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	12/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policy, and staff interview it was determined that the facility failed to ensure that a resident was informed of and allowed to exercise their right to leave the facility Against Medical Advise (AMA) for one out of 5 residents reviewed. (Resident CL1). Findings Include:A review of the facility policy titled Discharge Against Medical Advice (AMA), last revised 6/2025, stated: A Discharge Against Medical Advice form must be completed when a cognitively intact resident/patient or the legally responsible party for a non-cognitively intact resident/patient insists on leaving the facility Against Medical Advice (AMA). The attending physician, CEO, and Director of Nursing must be notified immediately following each AMA.Review of Resident CL1's nursing notes indicated that the resident was admitted to the facility on [DATE], at approximately 6:30 p.m. with a diagnosis of anoxic brain damage. A nursing note dated the same day at 7:19 p.m. stated, [Resident CL1] is Alert and Oriented to 1. person, 2. place and 3. Time (AAOX2-3) with confusion. [Resident CL1] is a high elopement risk, voicing concerns about leaving the facility and returning to the streets. [Resident CL1] was observed crying in the hallway and yelling, demanding to leave. The nursing supervisor and MD (physician) were made aware. New orders were received to place the patient on 1:1 rotation for further assessment.A review of the physician discharge completed on September 27, 2025, at 10:24 a.m. indicated [Resident CL1] was admitted for short rehab. Resident admitted but refuses to stay in the facility. Very aggressive behavior, she left AMA (against medical advice). Under condition upon discharge, it indicated [Resident CL1] stable/alert and oriented.On October 3, 2025, at 12:57 p.m. an telephone interview with the license nurse, Employee E3 who was assigned to Resident CL1 reported that Resident CL1 was alert and oriented and wanted to leave against medical advice (AMA), Resident CL1 was screaming and yelling wanting to leave, I verbalized to my supervisor, Employee E4 and briefly mentioned the AMA process by stating you could leave against medical advice.On October 3, 2025, at 1:22 p.m., a telephone interview was conducted with the registered nurse, Employee E4, who was acting as the supervisor for the evening shift. Employee E4 reported, Resident CL1 was admitted and was pacing, going into residents' rooms, which made people nervous. I learned she was experiencing withdrawal symptoms and completed the initial assessment after reviewing documents. A 1:1 was recommended to ensure safety. Resident CL1 was fully continuous and left the facility without signing AMA documents. Resident CL1 left Against Medical Advice (AMA). I did not personally review the AMA documents with her.On October 6, 2025, at 10:50 a.m., an interview was conducted with the Director of Nursing (DON), Employee E2, who reported that when Resident CL1 arrived at the facility, she/he wanted to leave because she/he is a young person and, upon seeing the elderly population, stated, I do not belong here. DON, Employee E2 confirmed that the facility failed to inform Resident CL1 of her right to leave Against Medical Advice (AMA). DON, Employee E2 interviewed licensed nurse, Employee E3 and supervisor nurse, Employee E4, who were responsible for educating Resident CL1 about her AMA rights. DON Employee E2 reported that Licensed nurse, Employee E3 stated he was an agency nurse and relied on the supervisor to conduct the AMA education and have Resident CL1 sign the AMA documentation.On October 6, 2025, at 11:30 a.m., the Administrator, Employee E1, and the Director of Nursing confirmed that Resident CL1 was not informed of her right to leave Against Medical Advice (AMA) and did not receive the required education about AMA policy.28 Pa. Code 201.29 (a) Resident Rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record reviews, interviews with staff, reviews of hospital records and policies and procedures, it was determined that the facility failed to provide the behavioral health care and services to meet the needs of one of sixteen residents reviewed to ensure that each resident attained or maintained the highest practicable physical, mental and psychosocial well-being. (Resident CL1) Findings include:A review of the facility policy titled behavioral mental health care substance use services dated March 19, 2025, revealed that it was the policy of the facility to provide an interdisciplinary approach to substance use disorder, trauma, withdrawal, anger or behavioral symptoms which lead to negative consequences for themselves or other residents. The policies said that the facility would have sufficient staff who have the skill sets to meet the