MDS-a periodic review of the residents needs) dated June 19, 2020, revealed that the resident is independent in decision making skills. The MDS additionally indicated that the resident was totally dependant on staff for bed mobility, transfers, dressing, eating and toileting. Observation of Resident R42's sacral area on August 27, 2020, at 12:30 p.m. revealed the presence of a healed sacral wound with moderate scarring on the sacrum. The observation further revealed the presence of two flies in the room. Employee E3, nurse, and Employee E5, nursing assistant, were present and observed the flies. The resident stated he has flies in his room at times. The resident further stated he has difficulty raising his arms to swat flies away. Review of facility policy and procedure, COVID - 19 Infection Prevention and Control, Pa Facilities, revised August 11, 2020, indicated, The facility, consistent with federal regulations, implements universal, standard infection control practices. This may include information pertaining to: Standard Precautions and Hand hygiene. The policy further indicated, Employees are educated and reminded to clean their hands according to CDC guidelines, including before and after any contact with residents. Observation on August 28, 2020, at 9:45 a.m. revealed Employee E10 , Social Worker, placing a face mask on Resident R77, and than placed a face mask on Resident R88. Interview with Employee E10 immediately following the observation, confirmed, No handwashing before placing the face mask on R77 or after placing the face mask on Resident R77, and/or before placing a face mask on Resident R88 and/or after placing a face mask on Resident R88. Review of facility policy and procedure, Medication Dispensing System, undated, indicated, Prior to preparing or administering medications, follow the facility's infection control policies, (example, Hand washing). Review of facility policy and procedure, Hand Hygiene, dated revised, June 2020, indicated, If hands are not visibly soiled, use an alcohol based hand rub, which is preferred method recommended by the CDC for routinely decontaminating hands in the before and after direct contact with residents and before medication administration. Observation of Employee E11, Licensed nurse, on August 28, 2020, at 10:10 a.m. revealed the employee at the medication cart for south side of the 5th floor nursing unit. Further observation of Employee E11 revealed she was taking apart a capsule and pouring the contents of the capsule into a small medication cup. Continued observation of Employee E11 revealed that she did not have gloves on when touching the medication, nor did she wash her hands before handling the medication. Interview with Employee E11, immediately following the observation revealed that the medication she was observed handling was [MEDICATION NAME] (drug used to treat [MEDICAL CONDITION]). Employee E11 also confirmed that she did not wash her hands prior to handling the medication and was not wearing gloves, as per facility policy. 28 Pa. Code: 207.2(a) Administrator's responsibility 28 Pa. Code: 201.18(a)(1) Management 28 Pa. Code: 201.18(a)(3) Management 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management 28 Pa. Code: 211.12(d)(5) Nursing services
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observation, review of documentation and staff interviews, it was determined that the facility failed to maintain an effective pest control program in the dietary department and one of three nursing units. (Dietary department and 5th floor nursing unit) Findings include: Observation of the Food and Nutrition Department (Kitchen) on August 25, 2020, at 9:30 a.m., revealed that the facility's three compartment equipment was in disrepair. The pipes located underneath these sinks were leaking. A pan was placed on the floor underneath the sink to catch the leaking liquid contents from the sinks. The pan was full of cloudy sediment containing liquid at the time of the observation. The wall boards protective covering, located behind the dish machine had detached. The caulking that ran along the entire wall area adjacent to the extended counter space used for sorting food debris and trash contained a black substance resembling mold. Interview with Employee E6, Director of Food and Nutrition Services, on August 25, 2020, at 10:00 a.m. confirmed that the food deliveries were being transported from the main entrance of the facility through the main lobby to the Food and Nutrition Department located behind the main lobby in the facility. Observations of the Food and Nutrition Department on August 25, and 26, 2020, revealed that the doors leading into the main kitchen were not closed at any time. Live flies were noted throughout the Food and Nutrition Department during the observations made on August 25 and 26, 2020, with the director of Food and Nutrition Services. Further observation of the facility revealed that the double doors leading directly outside the facility from the main lobby were not sealed tightly. The doors provided a gap (one inch) at the threshold of the doors. Reviews of the consulting pest control operators reports for February 2020, through August 2020, revealed that during the months of July and August, 2020, the Food and Nutrition Department had indicated that household pests (flies) were cited in the kitchen. Interview with Employee E1, nursing home administrator and Employee E6, Food and Nutrition Services Director, on August 27, 2020, at 10;00 a.m., confirmed that the pest control operator relied heavily on one fly light that had been installed inside the Food and Nutrition Department in February 2020, as the only means to eradicate household pests(flies) from the kitchen. Review of the fifth floor pest control log for the months of June, July and August 2020, revealed no documention of flies. Observation of wound treatment on August 27, 2020, at 11:20 a.m. in Resident R36's room with Employee E3, licensed nurse, revealed a fly present in the room. Interview with the resident, at the time of the observation, revealed that the resident stated he does see flies in his room often. Observation of wound treatment on August 27, 2020, at 12:30 p.m., in Resident R42's room with Employees E3, nurse, and Employee E5, nursing assistant, revealed the presence of two flies. Interview with Resident R42, at the time of the observation, revealed that the resident has flies in his room at times. The resident was observed with contractures (shortening of the tendons of a joint) of the wrist and hands and stated that he has difficulty raising his arms to swat flies away. 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa Code 207.2(a) Administrator's responsibility 28 Pa. Code 201.18(a)(1) Management