STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396129	A. BLDG: __--_____ B. WING: _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLOW TERRACE STATE LICENSE NUMBER: **072102**	**ONE PENN BLVD PHILADELPHIA, PA 19144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 29, 2025, at Willow Terrace, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

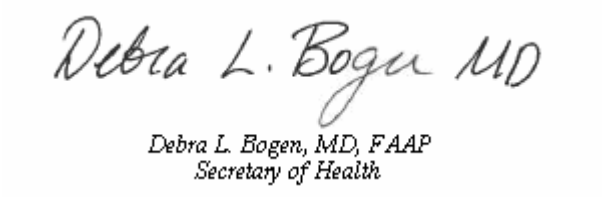
Certified End Page

WILLOW TERRACE

STATE LICENSE NUMBER: 072102

SURVEY EXIT DATE: 01/29/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 072102 Component 01 Willow Terrace Based on a Medicare/Medicaid Recertification Survey completed on January 29, 2025, it was determined that Willow Terrace was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a six-story, Type II (222), fire resistive building, that is fully sprinklered.	K 0000		
K 0374 SS=E		K 0374		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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K 0374 SS=E	Continued from page 1 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	This provider submits the following plan of correction in good faith and to comply with Federal regulations. This plan is not an admission of wrong doing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies. K0374 The closer was adjusted on the Double corridor smoke doors next to room 443, to allow doors to fully close. Maintenance staff will be educated on smoke barrier doors and the importance for doors to close smoke tight. Maintenance Director will perform monthly audits x3 months of facility smoke doors to ensure doors close smoke tight. Audits will be brought to QAPI Committee for review. QAPI	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0374 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain smoke doors affecting one of six floors. Findings include: Observation on January 29, 2025, at 10:15 a.m., revealed the double corridor smoke doors, next to room 443 did not close smoke tight when tested. Exit interview with the Facility Administrator and Maintenance Director on January 29, 2025, at 11:10 a.m., confirmed the doors did not close smoke tight.	K 0374	Committee will determine the need for continuance of audits.	
K 0522 SS=E		K 0522		

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K 0522 SS=E	Continued from page 3 NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by:	K 0522	Combustible materials were removed immediately from tops of heating units in resident rooms 412 and 414. Maintenance and nursing staff on fourth floor will be educated on the importance of heating units to be clear of combustible materials. Maintenance director or designee will conduct weekly audits x 4 weeks and monthly audits x2 months to ensure compliance. Audit results will be reviewed/reported to QAPI Committee. QAPI Committee will determine the need for continued audits.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0522 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain that heating units were free of combustible materials, affecting one of six floors. Findings include: Observations made on January 29, 2025, at 10:00 a.m., revealed that combustible materials were placed on top of a heating unit in resident rooms 414 and 412. Exit interview with the Facility Administrator and Maintenance Director on January 29, 2025, at 11:10 a.m., confirmed combustible materials on top of the heating units.	K 0522		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 5 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	Damaged duplex receptacles identified were repaired by Maintenance staff. Maintenance staff was educated on the importance of maintaining protection of electrical wiring, and receptacles free of damage. Maintenance director/designee will conduct monthly audits x 3 months to ensure all facility receptacles are free of damage. Audits will be reviewed/reported to QAPI Committee. QAPI Committee will determine the need for continued audits.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0911 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain protection of electrical wiring, affecting one of six floors. Findings include: Observations on January 29, 2025, between 9:15 a.m. and 10:35 a.m., revealed damaged duplex receptacles at the following locations: a. 9:15 a.m., on the sixth floor, Day Kitchen Area; b. 9:20 a.m., on the fourth floor, Beauty Salon; c. 10:05 a.m., on the third floor, Laundry Room; d. 10:15 a.m., on the third floor, Corridor next to resident room 327; e. 10:35 a.m., on the third floor, Day Lounge. Exit interview with the Facility Administrator and Maintenance Director on January 29, 2025, at 11:10 a.m., confirmed the broken duplex receptacles.	K 0911		

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K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 0923	Empty and Full Oxygen cylinder signage was hung in the clean utility room identified. Maintenance staff was educated on the importance of Oxygen cylinder signage. Maintenance director/designee will conduct monthly audits x 3 months to ensure all Oxygen storage areas have necessary signage. Audits will be reviewed/reported to QAPI Committee. QAPI Committee will determine the need for continued audits.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/21/2025**

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K 0923 SS=E	Continued from page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain oxygen storage requirements, affecting one of six floors. Findings include: Observation on January 29, 2025, at 9:07 a.m., revealed on the first floor, Clean Utility Room, missing " empty " and " full " cylinder signage. Exit interview with the Facility Administrator and Maintenance Director on January 29, 2025, at 11:10 a.m., confirmed the missing oxygen storage signage.	K 0923		

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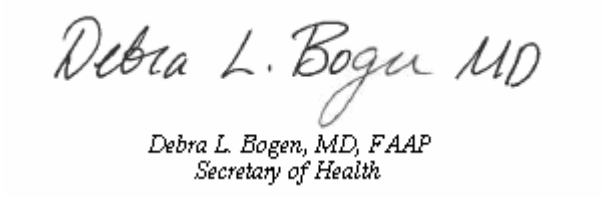

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