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/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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.

PROVISIONAL

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 **March 21, 2025** until **September 21, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **140171**

ISSUING OFFICER

ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 21, 2025

[redacted]
Executive Director
Stapeley Hall
6300 Greene Street
Philadelphia, Pennsylvania 19144

RE: Wesley Enhanced Living at Stapeley
License #: 140171

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection August 1, 2024 and September 26, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 140170 dated September 10, 2024 to September 10, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from March 21, 2025 to September 21, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

In accordance with 55 Pa. Code § 2600.269(b) (relating to ban on admissions), no new resident admissions are permitted after the date of this letter.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

[redacted]

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
183e	II	53	$5	$265	5 calendar days from mailing date of this letter
185a	II	53	$5	$265	5 calendar days from Mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST 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, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

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.

[redacted]

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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:** *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *75* **Waking Staff:** *56*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *08/01/2024*

Inspection Dates and Department Representative

08/01/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *53*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Bridges* **Capacity:** *30* **Residents Served:** *21*

Hospice

Current Residents: *na*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *54*

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

Have Mobility Need: *22* **Have Physical Disability:** *0*

Inspections / Reviews

08/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/06/2024*

Inspections / Reviews *(continued)*

10/21/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/08/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/26/2024*

10/29/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/08/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/08/2024*

12/04/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/08/2024*

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

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in safe management techniques during training year 2023.

Direct care staff person B did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident, and safe management techniques during training year 2023.

Plan of Correction ***Accept ([redacted] - 10/29/2024)***

All PC Staff has been Inservice for 65f requirements. All trainings are completed as of 10/13/24. All new staff will receive this training as part of new hire orientation, prior to being release to the floor. HR Check list has been updated to reflect this as part of onboarding. For 65F, the following items should resolve the issues cited by DHS.
- The learning center has assigned Direct care staff person A the module "Managing Aggressive Behaviors", due 11/01/2024, to satisfy the missing "safe management techniques" training.
- Direct care person B is no longer employed with Wesley as of [redacted]. A similar correction was accepted for 65G, so this should be acceptable.

Proposed Overall Completion Date: 10/26/2024

Licensee's Proposed Overall Completion Date: *10/26/2024*

Not Implemented ([redacted] - 12/04/2024)

65g - Annual Training Content

2. 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:

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

65g - Annual Training Content *(continued)*

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2023. 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.

Staff person B did not receive training in 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, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2023.

Plan of Correction ***Accept (- 10/21/2024)***

Staff person B is no longer an employee of WEL.
Staff person A did complete Fire Safety Training for 2023, the signed form was in HR file. PC Admin is working with Staff Development Director and Also HR to place all inservices that are conducted in house to be reflected on employee's transcript. This will prevent this this violation from occurring again.

Proposed Overall Completion Date: 09/13/2024

Licensee's Proposed Overall Completion Date: *09/13/2024*

Not Implemented (- 12/04/2024)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff Person C's official transcript from Relias does not include the source of training or the instructor's name for the following courses;

- *Disaster Preparedness WEL 2024,*
- *Fire Safety WEL 2024,*
- *Hazardous Chemicals 2024,*
- *PA Resident Rights,*
- *Welcome to Wesley.*

Staff Person D's official transcript from Relias does not include the source of training or the instructor's name for the following courses;

- *Fire Safety WEL 2024,*
- *Hazardous Chemicals 2024,*
- *Welcome to Wesley.*

Plan of Correction ***Accept (- 10/21/2024)***

The Director of Staff Development has included the name of the trainer and course information have been updated to reflect this information on the transcript. All transcripts going forward will also reflect this change. The Director of Staff Development has audited all PC staff transcript to assure this information is included.

65i - Training Record (continued)

Proposed Overall Completion Date: 09/13/2024

Licensee's Proposed Overall Completion Date: *09/13/2024*

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

82c - Locking Poisonous Materials

4. Requirements

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

Several items (see list below), with a manufacturer's label indicating "... if swallowed, call poison control or get medical help right away.", were unlocked, unattended, and accessible to residents of the memory care unit a/k/a Bridges. Not all the residents of the memory care unit have been assessed capable of recognizing and using poisons safely.

- *In room 304; 3 tubes of Colgate toothpaste, Clorox disinfecting wipes and Method surface cleaner.*
- *In the memory care kitchen (third floor); EcoLab Super Trump Dishwasher Detergent and EcoLab Jet Dry rinsing agent.*
- *In room 321; Crest Pro-Health Oral Rinse.*

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

on 07-23-24 we began and entered into PCC for Bridges residents: Check for poisonous materials every shift. any poisonous materials not in use should be locked and inaccessible to resident. any label that reads keep away from children must be locked. Done every shift to prevent resident from ingesting hazardous materials. Also please find audits of various locations.

