

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Willow Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE One Penn Boulevard Philadelphia, PA 19144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Willow Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE One Penn Boulevard Philadelphia, PA 19144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to provide adequate supervision to one of twelve residents reviewed (Resident R1) who was at risk for elopement. This failure resulted in Resident R1 exiting nursing unit via the elevator and walking out the front entrance doors. Resident R1 was unable to be located for over six hours. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1)Findings Include:Review of facility policy, titled, Prevention and Management of Accident, Hazards Adequate Supervision, and Assistive Devices with a revision date of July 24, 2025, revealed, the facility will ensure that the resident environment remains as free of accident hazards as is possible, and that the residents will receive adequate supervision and assistive devices to prevent hazards. Continued review of the policy revealed, iii. Wandering/Elopement Elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies define the mechanisms and procedures for assessing and identifying, monitoring and managing residents at risk for elopement to minimize the risk of a resident leaving a safe area without the facility's awareness and/or appropriate supervision. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with the following diagnoses; Unspecified Dementia (cognitive decline is evident, but the specific type of dementia cannot be determined), Adjustment Disorder with Depressed Mood (symptoms of depression or loss of interest, that arise in response to a specific stressful event), Depression (feelings of overwhelming sadness), Hyperlipidemia (elevated levels of lipids (fats and fat-like substances) in the blood, including cholesterol and triglycerides), and Hypertension (condition where the force of blood pushing against the artery walls is consistently too high). Review of Resident R1's Elopement Risk Evaluation completed on admission dated July 24, 2025, revealed the resident was ambulatory, with a history of elopement and exit seeking. The resident utilizes an electronic monitoring device, care plan for risk for elopement and place on secured unit. Review of Resident R1's admission MDS (Minimum Data Set- periodic assessment of resident's care needs) was not completed until July 28, 2025, and it revealed the resident was assessed with a BIMS (Brief Interview for Mental Status) score of 3. A score of 3 indicates severe cognitive impairment. Review of Resident R1's admission progress notes completed by the physician on July 25, 2025 revealed, .had some agitation at the hospital [he/she] wanders. Also noted in his progress notes, Psychiatry- no anxiety noted. Resident R1 has a history of wandering. Review of facility investigation provided by the facility revealed a timeline dated July 26, 2025. The following is the summary of the timeline:At 6:00 p.m. The resident was standing behind the unit door on or around 6:00 p.m. A staff member from housekeeping opened the door and the resident came out. The staff member asked the resident where [he/she] was going, and the resident responded outside. The staff member tried talking to the resident, but the resident headed straight to the elevator. The staff and resident rode down on the elevator together. As per housekeeping staff, the resident was unsure of where to exit the building, and security showed [him/her] the front door. As per security, he was unsure of the time this occurred but stated it was still light outside.At 7:45 p.m. staff noticed resident was missing at or around 7:45 p.m.At 8:00 p.m. a full search of the unit was performed, and the supervisor was notified around 8:00 p.m. The supervisor and facility staff conducted a full house check and check of the outside the perimeter of the facility for the resident. The Physician, Director of Nursing, and Responsible Party were notified at 8:45 p.m. A call was placed to the police, university security notified, and the elopement protocol initiated. 9:00 p.m.- 11:20 p.m. Continued perimeter and expanded perimeter search. Vicinity patrol over three local streets.July 27, 2025- 12:00 a.m. Approximately 12:00 a.m. phone call was placed to Resident R1's daughter to find out where resident would possibly go. Resident's last known address checked- no one was home. Daughter also provided alternative address.1:22 a.m. Resident was found at the alternative location at 1:22 a.m. The police were called several times while a staff member kept Resident R1 in sight until the police arrived to provide to transport the resident back to the facility at 2:00 a.m. 2:00 a.m. Upon arrival to the facility the Director of Nursing received the resident, the resident was assessed no injury. Resident R1 was confused and unable to give an account of where [he/she] went. Resident was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Willow Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE One Penn Boulevard Philadelphia, PA 19144	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Willow Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE One Penn Boulevard Philadelphia, PA 19144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records, job descriptions, review of facility policy, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure the safety of one of twelve residents reviewed (Resident R1) with a diagnosis of Dementia who eloped from the facility. This failure resulted in an Immediate Jeopardy situation for Resident R1 who was missing from the facility overnight for approximately six hours. (Resident R1) Findings Include: Review of the job description for the Nursing Home Administrator (NHA) with a revision date of June 15, 2023 states, Position Summary-this position is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meet residents' needs in accordance with federal, state and local regulations. Also, develop and maintain systems that are effective and efficient to operate the facility in a financially sound manner. Further review of the NHA job description revealed, Essential Duties and Responsibilities-. Develop, maintain and implement operational policies and procedures to meet residents' need in compliance with federal, state and local requirements. Determine the personnel requirements of the facility in collaboration with Department Managers and hire or arrange for sufficient staff to provide for sound resident care and implement the facility policies and procedures. Review of the job description for the Director of Nursing (DON) with a revision date on October 10, 2023 states, Position Summary- The Director of Nursing functions as the administrative authority for the Department of Nursing. This Director will be responsible for the organization and oversight of all nursing operations and for the supervision of care for all residents at the facility. Further review of the DON job essential requirements revealed, Must possess the ability to plan, organize, develop, implement and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality of care. Review of facility policy Abuse Policy- Prevention and Management last revised April 14, 2022 states, Policy-the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation/exploitation of resident/patient property by anyone including staff, family, friends, visitors, etc. The Facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. Further review of the policy revealed, .Neglect-Failure of the Facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of Unspecified Dementia (cognitive decline is evident, but the specific type of dementia cannot be determined), Adjustment Disorder with Depressed Mood (symptoms of depression or loss of interest, that arise in response to a specific stressful event), Depression (feelings of overwhelming sadness), Hyperlipidemia (elevated levels of lipids (fats and fat-like substances) in the blood, including cholesterol and triglycerides), and Hypertension (condition where the force of blood pushing against the artery walls is consistently too high). Review of Resident R1's Elopement Risk Evaluation completed upon admission dated July 24, 2025, revealed the resident was ambulatory, with a history of elopement and exit seeking. The resident utilizes an electronic monitoring device, care plan for risk for elopement and place on secured unit. Review of Resident R1's admission MDS (Minimum Data Set- periodic assessment of resident's care needs) completed on July 28, 2025, revealed the resident was assessed with a BIMS (Brief Interview for Mental Status) score of 3. A score of 3 indicates severe cognitive impairment. Review of facility investigation dated July 26, 2025, revealed the following timeline: At 6:00 p.m. The resident was standing behind the unit door on or around 6:00 p.m. A staff member from housekeeping opened the door and the resident came out. The staff member asked the resident where he was going, and the resident responded outside. Staff member tried talking to</p>		