

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 03/19/2026
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 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** Based on review of clinical records, facility documents, and interview with staff and residents, it was determined the facility failed to ensure Resident R1 was free from physical abuse. This failure resulted in actual harm to Resident R1 who was grabbed by a facility's employee by the collar, held in a choking position and placed (his/her) hand on the resident's face. The employee's hands had to be pried away from Resident R1's. A reasonable person would determine that a staff member holding a resident with a diagnosis of major depression and heart failure in a choking hold caused actual harm, placing Resident R1 at risk for psychological trauma or one of five residents reviewed. Findings include: Review of facility policy titled Abuse Policy-Prevention and Management with review date of August 2025 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 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. Continued review of the same facility abuse policy revealed under section title Staff to Resident Abuse revealed: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. Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to heart failure, muscle weakness, Major Depressive Disorder (loss of interest in pleasurable activities) and absence of left leg below knee. Review of Resident R1's Minimum Data Set (MDS- federally required resident assessment completed at a specific interval) section C0500 BIMS (Brief Interview of Mental Status) revealed Resident R1 had a BIMS score of 15 indicating Resident R1 was cognitively intact. Review of documentation submitted to the State Survey Agency on February 24, 2026, revealed on February 23, 2026, at 2:45 PM, Resident R1 reported a nurse aide verbally, physically, and mentally abused (him/her). The facility description of the incident revealed, The Resident who speaks Spanish and English asked the aid to repeat what (he/she) said to (him/her). The aide repeated it and the resident became very upset and grabbed the CNA (nurse aide) sweater by the neck. The Aide in response, grabbed the resident and place his arm around the resident's neck and told the resident he cannot do anything to him because the resident only have one leg. The ADON (Assistant Director of Nursing) had to separate the two parties. Nurse aide, Employee E4 was identified as the perpetrator and was suspended on February 23, 2024, immediately after the incident. The facility concluded that nurse aide, Employee (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>E4 fought back and grabbed Resident R1. It became a Physical Altercation between resident and staff. Both parties had to be separated. The facility terminated Nurse aide, Employee E4 on March 12, 2026. Review of undated facility investigation report completed by Director of Nursing (DON), Employee E2 related to the abuse incident revealed Staff to resident abuse [Nurse aide, Employee E4] said something in Spanish to [Resident R1]. Resident R1 responded stating, repeat what you just said. [Nurse aide, Employee E4] repeated it and [Resident R1] grabbed [Nurse aide, Employee E4's] sweater. [Nurse aide, Employee E4] in return placed [Resident R1] in a choke holding position while putting [Nurse aide, Employee E4's] hand on the [Resident R1's] face. This incident was witnessed by [Assistant Director of Nursing, Employee E3] who had to separate [Nurse aide Employee E4] and [Resident R1]. Further review of the investigation report revealed during the investigation, there was a verbal abuse incident that occurred on February 21, 2026, between Nurse aide, Employee E4 and Resident R1. Review of documentation submitted to the State Survey Agency on March 30, 2025, revealed the facility initiated an investigation of an allegation of verbal abuse involving Nurse aide, Employee E4. The facility documented During investigating another abuse investigation, A staff member reported a witnessed abuse event. as per staff she was new and did not know what she witnessed was abuse. she became aware that the event she witnessed was abuse during in-service and an example of abuse was presented. The facility substantiated the allegation of verbal abuse. The conclusion of both reported abuse incidents for February 21, 2026, and February 23, 2026, was Based on the nature of witnessed abuse- 2 incidents- recommended termination. This is not the first time this employee was suspended/suspected for abuse. Review of written statement by Nurse aide, Employee E4's dated February 23, 2026, revealed on February 23, 2026, Employee 4 was leaving the 6th floor unit when Resident R1 yelled for Employee E4 to hold the door (without Resident R1 signing out). Further, the statement revealed, Employee E4 previously told Resident R1 on February 21, 2026, that Resident R1 needs to sign out, so Employee 4 did not hold the door and left the unit. While Employee E4 was going back to the building Resident