pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
February 26, 2025

[redacted]
PC Administrator
Stapeley Hall
6300 Greene Street
Philadelphia, Pennsylvania 19144

RE: Wesley Enhanced Living at Stapeley
License #: 14017

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on July 9, 2024 and December 4, 2024 of the above facility, we have determined that your submitted plan of correction for the May 20 and 21, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *WESLEY ENHANCED LIVING AT STAPELEY* **License #:** *14017* **License Expiration:** *09/10/2024*

Address: *6300 GREENE STREET, PHILADELPHIA, PA 19144*

County: *PHILADELPHIA* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *STAPELEY HALL*

Address: *6300 GREENE STREET, PHILADELPHIA, PA, 19144*

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *09/10/2008* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *84* **Waking Staff:** *63*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal* **Exit Conference Date:** *05/21/2024*

Inspection Dates and Department Representative

05/20/2024 - On-Site: [redacted]

05/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *61*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Bridges* **Capacity:** *30* **Residents Served:** *23*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *60*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *23* **Have Physical Disability:** *24*

Inspections / Reviews

05/20/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/23/2024*

07/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/08/2024*

07/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/08/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/31/2024*

02/25/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The most recent Licensing Inspection Summary (LIS), dated 2/23/2023, was not posted in a conspicuous and public place in the home on 5/20/2024.

Plan of Correction ***Directed (- 07/09/2024)***

Book of violations is posted near the front desk as on June 17, 2024.
The receptionist or designee will oversee the upkeep of the binder. Extra security measures Alien Tape dots have been added to prevent removal of the VR binder.
(Directed)
The administrator/receptionist will check the postings monthly, beginning July 2024, to ensure that all required documents are available for review.

Proposed Overall Completion Date: 07/08/2024

Directed Completion Date: *07/08/2024*

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff Person B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. Staff Person B has a high school diploma from a non-U.S. educational institution.

Plan of Correction ***Directed (- 07/16/2024)***

HR has been instructed that High Diploma's outside of the US is not acceptable. In situations like this a waiver will be requested going forward. Staff person B is still currently employed working under supervision. PC Administrator will work with HR to obtain a waiver. I'm not certain of the process, I haven't had a need for it. I left a message with the regional manager (to help with the process.

Proposed Overall Completion Date: 07/08/2024

Directed
Staff person B will be removed from providing direct care until the required documentation is provided or a waiver is approved by the Department. The waiver process can be found on the Departments website.

Directed Completion Date: *07/08/2024*

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
2. Emergency medical plan.

Description of Violation

Staff Person B completed [redacted] 40th scheduled work hour on [redacted]. However, this staff person did not complete training on the following topic: Emergency medical plan.

Repeated Violation - 2/23/2023

Plan of Correction ***Directed ([redacted] - 07/09/2024)***

Staff person B will be trained with Medical Emergency plan and HR will conduct an audit for all staff records to assure this was completed by 7/31/24 Going forward Emergency medical plan training will be part of the new hire process. PC Administrator will conduct the training by 7/9/24.
(Directed)
Training needs will be reviewed during the next quality management meeting, to be held by 8/30/2024.

Proposed Overall Completion Date: 08/30/2024

Directed Completion Date: *08/30/2024*

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
6. Safe management techniques.

Description of Violation

Staff Person C did not receive training in medication self-administration or safe management techniques during the training years 2023–2024.

Plan of Correction ***Directed ([redacted] - 07/16/2024)***

Staff person C was trained in both areas this is an error. Please see attached documents.

Proposed Overall Completion Date: 07/08/2024

Directed
The administrator will oversee staff person C's training in the medication self-administration and safe management techniques by July 2024. Documentation will be kept in the staff record. [redacted]

Directed Completion Date: *07/08/2024*

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65g - Annual Training Content *(continued)*

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff Persons C and D did not receive in-person training for fire safety during the training years 2023–2024.

Plan of Correction ***Directed ([redacted] - 07/09/2024)***

1. Fire safety will be completed yearly in person by the Director of Facility Operations or certified trainer.

2. Adherence to this corrective action will be monitored by the Director of Ops.

3. Audit will be conducted by HR to assure all employees are in compliance. this will be done by 7/31/24. A previous Audit was conducted early this year, and it was confirmed that all employees have their 2024 training.

(Directed)

Training needs will be reviewed during the next quality management meeting, to be held by 8/30/2024.

