APR 2 2 2019

Ms. Kathy Baptiste
PC Administrator
Stapeley Hall
6300 Greene Street
Philadelphia, Pennsylvania 19144

RE: Wesley Enhanced Living at Stapeley

Dear Ms. Baptiste:

This is to acknowledge receipt of your request to appeal the Department's decision to issue a First Provisional license for Wesley Enhanced Living at Stapeley. Your request has been forwarded to the Department of Human Services, Bureau of Hearings and Appeals. You will be contacted regarding the date and time of the hearing.

Sincerely,

Jacqueline L. Rowe
Director

cc: Patrick Marano (Southeast), Office of General Counsel

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17120 | 717.783.3670 | F 717.783.5662 | www.dhs.state.pa.us

Human Services Licensing

APR 18 2019

WESLEY ENHANCED LIVING®
at Stapeley

Shivani Patel, Enforcement Manager
Human Services Licensing
Department of Human services
Room 631, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120

April 16, 2019

RE: Wesley enhanced Living at Stapeley
License # 140171

Dear Ms. Patel,

On April 9, 2019, Wesley Enhanced Living at Stapeley received notice of a provisional license. We disagree with the decision to issue this license and are requesting a hearing to appeal the information which prompted this license.

I look forward to presenting our findings and obtaining full and regular licensure.

Sincerely,

Kathy Baptiste, PC Administrator
Wesley Enhanced Living at Stapeley
6300 Green Street
Philadelphia, PA 19144
215-844-0700
kbaptiste@wel.org

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **STAPELEY HALL**
LEGAL ENTITY

To operate **WESLEY ENHANCED LIVING AT STAPELEY**
NAME OF FACILITY OR AGENCY

Located at **6300 GREENE STREET, PHILADELPHIA, PA 19144**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **79** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 30**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 9, 2019** until **October 9, 2019**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **140171**

Robert E. Robinson
ISSUING OFFICER

Carolyn K Ellison
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 2/18cse

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE:

APR 0 9 2019

Ms. Kathy Baptiste
PC Administrator
Stapeley Hall
6300 Greene Street
Philadelphia, Pennsylvania 19144

RE: Wesley Enhanced Living at Stapeley
License #: 140171

Dear Ms. Baptiste:

As a result of the Department's Bureau of Human Services Licensing inspection on August 16, 2018 of the above facility, the violations specified on the enclosed violation report were found.

A FIRST PROVISIONAL license is being issued based on the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Your PROVISIONAL license is enclosed.

All citations specified on the violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa.Code Part II,
Chs. 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Human Services Licensing
Department of Human Services
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jacqueline L. Rowe
Director

Enclosures
License
Violation Report

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: WESLEY ENHANCED LIVING AT STAPELEY	License Number: 14017
Address: 6300 GREENE STREET, PHILADELPHIA, PA 19144	County: Philadelphia
Administrator: Kathy Baptista	Region: SOUTHEAST
Legal Entity Name: STAPELEY HALL	
Legal Entity Address: 6300 GREENE STREET, PHILADELPHIA, PA 19144	

RECEIVED MAR 13 2019 BY

Certificate(s) of Occupancy
C-2 LP
08/08/1996
Dept. of LI

Staffing Hours
Resident Support: 68 | Total Daily Staff: 160 | Waking Staff: 120

Type of Inspection: Partial | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)
Complaint

On-Site Inspections Dates and Department Representatives On-Site
08/16/2018: Freeman, Sabrina

Off-Site Inspection Dates and Inspectors, If Applicable

Other Details
Partial or Full Triggers: | Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 79	Number of Residents who:
Number of Residents Served: 78	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 60
Area: Bridges - 3rd Floor	Have Mental Illness: 0
Secured Dementia Unit Capacity, If Applicable: 30	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable: 20	Have a Mobility Need: 24
Number of Current Hospice Residents: 0	Have a Physical Disability: 2
Number of Hospice Residents in past year: 3	

Violation Report: 14017 - 08/16/2018 - Freeman, Sabrina
PCH Name: WESLEY ENHANCED LIVING AT STAPELEY

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 07/08/18 resident # 1 wandered through a side rear fire exit door and continued to wander outdoors. The home received a call from the hospital at 8:00pm reporting the resident was admitted with an intraparenchymal bleed. The home was not aware resident # 1 was not in the home until they received a phone call at 6:40pm from a concerned citizen. The resident had fallen outside the home and lay at the bottom of a 13 foot drop on the Washington lane side of the street. There were no barriers present to prevent falls. Resident #1's RASP dated 08/10/17 documented the residents need for supervision inside and outside the home. The resident tends to wander and needs supervision in unfamiliar places. The resident expired on [redacted]18 at [redacted]

On 04/16/18 resident # 2, a resident of the SDCU with a wander guard on her leg, eloped from the SDCU on the 3rd floor. She was last seen in the home at approximately 2:45pm. Resident # 2 knocked on a neighbors door and the neighbor alerted police. The resident had traveled 3 blocks. The resident was returned to the home by police at 7:00pm. The residents whereabouts were unknown for 4 hours and 15 minutes.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident #1 had poor vision and because of vision issues her RASP did need to reflect that she would need supervision in unfamiliar places. When resident was in these environments there would be need for supervision.
A fence has been placed on the Washington Lane side of the campus.

