

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  04/30/2026
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 - Minimal harm or potential for 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 interviews with staff, it was determined the facility failed to ensure one of ten residents reviewed were free from verbal abuse. (Resident R1) Findings Include: Review of the facility policy titled Abuse Policy-Prevention and Management last revised September 2022 states verbal abuse is defined as, Verbal Abuse- Oral, written, or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient or their families, or within their hearing distance, to describe resident/patient, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: Harassing a resident, Mocking, insulting, ridiculing, yelling or hovering over a resident, with the intent to intimidate, threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends, and isolating a resident from social interaction or activities. Review of facility documentation revealed Resident R1 was admitted to the facility on [DATE] with the following diagnosis: Type Two Diabetes (a chronic condition causing high blood sugar because the body doesn't produce enough or effectively use insulin, leading to insulin resistance), Chronic Kidney Disease Stage 3 (involves moderate loss of kidney function, requiring management of complications like high blood pressure, anemia, and bone disease), Anemia (a medical condition defined by a deficiency in the number of healthy red blood cells or the hemoglobin concentration within them, reducing the blood's capacity to transport oxygen throughout the body), Generalized Anxiety a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things-like health), and Neuromuscular Dysfunction of Bladder (occurs when nerve damage from diseases or injuries disrupts signals between the brain and bladder, causing loss of bladder control). Review of Resident R1's physician orders revealed an order dated September 24, 2025 Empty Foley drainage bag every shift and record output. Review of facility Incident/Accident Witness statement, dated March 21, 2026 states, Resident reported that this he/she requested for his/her foley bag to be emptied because it was almost full. He/She stated nurse aide Employee E3 always comes into his/her room fussing. Nurse Aide Employee E3 refused to empty the bag. Nurse aide Employee E3 stated it was not full enough. I told nurse aide Employee E3 I still needed it emptied because I can get an infection. Employee E3 persisted in saying it was not full enough and it began to become uncomfortable because he/ she was yelling so I asked him/her What are you a witch. Employee E3 then said your mother. I told him/her if he/she did not want to do it I will get someone else to do it. I began to yell for a nurse loudly and several nurses came to my room. Review of facility Incident Investigation questionnaire signed March 23, 2026 stated, Did anything happen recently that was upsetting to you? YES- see attached. An attached typed statement from Resident R1 states, I asked the nurse aide Employee E3 to empty my foley bag because it was ninety-five percent full. The aide pressed the issue that it was not ready to be dumped yet. I told him/her that this is how I get an infection before behind the bag not being emptied. The aide kept pressing the issue about the bag not being full. He/She was combative towards me. He/She called me a liar and I asked him/her was he/she a witch and nurse aide Employee E3 said no your mother is I (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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Resident R1 told me that he/she called my mother a witch. After saying that, nurse aide Employee E3 went close to Resident R1's face pointing his/her finger and screaming you're a liar. Resident was shaking and became increasingly agitated. Nurse aide Employee E3 was asked to stop yelling but he/she continued to scream. Nurse aide Employee E1 then used resident basin to empty his/her foley out. When there was two urinals in his/her bathroom. Nurse aide employee E3 was asked to leave the room and he/she finally left. A phone interview was held with license nurse Employee E4 on April 30, 2026 at 12:14 p.m. Licensed Nurse Employee E4 stated that he/she was the oncoming nurse for the shift so him/her and licensed nurse Employee E5 were at the nurses station counting medications when they heard a call out loud for a nurse from down the hall. Employee E4 stated he/she and Employee E5 went down the hall immediately and upon entering heard and witnessed nurse aide Employee E3 yelling at Resident R1. Employee E4 stated that he/she asked Employee E5 to leave the room but he/she would not. Employee E4 stated he/she attempted to calm down Resident R1 because he/she was visibly upset but nurse aide Employee E3 would not stop yelling, you're a liar, you're a liar! and got up in Resident R1's face, pointing his/her finger in Resident R1's face. Employee E4 stated that Employee E3 continued to the bathroom and emptied out the residents foley improperly before being asked to leave again and finally leaving. Review of facility Incident/Accident Witness statement, undated from licensed nurse Employee E5 states, I heard a loud yelling at the end of the hallway, walked down to figure out what happened. Resident R1 and nurse aide Employee E3 was arguing. I couldn't understand how it started but I was able to break it up and came down resident R1. Review of facility Incident/Accident Witness statement, dated March 26, 2026 from nurse aide Employee E5 states, I nurse aide Employee E1 was assigned to the sixth floor. Resident R1 was one of my clients. I responded to a call bell for Resident R1 around 1:00 a.m. Resident R1 stated he/she needed pain medication and the nurse was informed about same. Another call was made by another client, on my way to this client, Resident R1 call bell rang for the second time. I stopped at the other client's room to answer their call I left without being able to change him/her as he/she requested. I told him/her I would find out what another client was calling about and I would be right back to meet his/her needs. On my arrival to Resident R1's room, he/she stated that his/her urine bag was full and was going to burst any minute now and he/she will get kidney infection and he was going to file law-suit. The urine bag wasn't full as he had stated, so I informed him/her about my findings. That it wasn't full and was not about to burst as he had stated. He started to shout at me that I should empty the bag. I got very nervous, my body felt numb. I told him/her that I needed to get a pair of gloves to empty the bag. I got a pair of gloves and put on same. The bag was held up to my eye level (1,300 milliliters) was noted in bag. I tried to show Resident R1 the bag which I had in both of my hands and also tried to tell him/her that the bag had a maximum capacity of 2,000 milliliters. I wasn't given the change to talk to Resident R1. Each time I tried to speak, he/she got louder and louder as if he was preventing me from voicing my findings. I tried to calm him and told him I just wanted him/her to see that I was telling the truth and the bag wasn't full and about to burst. While I was about to empty the urine bag he told me I was a witch and I should leave his room. The fact that he/she lied about the urine bag, shouted at me, and called me a witch and stated that he was going to file a lawsuit pertaining a full bag of urine. I saw all of his actions towards me as his caregiver as very humiliating, (continued on next page)</p>		

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