Proposed Overall Completion Date: 10/26/2024

Licensee's Proposed Overall Completion Date: *10/26/2024*

Not Implemented ([redacted] - 12/04/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 08/01/24 during a physical inspection starting at approximately 10:00 AM, the following unsanitary conditions were found in the home:

- *a reddish/brown substance, possibly blood, on the doorway between the kitchen and the hall in the memory care unit,*
- *several drops of dried red liquid, again, possibly blood, on the kitchen wall,*
- *There was a dirty shelf in the memory care unit's kitchen.*

85a - Sanitary Conditions (continued)

- *the cutting boards at the work stations in the second floor kitchen are dirty and have multiple grooves from use. The grooves are embedded with dirt.*
- *a heavy odor of cat urine was emanating from room 112 into the first floor hallway.*

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

85a-Area cleaned. Cleanliness will be maintained by housekeeping and over seen by the Housekeeping manager or designee. The housekeeping staff has been assigned daily to oversee the Maintenace and upkeep of the Bridges neighborhood,

Proposed Overall Completion Date: 10/26/2024

Licensee's Proposed Overall Completion Date: *10/26/2024*

Not Implemented ([redacted] - 12/04/2024)

88a - Surfaces

6. 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

Stairwell #4 is missing tiles on several landings, by the emergency exit doors and at the bottom of each set of steps. The missing tiles present various hazards including slips, trips and falls.

Plan of Correction ***Accept ([redacted] - 10/21/2024)***

All necessary supplies have been delivered. This project will begin on 9/16/24. Maintenance will see completion by September 30, 2024.

Proposed Overall Completion Date: 09/13/2024

Licensee's Proposed Overall Completion Date: *09/13/2024*

Not Implemented ([redacted] - 12/04/2024)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The seal on the stand up refrigerator/freezer in the second floor kitchen was leaking at the top of the unit.

The salad/sandwich prep refrigerator in the second floor kitchen was leaking liquid onto the floor.

Plan of Correction ***Accept ([redacted] - 10/28/2024)***

A new refrigerator was purchased and has been delivered. The drain was drained by dining staff. A line for condensation will be assigned and connected to the floor drain. The floor drain has been assigned and there has

95 - Furniture and Equipment (continued)

been any issue with that area.

Proposed Overall Completion Date: 10/26/2024

Licensee's Proposed Overall Completion Date: *10/26/2024*

Implemented (- 12/04/2024)

100a - Exterior - Free of Hazards

8. 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 floor boards of the 4th floor deck have areas covered with a green and black substance, possibly moss, that can be slippery when wet and presenting a tripping hazard.

Plan of Correction ***Directed (- 10/29/2024)***

Housekeeping has power washed floorboards preventing any hazard concerns. Upkeep will be monitored by the Housekeeping manager or designee. Quarterly checks will be conducted to ensure it remains hazard free.

Directed
The administrator or housekeeping will conduct weekly checks on the deck. Checks will start immediately. Documentation will be kept.

Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *11/08/2024*

Not Implemented (- 12/04/2024)

103f - Refrigerator/Freezer Temps

9. 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

On 08/01/24, at 10:38 AM, the temperature in the second floor stand up refrigerator was 60 degrees Fahrenheit.

There was no thermometer in the salad/sandwich prep refrigerator located in the second floor kitchen.

Plan of Correction ***Accept (- 10/29/2024)***

A new unit was placed on the 2nd floor Kitchen area. Daily logs are kept assure it is meeting temperature. A thermometer was mounted in a location that it can't me moved and visibly seen. The Lead Server will assure that daily checks of these items are in place.

Licensee's Proposed Overall Completion Date: *10/26/2024*

Not Implemented (- 12/04/2024)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 08/01/24, at 10:09 AM, an open and unsealed bottle of "Pancake & Waffle Syrup" was found on a shelf under a counter in the third floor kitchen.

Two parfait cups of ice cream were found in the second floor kitchen freezer uncovered, and unlabeled.

Plan of Correction ***Directed (- 10/29/2024)***

The Lead server will assure all items are labeled and dated. A daily check will be kept.

Directed

By 11/8/24: All staff persons involved in food preparation, serving and storage will be educated on the requirement to store food in closed or sealed containers.
Starting 11/4/24: A designated staff person will check all food storage areas after each meal to ensure all food is stored in closed or sealed containers. Documentation of education and food checks will be kept.

Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *11/08/2024*

Not Implemented (- 12/04/2024)

Withdrawn 3/5/25

[redacted]

125a - Combustible Storage

12. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 08/01/24, at 10:11 AM, a box of Facial Tissues, a pack of Scott paper towels and a pack of Premoistened Washcloths were observed inside the oven behind two pieces of wadded up aluminum foil in the third floor kitchen. Additionally, a pack of seven ounce plastic cups and a sleeve of foam cups with a sleeve of lids were observed in the "warming" drawer of the same oven.

Plan of Correction ***Directed ([redacted] - 10/29/2024)***

All Materials was removed from oven area. A meeting was held with each shift regarding the dangers. We have also powered the power off to the oven. It will only be turned on when needed, Otherwise the switch will remain turned off. We have also added a safety feature to the stove.

Directed

By 11/8/24: All staff persons will be educated on keeping combustible or flammable materials away from heat sources. Documentation will be kept.
Starting 11/4/24: A designated staff person will check the home daily to ensure combustible or flammable materials are not near heat sources. [redacted]

Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *11/08/2024*

Not Implemented ([redacted] - 12/04/2024)

132h - Designated Meeting Place

13. 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

During fire drills, residents are not evacuating to a fire-safe area. Residents stand outside the fire tower because staff do not want residents to go down the stairs and there is not enough room for residents to stand on the landing. Or the residents go to the third floor patio which is made of wood and has a glass door. This patio is accessible from other floors of the building by elevator only.

Plan of Correction ***Accept ([redacted] - 10/29/2024)***

Fire Safety expert was onsite providing training and education. Fire safety expert has requested that we label the stairwell, so the staff knows which route to follow when the fire alarm goes off. [redacted] *has trained staff other routes of egress; it does not only have to be the fire tower.*

132h - Designated Meeting Place *(continued)*

Licensee's Proposed Overall Completion Date: *10/26/2024*

Not Implemented ([redacted] - 12/04/2024)

183b - Meds and Syringes Locked

14. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 08/01/24, at 10:05 AM, a bottle of Systane Lubricant Eye Drops was unlocked, unattended, and accessible in memory care room #304.

On 08/01/24, during a medication cart audit, staff member E walked away from an unlocked, open med cart.

Plan of Correction ***Directed ([redacted] - 10/29/2024)***

Resident family was notified to let friends know not to bring in any OTC medication when visiting. Staff person E was educated about not walking away from cart to assist a resident, even if it is a surveyor. PC med tech as been educated not to leave med cart unattended even if it is an employee from DHS.

Directed

By 11/8/24: All staff persons qualified to administer medications will be educated on the required locked storage of medications. Documentation of education will be kept.
Starting 11/4/24: The administrator or designated staff will check the home weekly to ensure prescription medications, OTC medications, CAM and syringes are be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Proposed Overall Completion Date: 11/08/2024

Directed Completion Date: *11/08/2024*

Not Implemented ([redacted] - 12/04/2024)

183e - Storing Medications

15. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 08/01/24, during a medication audit of the first floor medication cart, the following errors were identified:

- *Three Fluticasone Furoate/Vilanterol Elipta Inhalers for resident #1 were open and undated. According to the manufacturer's instructions this product should be discarded six weeks after opening the moisture protective foil tray.*
- *Resident #2's Latanoprost Sol 0.005% eye drops were open and undated. According to the manufacturer's instructions this product should be discarded six weeks after opening. Repeat violation: 2/23/2023*

183e - Storing Medications *(continued)*

Plan of Correction ***Directed (- 10/29/2024)***

LPN Supervisor conducts weekly cart audits to ensure the cart is clean with no loose pill. Also making sure all items are dated when first opened. A binder is kept with the audits. The audits begin the beginning of August 2025, Please see attached of detailed cart audit.

Directed

In addition to the above plan of correction by 11/8/24: All staff persons administering medication will be reeducated on medication administration and storage practices.

Proposed Overall Completion Date: 09/13/2024
Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *11/08/2024*

Not Implemented (- 12/04/2024)

184b - Labeling OTC/CAM

16. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 08/01/24, a package of Systane Lubricant Eye Drops belonging to resident #3 was in the resident's room on the memory care unit and was not labeled with the resident's name.

Plan of Correction ***Directed (- 10/29/2024)***

Systane eye drops was removed from resident room, this was provided to the resident by a friend. POA was made aware all OTC must come to nursing office to obtain order from PCP, before usage. Nursing supervisor has also kept an audit of activities in PC.

