STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396129	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of facility policies and documentation, clinical record review and interviews with staff, it was determined that the facility failed to ensure that a resident remained free from abuse, which resulted in actual harm to Resident R2 who was pushed by a nursing staff, fell to the floor and sustained an acute fracture of the distal radial metaphysis for one of eight residents reviewed. (Resident R2) Findings include: Review of facility policy, 'Abuse policy- Prevention and Management', dated September 8, 2022, reviewed on august 2024, revealed 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 must provide a safe resident environment and protect residents from abuse. This includes but is not limited to freedom from corporal punishment and involuntary seclusion . Continued review revealed, abuse was defined as the willful infliction of injury. Examples of injuries that could indicate abuse include, but are not limited to injuries that are non-accidental or unexplained; fractures, sprains, or dislocations. Further review of the Abuse Policy indicated; When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. The facility is responsible to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population. Facility cannot disown the acts of staff since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. Striking a combative resident is not an appropriate response in any situation. Not acceptable for an employee to claim his/her action was reflexive or a knee-jerk reaction and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be reported. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R2's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated March 6, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses of Dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age),Thyroid Disorder (Thyroid disease is a general term for a medical condition that keeps your thyroid from making the right amount of hormones), Diabetes Mellitus (DM) (Diabetes Mellitus is a disease of inadequate control of blood levels of glucose), and Cirrhosis (Cirrhosis is severe scarring of the liver). Further review revealed that the Resident R2 had a Summary Score of 6 in Brief Interview for Mental Status (BIMS). (The patient can score 0 to 15 points on the test. A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). Review of Resident R2's care plan, dated May 2, 2024, revealed that the resident was at risk for falls; was dependent on activities or staff to remind, invite, escort him to a variety of programs that meet his emotional, intellectual, physical, social needs; had non-compliant behaviors, potential to be physically aggressive behavior related to anger; and had impaired thought processes due to Dementia. Interventions included for staff to maintain a safe environment free of clutter and wet floors; ensure adequate lighting; when Resident R2 becomes agitated, intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Review of facility documentation submitted to the Department of Health on August 17, 2024, revealed that on August 17, 2024, at 1:42 p.m., Resident R2 was in the 5th floor dining room. At that time, Employee E3, Director of Rehab, was walking into the 5th floor dining area. Employee E3 saw, Resident R2 yelling and cursing and walking towards a staff member, Nurse aide, Employee E4. The Nurse aide, Employee E4, approached Resident R2; then Resident R2 grabbed onto Nurse aide, Employee E4's hands. Director of Rehab, Employee E3, observed that the Nurse aide Employee E4 was pushing Resident R2 to get him off her. When Nurse aide, Employee E4 pushed Resident R2, the resident landed against the wall and then slid to the floor. Director of Rehab, Employee E3 immediately went to the Resident R2 to assist him. Resident R2 wanted to get up on his own, so Director of Rehab, Employee E3 stood by Resident R2 until he got up and then assisted him to his room. Director of Rehab, Employee E3 called the Nursing Supervisor, Registered Nurse, Employee E6, to explain what had occurred. The Nursing Supervisor, Employee E6, came to the unit and assessed Resident R2. The resident was noted to have two abrasions on his back and swelling was noted to his left wrist. The physician was called, and orders were received. The supervisor requested a statement from the nurse aide, Employee E4, and sent her home. Supervisor contacted the Nursing Home Administrator (NHA) to inform her of what occurred. Resident R2 received Tylenol for pain and orders to cleanse the abrasions to his back with normal saline and leave open to air. X-rays were ordered to the left hand and wrist as well as ice pack to be applied every 15 minutes for swelling. X-ray results were received and indicated a fracture of the left distal radial metaphysis (wrist). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility investigation related to the incident revealed a written statement from Employee E3, Director of Rehab, dated August 17, 2024, which stated that he was in the fifth-floor dining room, where Resident R2 was observed yelling and cursing. Nurse Aide, Employee E4, approached Resident R2, when Resident R2 grabbed on to the Nurse aide, Employee E4. The Nurse Aide, Employee E4, was observed by the Director of Rehab, Employee E3, pushed Resident R2 to the ground, where Resident R2 landed on his side, with Resident R2's back against the wall. Director of Rehab, Employee E3 assisted Resident R2 off the ground and helped him to the room, where the Nurse Supervisor was contacted to assess the resident. Director of Rehab, Employee E3 contacted police and reported the incident. On August 29, 2024, at 12:30 p.m., interview with Director of Rehab, Employee E3 repeated the information given in his written statement as mentioned above. Review of facility investigation related to the incident revealed a written statement from the Nurse aide, Employee E4, dated August 17, 2024, which stated that: [Resident R2] walked up to me, grabbed my neck, I snatched away real quick and he fell on the floor. Phone interview conducted with Nurse aide, Employee E4 on August 29, 2024, at 12:15 p.m., revealed that on August 17, 2024, Resident R2 was there in the dining room of fifth floor for lunch. Resident R2 wanted to sit with a group of four residents, along with a female resident, but there was no space. Nurse aide, Employee E4 pulled the chair. Then Resident R2 spit on nurse aide, Employee E4's face. Resident R2 was not steady on his feet. Resident R2 fell backward. Nurse aide, Employee E4 stated that she did not touch Resident R2, as she was carrying the food tray in her left hand, and was using the right hand to prevent the spit falling on her face. Review of clinical nurses note, dated August 17, 2024, by Nursing Supervisor, Registered nurse, Employee E6, revealed as follows: This nurse was made aware by physical therapy (PT) staff that resident sustained physical injury from a care nurse while in the dining room. PT staff states that he witnessed resident behaving aggressively in the dining room and the resident hit a care nurse, and then the care nurse grabbed the resident by his neck and forcefully pushed him against the wall. The resident fell to the floor. The PT staff quickly intervene, and safely removed the resident from the dining area and took him to his room. Resident is not a good historian of the event. Resident assessed; injuries noted, two abrasions to his upper back, #1 measured 12 x 2.5 cm, #2 measured 5 x 1 cm. Upon further assessment swelling noted to (L) hand and wrist, facial grimacing, and guarding of the arm noted. Resident was able to wiggles fingers. Acetaminophen administered for pain. Call place to Physician, new order to X-ray the (L) arm. Ice pack x 3 days for swollen. Q (every) Shift pain assessment in place. New order to clean upper back daily with NSS (Normal Saline Solution), Leave Open To Air. Staff was immediately removed from premises. Department head notified. On August 29, 2024, at 3:00 p.m., interviewed Nursing Supervisor, Registered nurse, Employee E6 restated the above information, and added that she did not witness the incident. Review of Imaging Narrative Note for Resident R2, dated August 18, 2024, for the X- ray service performed on August 17, 2024, indicated as follows: There is an acute fracture of the distal radial metaphysis. (Distal radial fractures are fractures that occur at the wrist). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Employee E4's personnel file revealed that she was hired by the facility on January 26, 2022, as a nurse aide. Continued review revealed that Employee E4, nurse aide, received training on the prevention of elder abuse on January 26, 2022. Further review revealed that Employee E4, nurse aide, received training on facility policy, De-escalation on May 9, 2022 and continued in-service on December 14, 2023. Interview on August 29, 2024, at 12:54 p.m., the Nursing Home Administrator, while reviewing the video footage of the incident, dated August 17, 2024, confirmed that Resident R2 fell , whereas Nurse aide, Employee E4, pushed the resident. The NHA confirmed that the resident sustained acute fracture of the distal radial metaphysis. The NHA confirmed that the facility substantiated the allegation of physical abuse against Employee E4, nurse aide, and subsequently terminated her from employment. The facility failed to ensure that Resident R2 remained free from abuse, resulting in actual harm to Resident R2 who was pushed by a nursing staff, fell to the floor and sustained an acute fracture of the distal radial metaphysis. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.29(c) Resident rights