Proposed Overall Completion Date: 08/30/2024

Directed Completion Date: *08/30/2024*

81b - Resident Personal Equipment

7. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/21/2024, the bed rail in Room 220 was not attached to the bedframe. A staff member reported that it was attached a month ago. The staff member pulled it completely out from under the bed with little effort.

On 5/21/2024, the bed rail in Room 208 was not securely attached; it moved more than 6 inches from the side of the bed when pulled.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Maintenance and Therapy will be installing the bed rails together going forward. Therapy will sign off to assure that the bed rail is secured and of good working condition. PC staff will document daily of the condition or concern of the bed rail.

On 5/21/24 Director of Therapy made certain that all bed rails were properly secured 220 & 208. Staff will be instructed to check all apparatus used by residents at least once per shift to ensure that it is clean, in good repair, and free of hazards. - - Staff will be instructed to report any apparatus that is in need of cleaning, repair, or replacement to the administrator or designee immediately, beginning July 2024.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented ([redacted] - 12/04/2024)

82c - Locking Poisonous Materials

8. Requirements

82c - Locking Poisonous Materials *(continued)*

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

DynaCare Toothpaste with a manufacturer's label indicating, "Call poison control if swallowed" was unlocked, unattended, and accessible to residents in the kitchen drawer near the entrance of the kitchen area. Not all the residents of the home, including residents in the memory care unit, have been assessed as capable of recognizing and using poisons safely.

DynaCare Toothpaste and an open glass cleaner with no lid and which had a manufacturer's label indicating, "Call poison control if swallowed" were unlocked, unattended, and accessible to the resident in Room 303. Not all the residents of the home, including those in Room 303, have been assessed as capable of recognizing and using poisons safely.

Crest Toothpastes and Head & Shoulders shampoo with a manufacturer's label indicating, "Call poison control if swallowed" were unlocked, unattended, and accessible to the resident in Room 305. Not all the residents of the home, including those in Room 305, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

1. In house maintenance staff will build a sliding door counter length. It will have a latch to keep residents out. This will be completed by July 31, 2024.
2. Adherence to this corrective action will be monitored by the Director of Ops.
[redacted] identified materials were immediately moved to a locked area that is inaccessible to residents.

- Staff will be instructed to check all areas of the home for poisonous materials at least once per shift, beginning July 2024. Any poisonous materials not in use will be made locked and inaccessible to residents immediately.

Licensee's Proposed Overall Completion Date: *07/08/2024*

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/20/2024, there was a very strong smell of cat's urine on the 1st floor back hallway by Room 112.

On 5/20/2024, at 9:51 am, there were no lids on the trash can of the memory care unit kitchen; food and garbage half-filled the trash can. The back wall behind the trash can was dirty and covered in dried food.

On 5/21/2024, the padlocked bathroom on the 3rd floor of the memory care unit has a strong odor of urine.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

1. Housekeeping adds additional carpet cleaning weekly. The housekeeping department has placed two additional

85a - Sanitary Conditions (continued)

trash cans in the apartment as of 6/17/2024.

2. Adherence to this corrective action will be monitored by the Housekeeping Manager or designee.

1. Lids placed on the trashcans as of June 17, 2024.

2. Adherence to this corrective action will be monitored by the Housekeeping Manager or designee.

Licensee's Proposed Overall Completion Date: *06/20/2024*

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/20/2024 at 9:51 am, there was an uncovered, unattended trash can in the memory care unit kitchen.

On 5/21/2024, there was an uncovered, unattended trash can in the padlocked bathroom in the memory care unit.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

1. Lids placed on the trashcans as of June 17, 2024.

2. Adherence to this corrective action will be monitored by the Housekeeping Manager or designee.

Licensee's Proposed Overall Completion Date: *06/20/2024*

Implemented ([redacted] - 12/04/2024)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/21/2024, there were green trash bags and wood pallets outside the dumpster.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Dietary manager and housekeeping manager will both inservice there staff on the importance of trash outside of the home. Training will begin 7/15/24 with a completion date of 7/31/24. They will also call for pick up as often as needed for recycling pickup.

Dietary manager and housekeeping manager will check outside trash daily beginning July 2024.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 12/04/2024)

88a - Surfaces

12. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/21/2024, there was an in-use fire tower that had broken stairs outside of the building attached to Floors 2, 3, and 4.