R1 saw Employee E4 in the lobby and Resident R1 proceeded to curse at Employee E4 and asks why Employee E4 did not hold the door. Employee E4 did not respond. Once Employee E4 got back to the 6th floor unit Employee E4 had a general conversation with Assistant Director of Nursing (ADON), Employee E3, after a few minutes Resident R1 came over and told ADON, Employee E3 that Employee E4 had a problem with (him/her) by not opening the door for (him/her). Further Nurse aide, Employee E4's statement revealed Resident R1 started cursing and making threats. Employee E3 (ADON) asked Resident R1 to sign out and Resident R1 refused and continued yelling. Resident R1 started to move towards Employee E4 and backed Employee E4 against the wall. Employee E3 (ADON) told Resident R1 to stop and to go the other way but resident refused and grabbed Employee E4 and pulling Employee E4 towards (him/her). Employee E3 (ADON) started yelling for help. Employee E4 extended his arms to stop Resident R1 from hitting (him/her). Observation conducted on March 19, 2026, at 10:00 AM of the 6th floor nursing unit revealed the door to the unit is locked. A sign out book was located at the nurse station for residents to sign out before exiting the unit. Telephone interview with Director of Nursing (DON), Employee E2 conducted on March 19, 2026, at 12:03 PM revealed Employee E2 was not aware of the first incident which occurred on February 21, 2026, between Nurse aide, Employee E4 and Resident R1. Continued interview with Employee E2 (DON) revealed she became aware of the February 21, 2026, incident as she was investigating the incident that occurred on February 23, 2026. Employee E2 (DON), confirmed the February 21, 2026, incident was not reported in a timely manner due to the incident not being reported to her at the time of the incident. Employee E2 confirmed both incidents of resident abuse were reported on February 24, 2026, due to the Director of Nursing not being in the facility on February 23, 2026. Interview with Nurse aide, Employee E6 conducted on March 19, 2026, at 12:10 PM revealed on February 21, 2026, after lunch, Nurse aide, Employee E6 who was coming out of a resident room, observed Nurse aide, Employee E4 and Charge nurse, Employee E7 sitting behind the nurse's station. Nurse aide, Employee E6 revealed observation of Nurse aide, Employee E4, having a (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>loud back and forth argument with Resident R1 who was in a wheelchair stationed in front of the nurse's station. Nurse aide, Employee E4 repeatedly speaking to Resident R1 in Spanish with each time Employee E4 said something Resident R1 became increasingly agitated. Nurse aide, Employee E6 revealed she did not understand what was being said as she did not understand Spanish. Nurse aide, Employee 6 also revealed the only thing she understood was Employee E4 saying I won't open the door! which was said in English. Employee E6 (nurse aide) revealed both Resident R1 and Employee E4 (N.A) were speaking in loud voices. Employee E6 further indicated in order to calm Resident R1 down Nurse aide, Employee E6, assisted Resident R1 in signing the logbook to leave the unit. Nurse aide, Employee E6 proceed to open the door for Resident R1. Further interview with Nurse aide, Employee E6 revealed Employee E6 then went to the Nursing Supervisor, Employee E8's office to report the incident. Additionally, Employee E6 revealed when she got to Nursing Supervisor's office, Employee E8 asked her what the noise was all about because Nursing supervisor, could hear raised voices from the office. Nurse aide, Employee E6 reported the incident to Employee E8, the Nursing Supervisor. Surveyor attempted phone interview with Nurse aide, Employee E4 which was unsuccessful. Telephone interview was attempted with Nursing Supervisor, Employee E8 and it was unsuccessful. Interview conducted with Assistant Director of Nursing (ADON), Employee E3 on March 19, 2026, at 3:25 PM, revealed on February 23, 2026, approximately 2:00 PM, Employee E3 was administering medications on the 6th floor unit. Employee E3 revealed Nurse aide, Employee E4 was working on the 6th floor and was in the hallway close to Employee E3. Resident R1 approached ADON, Employee E3 and told Employee E3 (he/she) wanted to report Nurse aide, Employee E4. Resident R1 told Employee E3 that Employee E4 doesn't want to open the door for him and Employee E4 doesn't want to do anything for (him/her). Employee E3 told Resident R1 she will take care of it. Resident R1 turned to wheel (himself/herself) away when Employee E4 said something in Spanish which made Resident R1 become suddenly very agitated. Resident R1 started to propel (himself/herself) towards Employee E4. Employee E3 instructed Employee E4 to move away but Employee E4 said I will not move! When Resident R1 was in front of Employee E4, Employee E4 bent forward and Resident R1 grabbed Employee E4's sweater collar. Employee E3 then removed Resident R1's hands from Employee E4's collar. When Resident R1 let go of Employee