As a result of the incident to resident #2 Stapeley Ancillary came in to review the wanderguard system to see if any further modifications can be done to prevent this from occurring. Any and all recommendations were followed. Resident was wearing Wanderguard. Please see attachment 1A and 1B

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page): [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Kathy Bergkstre — Date 3/13/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 04-03-19 (Date)

The above plan of correction was approved by SP (Initials)

Plan of correction implementation status as of 04-03-19 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

While we question the findings cited in the violation and disagree with the implication, the well-being and safety of all of our residents is always paramount. All guidance from the Department to make procedures as robust as possible is welcome and will be followed.

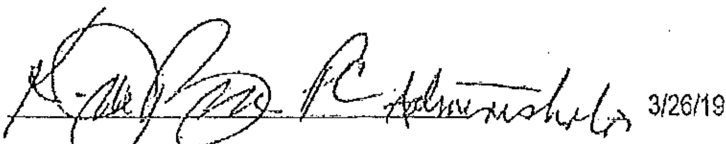
The cognition, vision, safety awareness and elopement potential for all secured and non-secured Residents are assessed at each Physician visit, which occurs at least every two months, more frequently as needed. RASPs reviewed and approved by the Administrator with information provided by the Physician as indicated. Those assessments are subject to continuous review by on-site licensed practical nurse as needed or indicated by a change in a resident's, especially and particularly any resident that exhibits exit-seeking behavior, soliciting and incorporating the input of direct care employees.

The Community installed a fence along the wall that borders the home on Washington Lane as additional protection for residents. The administrator has always and continues to assure in advance and confirm daily that there is adequate staff scheduled to oversee the needs of all residents, that they are trained and qualified, and only those able to meet these requirements are hired.

All direct care employees have been retrained on elopement risk and prevention, which will be repeated twice per year. Any Department guidance on that training program will be incorporated.

All wander guard devices always have been and continue to be tested and documented at the beginning of every shift to assure proper functioning. Resident #2 was wearing a wander guard device that was tested immediately upon her return to the community and was functioning properly. The vendor of the system was dispatched immediately following and no problems were found.

On April 16, 2018, Resident #2 was seen at 2:45pm and discovered to be missing by 3:00pm when the elopement protocol was triggered and appropriate authorities were notified. That protocol, and all relevant dementia and elopement policies and procedures, which have been in place for more than a decade and reviewed by the Department through its oversight, will be reviewed again by a qualified consultant by May 26, 2019, and whose findings and recommendations will be incorporated.

 3/26/19

Kathy Baptiste, Personal Care Administrator

Attachment 1A

42b

Administrator or designee will ensure that the fence installed on the Washington Lane side of the home covers the entire length of the steep grade and provides adequate safety protection to the residents to prevent falls and is kept in good repair. Administrator or designee will monitor all areas of the building and grounds that are accessible to the residents daily to ensure that the building and grounds are free of potential hazards.

Effective immediately, for at least 6 months, at least one-hour checks of each individual resident in the secured care dementia unit and at least two-hour checks of each individual resident in the non-secure care section will be conducted to monitor the safety of each resident. Observational checks will be documented to include at minimum the date, time, the identity of the resident observed, the location where the resident was observed, and concerns identified during observation. Documentation shall be immediately available to the Department upon request.

The wander guard system will be tested at least monthly to ensure it is working properly to provide safety to residents and prevent them from eloping. Wander guard system testing logs will be kept for the Department review.

Within 15 days of receipt of this POC, the administrator or administrator designee will review and update all residents RASP to ensure supervision needs are adequately identified and addressed. All Direct Care Staff persons will be trained on the updated RASP.

Within 30 days of receipt of this POC, the home will complete an elopement risk assessment for each resident who resides in the secure dementia care unit and the non-secure care section. The risk assessment will be completed by a registered nurse or licensed practical nurse. Direct care staff will be consulted during the elopement risk assessment process. This assessment will be completed at least every six (6) months for two years and more frequently if a resident demonstrates evidence of exit-seeking behavior. The resident's support plan will be updated in accordance with the risk assessment to indicate any appropriate risk prevention strategies to be implemented including a plan of increased supervision and the use of Wander guards. The resident's support plan will be updated within 5 calendars days of a new elopement risk assessment or significant change in an elopement risk assessment. The home will maintain documentation of direct care staff participation in the completion of an elopement risk assessment.

Within 30 days of receipt of this POC, elopement prevention and elopement risk training will be provided for all staff persons by an outside source. The training source(s) will be approved by the Department.

Within 60 days of receipt of this POC, a qualified outside consultant, with expertise in Dementia care and behavior management, approved by the Department will review the home's policies and procedures and recommend improvements, as appropriate, related to dementia care and elopement risk. The home will update its policies and procedure based on the consultant's findings and recommendations.