There were also stairwells on Floor #4 that had floor tiles that were removed from each landing area.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

1. Requesting bids from contractors. ETA to be determined as this will be a custom built item.
2. Adherence to this corrective action will be monitored by the Director of Community Ops.
1. The stair well #4 will have installed tiles at the landing areas no later than July 31, 2024
2. Adherence to this corrective action will be monitored by the Director of Facility Ops.

Licensee's Proposed Overall Completion Date: *08/01/2024*

96b - First Aid Location

13. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff Person E did not know the location of the first aid kit.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

All Staff will be inserviced of location of FA kit continuation of the inservice will be done upon new hire and on a yearly basis. All staff will be trained by 7/31/24. Training will be conducted by PC Administrator and Charge nurses

Licensee's Proposed Overall Completion Date: *07/31/2024*

100a - Exterior - Free of Hazards

14. Requirements

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

Description of Violation

The ramp leading up to the building has multiple cracks in the sidewalk area. Some of it has been caulked over, which makes it spongy when walked on. There are broken pieces of concrete at the bottom of the ramp. These create a tripping hazard.

The 4th floor deck is mossy and very slippery when it is wet.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

1. Inhouse maintenance will remove existing debris and replace with concrete.
2. The Director of Ops or designee will oversee completion by July 31, 2024.
1. Housekeeping will power wash the 4th floor deck. Deck will be completed no later than June 30, 2024.
2. Adherence to this corrective action will be monitored by the Housekeeping Manager or designee.

100a - Exterior - Free of Hazards (continued)

Licensee's Proposed Overall Completion Date: *07/05/2024*

103f - Refrigerator/Freezer Temps

16. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the memory care unit refrigerator.

Plan of Correction ***Accept (- 07/01/2024)***

The dining service department has implemented a system when food is delivered to the Bridges Unit, they will be checking temperature and documenting the readings twice daily [beginning 6/24/2024].

Licensee's Proposed Overall Completion Date: *06/20/2024*

103i - Outdated Food

17. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There were unlabeled, undated pitchers of drinks of iced tea, lemonade, and cranberry juice in the main kitchen refrigerator.

Plan of Correction ***Accept (- 07/09/2024)***

The dining staff will be inserviced of the importance of labeling all pitchers and opened food items. The training will be conducted by the Dining Manager, and the sous chef will maintain the ongoing compliance. Training for the staff will begin on 7/15/24 and be completed by 7/31/24

Licensee's Proposed Overall Completion Date: *07/31/2024*

109a - Pets

19. Requirements

2600.
109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home pets policy does not specify what kind of pets are permitted.

Plan of Correction ***Accept (- 07/16/2024)***

Wesley enhanced living now has a no pet policy. Communications will officially go out to all residents, families, POA's and friends notifying them pets will now be allowed in Personal Care. The home rules will be updated by 8/9/2024 of the change in policy.

Licensee's Proposed Overall Completion Date: *08/09/2024*

Implemented (- 12/04/2024)

109a - Pets *(continued)*

121a - Unobstructed Egress

20. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/21/2024 at 8:59 a.m., there was a silver car blocking the egress that is used for a fire exit on the right side of the building's entrance.

Plan of Correction ***Directed ([redacted] - 07/16/2024)***

All employees were instructed not to park beyond 10FT of the entrance. Cones were placed beyond the 10FT to prevent anyone from parking there.

Proposed Overall Completion Date: 07/08/2024

Directed

The administrator will ensure all egress routes are unlocked and unblocked. The administrator will ensure that residents and staff are able to evacuate the building in case of emergency through all fire exits. The administrator or designee will audit all egress routes daily for 12 weeks and weekly thereafter. [redacted]

Directed Completion Date: *07/08/2024*

131d - UL Approved Extinguishers

21. Requirements

2600.
131.d. Fire extinguishers must be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

Description of Violation

The fire extinguisher in the facility bus is not listed by Underwriter's Laboratory or approved by Factory Mutual Systems.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

1. The Director of Opps will reach out to vendor Cintas to get the fire extinguishers in the vehicles included in the yearly inspection. As of 6/20/24 all three have been tested, inspected, and tagged.
2. Adherence to this corrective action will be monitored by the Director of Community Ops.