E4's collar, Employee E4 then put his hand around Resident R1's neck. Employee E3 initiated a call for help while attempting to pry Employee E4's hand from Resident R1's neck. When Employee E3 was able to remove Employee E4's hand from Resident R1's neck, Employee E4 then put his other hand on Resident R1's face and pushed it. Employee E3 removed Employee E4's hand from Resident R1's face and redirected Resident R1's wheelchair away from Employee E4. Additional interview with ADON, Employee E3 revealed she immediately reported the incident to Nursing Home Administrator, Employee E1. Nurse aide, Employee E4 was immediately suspended the same day. Interview conducted with Social Worker, Employee E9 on March 19, 2026, at 11:29 AM revealed Employee E9 learned of the incident on February 24, 2026. Further Employee E9 revealed Resident R1 did not want to discuss the incident. Interview conducted with Resident R1 on March 19, 2026, at 9:25 AM reveal Resident R1 stated It's all good now. I'm over it. Resident R1 refused to provide further information. Follow up interview conducted with Resident R1 on March 19, 2026, at 1:47 PM revealed the incident had caused (him/her) some distress but did not want to talk any further about it. Interview conducted with facility Nursing Home Administrator, Employee E1 on March 19, 2026, at 1:30 PM confirmed the incident on February 21, 2026, was not reported to her or to the Director of Nursing, Employee E2. The Nursing Home Administrator, Employee E1 found out about the incident of February 21, 2026, during the investigation into the incident that occurred on February 23, 2026. The facility failed to ensure Resident R1 was free from physical abuse. This failure resulted in actual harm to Resident R1 who was grabbed by a facility's employee by the collar, held in a choking position and placed (his/her) hand on the resident's face. The employee's hands had to be pried away from Resident R1's. A reasonable person would determine that a staff member holding a resident with a diagnosis of major depression in a choking hold caused (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	actual harm, placing Resident R1 at risk for psychological trauma. 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa. Code 202.29(a) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 PA. Code 211.12(c) Nursing services		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documents, and interview with staff and residents, it was determined that the facility failed to ensure to immediately protect a resident involved in a staff to resident abuse for one of five residents reviewed. (Resident R1) Findings include: Review of facility policy title Abuse Policy-Prevention and Management review date 8/2025 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 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. Continued review of the facility abuse policy under section title Staff to Resident Abuse revealed: 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 Shift Supervisor is identified as responsible for immediate initiation of the reporting process. 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. Further, a NOTE indicating that 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 residents Under section Protection: Provide for the immediate safety of the resident/patient, upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property: Immediate suspension of suspected employee(s), pending outcome of the investigation. Under section Investigation, The Facility will begin the investigation process immediately upon notification of the incident and will prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The Shift Supervisor/Charge Nurse is identified as responsible for immediate Initiation of the reporting process. Upon receiving reports of physical or sexual abuse the DON/designee shall immediately examine the resident. Findings of the examination must be recorded in the Resident's record: The nurse shall immediately notify the physician, and the resident's representative, The Administrator, Director of Nursing or designee shall notify the appropriate Agency/State office according to State specific guidelines for timeliness of reporting as applicable. Applicable reports will be completed per State, requirements or as designated by reporting agencies. Under section Reporting The Facility will report abuse, neglect, misappropriation, and/or exploitation incidents timely and within the Federal/State requirements. Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnosis of Major Depressive Disorder (major loss of interest in pleasurable activities). Review of Resident R1's Minimum Data Set (MDS- a federally required resident assessment completed at a specific interval) completed January 5, 2026, section C0500 BIMS (Brief Interview of Mental Status) revealed that Resident R1 had a BIMS score of 15 suggesting that Resident R1 was cognitively intact. Review of documentation submitted to the State Survey Agency on February 24, 2026, related to an incident that occurred on February 23, 2026, revealed that on February 23, 2026, at 2:45PM, Resident R1 reported that a nurse aide verbally, physically and mentally abused (him/her). Nurse aide, Employee E4 was identified as the perpetrator and was suspended on February 23, 2024, immediately after the incident. The facility completed the investigation and terminated Nurse aide, Employee E4 on March 12, 2026. Further facility investigation revealed that Resident R1 also reported that [Nurse aide, Employee E4] (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>always argue with (him/her). Review of undated facility investigation report completed by Director of Nursing (DON), Employee E2 related to the abuse incident reported by Resident R1 revealed Staff to resident abuse [Nurse aide, Employee E4] said something in spanish to [Resident R1]. Resident R1 responded stating, repeat what you just said. [Nurse aide, Employee E4] repeated it and [Resident R1] grabbed [Nurse aide, Employee E4's] sweater. [Nurse aide, Employee E4] in return placed [Resident R1] in a choke holding position while putting [Nurse aide, Employee E4's] hand on the [Resident R1's] face. This incident was witnessed by [Assistant Director of Nursing, Employee E3] who had to separate [Nurse aide Employee E4] and [Resident R1]. Further review of the investigation report revealed that during the investigation, it was determined that there was another abuse incident that occurred on February 21, 2026, between Nurse aide, Employee E4 and Resident R1. The incident was substantiated. The facility was not able to provide a written investigation related to the abuse incident of February 21, 2026. Telephone interview with Director of Nursing (DON), Employee E2 conducted on March 19, 2026, at 12:03PM revealed that there was a verbal abuse incident that occurred between Nurse's Aide Employee E4 and Resident R1 on March 21, 2026, and that a physical abuse incident also occurred between Employee E4 and Resident R1 on February 23, 2026. Further Employee E2 revealed that Employee E2 was not made aware of the first incident that occurred on February 21, 2026, between Nurse aide, Employee E4 and Resident R1. Further DON, Employee E2 revealed that she became aware of the February 21, 2026, incident as she was investigating the incident that occurred on February 23, 2026. Further Employee E2 also confirmed that the February 21, 2026, incident was not reported in a timely manner because the incident was not reported to her at the time of the incident. Further DON, Employee E2 also confirmed that both incidents of resident abuse were reported on February 24, 2026, because she was not in the facility on February 23, 2026. Further interview with DON Employee E2 revealed that she was not aware of the February 21, 2026, verbal abuse incident between Nurse's Aide Employee E4 and Resident R1. Further Employee E2 confirmed that Employee E4 continued to work after the incident on February 21, 2026 until Employee E4's suspension on February 23, 2026, when an incident of a physical abuse incident between Employee E4 and Resident R1 that occurred on February 24, 2026, was reported to the Nursing Home Administrator. Interview with facility Nursing Home Administrator, Employee E1 conducted on March 19, 2026, at 1:30 PM confirmed that the incident on February 21, 2026, was not reported to her and to the Director of Nursing, Employee E2. Further, Employee E1 revealed that Employee E1 found out about the verbal abuse incident between Employee E4 and Resident R1 on February 21, 2026, while investigating the physical abuse incident between Employee E4 and Resident R1 that occurred on February 23, 2026. Further interview with Nursing Home Administrator Employee E1 confirmed that Employee E4 continued to work after the incident on February 21, 2026, until Employee E4's suspension on February 23, 2026, when an incident of a physical abuse incident between Employee E4 and Resident R1 that occurred on February 24, 2026, was reported to Employee E1. 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa. Code 202.29(a) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 PA. Code 211.12(c) Nursing services</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, review of clinical record, review of facility policies, interview with staff and residents, it was determined that the facility failed to ensure that all alleged violations involving abuse is reported immediately, but not later than 2 hours after the allegation is made for one of five residents reviewed. (Resident R1) Findings include: Review of facility policy title Abuse Policy-Prevention and Management review date 8/2025 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 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. Continued review of the facility abuse policy under section title Staff to Resident Abuse revealed: 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 Shift Supervisor is identified as responsible for immediate initiation of the reporting process. 