behavioral needs of the residents who have a diagnosis of mental health disorder, substance abuse disorder, trauma, increased withdrawal, anger or behavioral symptoms which lead to negative consequences for themselves or other residents. The policy indicated that resident's demonstrating changes in behavior were to be evaluated to ensure that appropriate interventions both non-pharmacological and pharmacological measures were instituted timely.A review of the policy titled behaviors-continuous one to one supervision dated May 7, 2025, revealed that the whereabouts and well-being of residents was the responsibility of the nursing staff. Enhanced supervision or one to one supervision of each resident was also the responsibility of the nursing staff. A designated staff member would be assigned to be responsible for the one-to-one supervision of each resident. The policy indicated that the staff member assigned to one-to-one supervision of a resident shall be aware of the resident at all times and be within arm's length of the resident assigned. The policy said that the nursing staff member may be assigned to one-to-one close supervision of a resident. This would require the staff assigned to be aware of the resident, have eyes on the resident at all times and be at close distance to the resident at all times.Clinical record review revealed that Resident CL1 was admitted to the facility at 6:30 p.m., on September 26, 2025. The nursing admission assessment indicated that the resident was received from the hospital after being treated September 5 through September 26, 2025, for anoxic brain damage (the brain does not receive enough oxygen for an extended period of time usual causes poisoning from drug overdose). The assessment indicated that the resident was a smoker with a history of poly substance abuse methadone, heroin and cocaine. The nurse documented that the resident had adequate hearing, was alert and had adequate vision. The nurse documented that Resident CL1 was alert times 2 to 3 with confusion. The licensed practical nurse, Employee E3 indicated that the medication orders were confirmed with the physician.Hospital record review revealed that Resident CL1 had a history of polysubstance use disorder. The hospital indicated that Resident CL1 was to continue with buprenorphine-naloxone (suboxone) a medication used to manage opioid cravings and withdrawals. The physician ordered 8-2 mg. of suboxone one film under the tongue for seven days, twice a day, melatonin 5mg at bedtime and Narcan 4mg spray into nostril for opioid reversal may repeat every 2 to 3 minutes until medical assistance arrives.Clinical record review revealed that the licensed practical nurse confirmed medication orders upon admission for Resident CL1 as follows buprenorphine-naloxone (suboxone) 8-2 mg. twice a day, one film under the tongue for seven days, twice a day and Narcan 4mg spray into nostril for opioid reversal may repeat every 2 to 3 minutes until medical assistance arrives.Interview with the licensed practical nurse, Employee E3 at 1:00 p.m., on October 3, 2025, revealed that upon admission to the facility Resident CL1 was requesting and demanding suboxone medication. The licensed practical nurse said that the registered nurse on duty was notified that Resident CL1 needed the suboxone medication immediately. There was no evidence the licensed nurse, Employee E3 notified the physician of the residents request for the medication (suboxone). The licensed practical nurse indicated that Resident CL1 was crying in the hallway and stating that she wanted to leave the facility to get back to the streets. There was no documentation to indicate that the licensed practical nurse counselled and educated the resident about leaving the facility.Interview with the registered nurse, Employee E4, at 1:30 p.m., on October 3, 2025, revealed that the nurse assessed the resident upon admission and noted that Resident CL1 was pacing, anxious and exhibiting withdrawal symptoms. The registered nurse reported that the medication (suboxone) was supposed to be delivered STAT (immediately) to the facility. The registered nurse said that STAT means within an hour. The medication that was being requested was not delivered within an hour of the resident's admission to the facility. The registered, Employee E4 reported that Resident CL1 was placed on one-to-one observation upon admission to the facility.Interview with nursing assistant, Employee E5, at 2:30 p.m., on