Effective Immediately staff will be trained on making sure SDCU doors are properly shut and secure after fire drills to ensure residents are safe. Within 15 days receipt of this POC all training will be available for Department review.

Violation Report: 14017 - 08/15/2018 - Freeman, Sabrina
PCH Name: WESLEY ENHANCED LIVING AT STAPELEY

1. REGULATION 55 Pa.Code §2600
2600.88(a) - Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION
The exit sign on the 2nd floor next to room 222 was hanging and tearing from the ceiling tile posing a safety hazard.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The exit sign was replaced during the time of inspection and replaced in a manner that would not pose any safety hazard

Home will ensure all surfaces are in good repair and free of hazards at all times

SP 04-03-19

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kathy Baptiste — Date 3/13/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 04-03-19 (Date)

The above plan of correction was approved by SP (Initials)

Plan of correction implementation status as of 04-03-19 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 14017 - 08/15/2018 - Freeman, Sabrina
PCH Name: WESLEY ENHANCED LIVING AT STAPELEY

1. REGULATION 55 Pa.Code §2600

2600. 100(a) - The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION

There is a 13 foot drop on the side of the Washington Lane side of the home. This cliff is not fenced, blocked, or secured and it is hazardous to residents that venture to the edge.

On 7/8/18, resident #1 wandered through a side rear fire exit door and fell down the 13 foot drop. Resident #1 was admitted to the hospital after the fall and diagnosed with an intraparenchymal bleed. The resident passed away in the hospital [redacted]

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A fence has been placed on the Washington Lane side of the campus.

Please see attachment 2A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page)	[signature]	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Kitty Baptiste	Date 3/13/19

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Plan of correction implementation status as of 04-03-19 (Date)

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- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

100a

Administrator or designee will ensure that the fence installed on the Washington Lane side of the home covers the entire length of the steep grade and provides adequate safety protection to the residents to prevent falls and is kept in good repair. Administrator or designee will monitor all areas of the building and grounds that are accessible to the residents daily to ensure that the building and grounds are free of potential hazards.

Attachment 2A SP 04/03/19

Violation Report: 14017 - 08/15/2018 - Freeman, Sabrina
PCH Name: WESLEY ENHANCED LIVING AT STAPELEY

1. REGULATION 55 Pa.Code §2600

2600.201 - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself/herself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

2a. DESCRIPTION OF VIOLATION

Resident #1 was admitted to the home on 8/1/17 with a diagnosis of unspecified dementia with behavioral disturbances and glaucoma. Resident #1's assessment and support plan documented that the resident requires some supervision in the home and needs attendance when outside the home. The resident tends to wander and that the "resident needs supervision in unfamiliar areas, has low sight and needs." The summary and determination statement read, "resident wanders and needs supervision; has low vision due to glaucoma."

Resident #1's exit seeking behaviors and agitation was initially documented on 6/5/18, at which time the "resident showed confused behaviors by repeatedly stating she had to go home down the street."

On 7/1/18, at 14:10 it was documented that resident #1 was administered ativan for anxiety or agitation.
On 7/1/18, at 21:00 it was documented that resident #1 refused ativan which was prescribed as needed for anxiety or agitation.
On 7/1/18, at 22:32 it was documented that resident #1 was administered ativan for anxiety or agitation.
On 7/2/18, at 1:34 it was documented that resident #1 was administered ativan for anxiety or agitation.

On 7/6/18, at 12:51 it was documented that resident #1 was observed wandering in the rec room and became verbally and physically aggressive

On 7/8/18, resident #1 wandered through a side rear fire exit door. The home did not know resident #1 was not in the home until they received a phone call at 6:40PM stating that someone had fallen outside. The home then received a call from the hospital at 8:60PM stating that the resident was admitted with a diagnosis of intraparenchymal blood. Then at approximately [redacted] the home received a call from the resident's daughter stating that the resident passed away. The home failed to implement positive interventions to modify resident #1's behavior.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

[handwritten] Resident had recovery [illegible] prior to 6/5. [illegible] interventions included a visit / consult c. psych on 7/6/18 which resulted in med change

Please see attachment 3A

Repeat Violation: No	Date(s) of Previous Violation(s):		

Signature of Legal Entity Representative (Required on EVERY Page): [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Kathy Baptiste — Date: 3/13/19

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Plan of correction implementation status as of 04-03-19 (Date)

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- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

201

Within 15 days of receipt of this POC, the administrator or administrator designee will review and update all residents' assessments and support plans (RASP) to ensure behavior needs are adequately identified and addressed to include specific positive interventions. All Direct Care Staff persons will be trained on the updated RASP. Home will train all direct care staff on positive interventions. Techniques will be utilized by staff to prevent future behaviors that endanger residents.

Effective immediately, residents' physicians will be notified when resident behaviors that endanger the resident or others cannot be modified using positive interventions in accordance with the resident's RASP. All recommendations from the physician shall be implemented. Documentation to the physician and the physician's response shall be kept in the resident's record.

Attachment 3A SP 04/03/19