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. The Shift Supervisor/Charge Nurse is identified as responsible for immediate Initiation of the reporting process. Further review of the facility policy revealed that The Administrator, Director of Nursing or designee shall notify the appropriate Agency/State office according to State specific guidelines for timeliness of reporting as applicable. Applicable reports will be completed per State, requirements or as designated by reporting agencies. Under section Reporting The Facility will report abuse, neglect, misappropriation, and/or exploitation incidents timely and within the Federal/State requirements. Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnosis of Major Depressive Disorder (major loss of interest in pleasurable activities). Review of Resident R1's Minimum Data Set (MDS- a federally required resident assessment completed at a specific interval) completed January 5, 2026 section C0500 BIMS (Brief Interview of Mental Status) revealed that Resident R1 had a BIMS score of 15 suggesting that Resident R1 was cognitively intact. Review of documentation submitted to the State Survey Agency on February 24, 2026, related to an incident that occurred on February 23, 2026, revealed that on February 23, 2026, at 2:45PM, Resident R1 reported that a nurse aide verbally, physically and mentally abused (him/her). Nurse aide, Employee E4 was identified as the perpetrator and was suspended on February 23, 2024, immediately after the incident. The facility completed the investigation and terminated Nurse aide, Employee E4 on March 12, 2026. Further facility investigation revealed that Resident R1 also reported that [Nurse aide, Employee E4] always argue with (him/her). Review of undated facility investigation report completed by Director of Nursing (DON), Employee E2 related to the abuse incident reported by Resident R1 revealed Staff to resident abuse [Nurse aide, Employee E4] said something in spanish to [Resident R1]. Resident R1 responded stating, repeat what you just said. [Nurse aide, Employee E4] repeated it and [Resident R1] grabbed [Nurse aide, Employee E4's] sweater. [Nurse aide, Employee E4] in return placed [Resident R1] in a choke holding position while putting [Nurse aide, Employee E4's] hand on the [Resident R1's] face. This incident was witnessed by [Assistant Director of Nursing, Employee E3] who had to separate [Nurse aide Employee E4] and [Resident R1]. Further review of the investigation report revealed that during the investigation, it was determined that there was a (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>verbal abuse incident that occurred on February 21, 2026, between Nurse Aide, Employee E4 and Resident R1. The incident of verbal abuse was substantiated. Telephone interview with Director of Nursing (DON), Employee E2 conducted on March 19, 2026, at 12:03PM revealed that Employee E2 was not made aware of the verbal abuse incident that occurred on February 21, 2026, between Nurse Aide, Employee E4 and Resident R1. Further DON, Employee E2 revealed that she became aware of the February 21, 2026, verbal abuse incident while she was investigating the incident that occurred on February 23, 2026. Further interview with DON Employee E2 confirmed that the February 21, 2026, verbal abuse incident was not reported in a timely manner because the incident was not reported to her at the time of the incident. Further DON, Employee E2 also confirmed that both incidents of resident abuse were reported on February 24, 2026, because she was not in the facility on February 23, 2026. Interview with facility Nursing Home Administrator, Employee E1 conducted on March 19, 2026, at 1:30 PM confirmed that the verbal abuse incident on February 21, 2026, was not reported to her and to the Director of Nursing, Employee E2. Further the Nursing Home Administrator, Employee E1 found out about the verbal abuse incident of February 21, 2026, during the investigation of the incident that occurred on February 23, 2026. Further interview with Employee E1 confirmed that both incidents were reported on February 24, 2026. The facility was not able to provide a written investigation related to the abuse incident of February 21, 2026. 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa. Code 202.29(a) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 PA. Code 211.12(c) Nursing services</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 03/19/2026