Licensee's Proposed Overall Completion Date: *06/20/2024*

Implemented ([redacted] - 12/04/2024)

132a - Monthly Fire Drill

22. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

132a - Monthly Fire Drill *(continued)*

Description of Violation

An unannounced fire drill was not held during the months of November 2022 to February 2023 and from December 2023 until the date of this inspection.

Plan of Correction ***Directed (- 07/16/2024)***

Please see attached list of recorded fire drill held by Croker.

Proposed Overall Completion Date: 07/08/2024

Directed

All staff persons will be educated on the fire drill requirements of 2600.132(a) including all fire drills will be unannounced, and the required documentation of fire drills in 2600.132(c) by 7/31/24. All residents and staff will be educated on the requirements of the home to conduct a fire drill at least once a month, a fire drill in conducted during sleeping hours every 6 months, all residents are evacuated to a public thoroughfare or to a fire-safe area within the time specified in writing by a fire safety expert within the past year by 7/31/24. Documentation of education shall be kept. The administrator will monitor all fire drills and the fire drill record to ensure at least one unannounced fire drill is conducted monthly. Documentation will be kept at the time of each fire drill.

Directed Completion Date: *07/08/2024*

132h - Designated Meeting Place

23. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

According to the interviews with the residents, the residents are unaware of the location of the fire-safe area, the designated meeting place, or how to evacuate.

Plan of Correction ***Directed (- 07/16/2024)***

Please see attached list of Fire Drills held by Crocker.

Proposed Overall Completion Date: 07/08/2024

Directed

All staff persons will be educated on the requirement that all residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during a fire drill by 7/31/24. All residents will be educated on the requirements of the home to conduct a fire drill at least once a month, a fire drill in conducted during sleeping hours every 6 months, all residents are evacuated to a public thoroughfare or to a fire-safe area within the time specified in writing by a fire safety expert within the past year by 7/31/24. Documentation of education shall be kept.

Directed Completion Date: *07/08/2024*

141a 1-10 Medical Evaluation Information

24. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 1's medical evaluation, dated [redacted] did not include the medical information pertinent to diagnosis and treatment in case of an emergency and the medication regimen, contraindicated medications, medication side effects, and the ability to self-administer medications.

Resident 2's medical evaluation, dated [redacted], did not include the medical information pertinent to diagnosis and treatment in case of an emergency.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

All Medical Evaluation will be audited by LPN Supervisor to assure all information is correct and also include all pertinent information. LPN supervisor begin the audit on 5/27/24 Prior to finalizing the document, PC Admin will review and sign off. medical evaluations for Residents 1 and 2 were amended 5/29/24

Licensee's Proposed Overall Completion Date: *08/01/2024*

185a - Implement Storage Procedures

25. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 5/18/2024 at 3:46 p.m., Resident 3 had a glucometer reading of 102 but 201 was recorded in the resident's record.

On 5/19/2024 at 11:09 a.m., Resident 4 had a glucometer reading of 201 but 102 was recorded in the resident's record.

On 5/21/2024, there were 1½ loose pills on the 2nd drawer of the 4th floor medication cart and 1 loose pill under the medication cart on the 1st floor of the personal care unit.

Repeated Violation - 9/28/2022, et al

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

All PC Staff is required to have another staff person review the glucometer readings before documenting the final

185a - Implement Storage Procedures (continued)

number. Both residents were not issued a new glucometer as all other readings were correct. While this is an honest mistake staff will be inserviced by LPN Supervisor of the challenges with incorrect readings. This training is scheduled for 7/9/2024 The goal is to capture all employees by 7/31/24

The LPN Supervisor will conduct weekly medication cart audits and audits of the actual readings on the residents' glucometers as compared with the documented readings on the MAR's, as well as checking medication carts for loose pills, for a period of 1 month, beginning July 2024.

Licensee's Proposed Overall Completion Date: *07/31/2024*

225a - Assessment 15 Days

26. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 5 was admitted on [redacted] however, the resident's assessment was not completed until [redacted].

Resident 6 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted]

Repeated Violation - 9/28/2022, et al

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

All RASP will be audited by LPN Supervisor to assure all information is correct and also meets the time frame that is set by BHS. The audit will be completed by 7/31/24. Prior to finalizing the document, PC Admin will review and sign off.

The administrator will create and implement a tracking system to identify the due dates of each initial resident assessment to ensure that the assessment is completed within 15 days from the resident's admission.

Licensee's Proposed Overall Completion Date: *07/31/2024*