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records, job descriptions, 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 investigate alleged violations or incidents related to a resident not being informed of and allowed to exercise their right to leave the facility Against Medical Advice (AMA) for one out of five residents reviewed (Resident CL1). Findings Include:Review of the facility policy titled Incident Reporting and Investigation of Accident Hazards, and Supervision, Assistive Devices, last revised October 2024, revealed the following:It is the policy of the Facility to monitor and evaluate any adverse occurrence that is not consistent with the routine operation of the Facility or the care of a resident(s). All accidents/incidents involving mistreatment, neglect, abuse, or injuries of unknown origin will be reported immediately to the Director of Nursing (DON) and Administrator (NHA) for further review and reporting based on State and Federal regulations.The policy further states under Data Collection:Complete the incident report:a. Collect information related to the facts and circumstances of the incident being investigated: Witness statements should include only factual information. Employees should be educated to include only firsthand information and not secondhand information in their statements. Witness statements must be completed at the facility; they should not be written from home or emailed to the facility. Witness statements should be reviewed by the Unit Manager, Supervisor, Assistant Director of Nursing (ADON), DON, or NHA prior to the employee leaving the facility to ensure the information is pertinent to the incident, includes applicable details, and is legible, signed, and dated.Review of Resident CL1's clinical progress notes indicated that the resident was admitted to the facility on [DATE], at approximately 6:30 p.m. with a diagnosis of anoxic brain damage. A progress note dated the same day at 7:19 p.m. stated, CL1 is Alert and Oriented to 1. person, 2. place and 3. Time (AAOX2-3) with confusion. CL1 is a high elopement risk, voicing concerns about leaving the facility and returning to the streets. CL1 was observed crying in the hallway and yelling, demanding to leave. The nursing supervisor and MD were made aware. New orders were received to place the patient on 1:1 rotation for further assessment. A review of the physician discharge completed on September 27, 2025, at 10:24 a.m. indicated CL1 was admitted for short rehab. Resident admitted but refuses to stay in the facility. Very aggressive behavior, she left AMA. Under condition upon discharge, it indicated CL1 stable/alert and oriented.On October 3, 2025, at 12:57 p.m. an telephone interview with the license nurse, Employee E3 who was assigned to CL1 reported that CL1 was alert and oriented and wanted to leave against medical advice (AMA), CL1 was screaming and yelling wanting to leave, I verbalized to my supervisor, Employee E4 further reported that CL1 disappeared at approximately 08:05 p.m. off the unit.On October 3, 2025, at 1:22 p.m., a telephone interview was conducted with the registered nurse, Employee E4, who was acting as the supervisor for the evening shift. E4 reported, CL1 was admitted and was pacing, going into residents' rooms, which made people nervous. I learned she was experiencing withdrawal symptoms and completed the initial assessment after reviewing documents. A 1:1 was recommended to ensure safety. CL1 was fully continuous and left the facility.On October 6, 2025, at 10:50 a.m., an interview was conducted with Nursing Aide (NA), Employee E5, who was assigned to provide 1:1 supervision for Resident CL1 from 7:00 p.m. to 8:00 p.m. on September 26, 2025. Employee E5 reported that she was informed she needed to supervise Resident CL1 on a 1:1 basis. According to NA, Employee E5, the 1:1 supervision appeared to frustrate Resident CL1, and her behaviors escalatedshe began banging on the entry door, pacing in the hallways, cursing, screaming, and yelling that she wanted to leave the facility.All facility doors were coded, so Resident CL1 was initially unable to exit. However, she then attempted to open a fire exit door. After pushing on it for approximately 15 seconds, the fire door opened, triggering the alarm. Resident CL1 proceeded down the stairs from the third floor to the first floor, with NA, Employee E5 following her. Both Resident CL1 and NA, Employee E5 exited the building onto the front porch, where NA, Employee E5 was able to temporarily calm Resident CL1 down.Resident CL1 repeatedly stated, I'm not staying here. I'm going to leave. [NA, Employee E5] asked [Resident CL1] to sit on a bench and wait while she contacted security at the front desk. Although [Resident CL1] was still within [NA, Employee E5's] line of sight, she got up and eloped from the area before security arrived.On October 6, 2025, at 11:30 a.m., the Administrator, Employee E1, and the Director of Nursing confirmed that Resident CL1 left the facility without authorization and was not given the opportunity to sign the required Against Medical Advice (AMA) documentation. Additionally, the facility failed to investigate the incident by not