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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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, review of facility documents and review of facility policy, it was determined that the facility failed to assess/evaluate a resident after an incident of physical abuse for one of five residents reviewed. (Resident R1) Findings include: Review of facility policy title Abuse Policy-Prevention and Management review date 8/2025 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. Continued review of the facility abuse policy revealed that upon receiving reports of physical or sexual abuse the DON/designee shall immediately examine the resident. Findings of the examination must be recorded in the Resident's record: The nurse shall immediately notify the physician, and the resident/resident's representative. Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnosis of Major Depressive Disorder (major loss of interest in pleasurable activities). Review of Resident R1's Minimum Data Set (MDS- a federally required resident assessment completed at a specific interval) completed January 5, 2026 section C0500 BIMS (Brief Interview of Mental Status) revealed that Resident R1 had a BIMS score of 15 suggesting that Resident R1 was cognitively intact. Review of documentation submitted to the State Survey Agency on February 24, 2026, related to an incident that occurred on February 23, 2026, revealed that on February 23, 2026, at 2:45PM, Resident R1 reported that a nurse aide verbally, physically and mentally abused (him/her). Nurse aide, Employee E4 was identified as the perpetrator and was suspended on February 23, 2024, immediately after the incident. The facility completed the investigation and terminated Nurse aide, Employee E4 on March 12, 2026. Further facility investigation revealed that Resident R1 also reported that [Nurse aide, Employee E4] always argue with (him/her). Review of undated facility investigation report completed by Director of Nursing (DON), Employee E2 related to the abuse incident reported by Resident R1 revealed Staff to resident abuse [Nurse aide, Employee E4] said something in spanish to [Resident R1]. Resident R1 responded stating, repeat what you just said. [Nurse aide, Employee E4] repeated it and [Resident R1] grabbed [Nurse aide, Employee E4's] sweater. [Nurse aide, Employee E4] in return placed [Resident R1] in a choke holding position while putting [Nurse aide, Employee E4's] hand on the [Resident R1's] face. This incident was witnessed by [Assistant Director of Nursing, Employee E3] who had to separate [Nurse aide Employee E4] and [Resident R1]. Interview with ADON, Employee E3 conducted on March 19, 2026, at 3:25PM, revealed that on February 23, 2026, at around a little past 2:00PM, Employee E3 was giving out meds on the 6th floor unit. Further, ADON, Employee E3 revealed that Nurse aide, Employee E4 was working on the 6th floor and was in the hallway close to ADON, Employee E3. Resident R1 then approached ADON, Employee E3 and told ADON, Employee E3 that he wanted to report Nurse aide, Employee E4. Resident R1 told ADON, Employee E3 that Employee E4 doesn't want to open the door for him and that Employee E4 doesn't want to do anything for him. Employee E3 told Resident R1 that she will take care of it. Resident R1 then started to wheel himself away when Employee E4 said something in Spanish which made Resident R1 become suddenly very upset. Resident R1 then started to propel (himself/herself) towards Employee E4. Employee E3 then told Employee E4 to move away but Employee E4 said I will not move! When Resident R1 was in front of Employee E4, Employee E4 bent forward and Resident R1 grabbed Employee E4's sweater collar. Employee E3 then removed Resident R1's hands from Employee E4's collar. When Resident R1 let go of Employee E4's collar, Employee E4 then put his hand around Resident R1's neck. Employee E3 started to call for help while attempting to pry Employee E4's hand from Resident R1's neck. When Employee E3 was able to remove Employee E4's hand from Resident R1's neck, Employee E4 then put his other hand on Resident R1's face and pushed it. Employee E3 then removed Employee E4's hand from Resident R1's face and pushed Resident R1's wheelchair away from Employee E4. Further review of Resident R1's clinical record (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revealed no documented evidence that the resident was assessed by a licensed nurse after an incident of verbal abuse by Nurse's Aide Employee E4 on February 21, 2026, no documented evidence that Resident R 1 was evaluated, by a psychologist or was provided with emotional or psychological support after the verbal abuse incident. Further review of Resident 1's clinical record revealed no documented evidence that Resident R1 was assessed by a licensed nurse and an incident of physical abuse by Nurse's Aide Employee E4 on February 23, 2026. Further there was documented evidence that a physician was made aware of the incident. Further, there was no documented evidence that Resident R1 was examined by the physician after the incident of physical abuse by Employee E4 on February 23, 2026. Interview with facility Nursing Home Administrator, Employee E1 conducted on March 19, 2026, at 1:30 PM confirmed that an incident of staff to resident verbal abuse between Employee E1 and Resident R1 had occurred on February 21, 2026 and a staff to resident physical abuse occurred between Employee E4 and Resident R1 occurred on February 23, 2026, where Employee E4 put resident R1 on a choke hold. 28 Pa. Code 201.18(b)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 PA. Code 211.12(c) Nursing services</p>		