Directed

By 11/8/24: All staff persons qualified to administer medications will be educated on the required locked storage and labeling medications belonging to residents with residents name. Documentation of education will be kept.
Starting 11/4/24: The administrator or designated staff will check the home weekly to ensure prescription medications, OTC medications, CAM and syringes are labeled with the residents name.

Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *11/08/2024*

Not Implemented (- 12/04/2024)

185a - Implement Storage Procedures

17. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Several errors were observed in documenting the blood glucose levels for resident #4;

Date / Time	*Meter Reading*	*As Recorded on Medication Administration Record (MAR)*
07/18/24 at 4:30 PM	*168*	*158*
07/20/24 at 8:21 AM	*60*	*131*
07/20/24 at 11:30 AM	*None*	*248*
07/20/24 at 8:13 PM	*105*	*106*
07/21/24 at 8:02 AM	*72*	*89*
07/21/24 at 8:38 PM	*94*	*150*
07/25/24 at 8:19 AM	*129*	*76*
07/31/24 at 3:45 PM	*225*	*222*

Additionally, the 4:30 PM glucose reading for resident #5 was 193; however, this reading is recorded on the MAR as 196. Repeat violation: 2/23/2023

Plan of Correction ***Accept ([redacted] - 10/21/2024)***

In Reviewing this resident meter what I was able to establish on days that this resident blood sugar is low, the staff is contacting the PCP and being instructed to give OJ then retake in 15 minutes. The original number is the number that appears in Blood sugar reading. The second number will appear in the notes. To solve the human error aspect staff will begin to sign off after every shift. LPN Supervisor will oversee that is done. We are currently working with a company that has a machine that uploads the BS reading into PCC once completed. It is currently being trailed, once completed the plan is to go live. This will eliminate human error. The plan is to begin usage 11/12024

Proposed Overall Completion Date: 09/13/2024

Licensee's Proposed Overall Completion Date: *09/13/2024*

Not Implemented ([redacted] - 12/04/2024)

233c - Key-Locking Devices

18. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit's (SDCU's) middle stairwell.

Plan of Correction ***Directed ([redacted] - 10/29/2024)***

Going forward we will have every new employee acknowledge during new hire orientation that the code for the Bridges doors will on the panel, this will be for every employee going forward including current employees.

Directed

Immediately: The administrator or designated staff person will monitor the SDCU to ensure the directions for the operation of the keypad system are conspicuously posted near the device. [redacted]

Proposed Overall Completion Date: 10/26/2024

233c - Key-Locking Devices *(continued)*

Directed Completion Date: *10/26/2024*

Implemented (- 12/04/2024)

252 - Record Content

19. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident #6's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Directed (- 10/29/2024)***

Resident number 6 picture has been updated, PC Admin Assistance conducted an audit of all the charts to assure all pictures were up to date. has also created a checklist for due dates.

Directed

In addition to the above plan of correction the administrator or designated staff with check all resident records

252 - Record Content (continued)

monthly to ensure the there is a current picture no more than 2 years old in the record. [redacted]

Proposed Overall Completion Date: 10/26/2024

Directed Completion Date: *10/26/2024*

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

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:** *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *72* **Waking Staff:** *54*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *09/26/2024*

Inspection Dates and Department Representative

09/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *53*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Bridges* **Capacity:** *30* **Residents Served:** *19*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *52*

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

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

09/26/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/13/2024*

Inspections / Reviews *(continued)*

10/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/13/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/22/2024*

10/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/13/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/13/2024*

12/04/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/13/2024*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for resident 1 was not signed by the administrator.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

Resident 1 is no longer a resident at this facility. PC administrator along with the admission team conducted an audit assure no other files had missing signatures. All files that were checked did not have missing signatures. To assure this does not occur, in the future the contract will give more than one person the ability to sign.

Licensee's Proposed Overall Completion Date: *10/21/2024*

Not Implemented ([redacted] - 11/15/2024)

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test. The home provided a non-department approved certificate with staff person B's name, and a Department issued certificate with the first name blacked out for the staff person, making it so that it cannot be verified as belonging to staff person B.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

A new certificate has been uploaded. The original certificate, the state of PA did not keep any of those records before Temple took over. HR has been informed prior to onboarding PC Administrator will need to check off on new hire packages.

Directed Plan of Correction.
Staff person A completed DC course and passed the test on 10/17/24.
The designated HR person shall receive a documented in-service training on the requirements of this regulation and on the homes policy for onboarding new employees.
The PC administrator or designee shall begin to review new hire files within 10 business days of the receipt of this plan of correction. This process of reviewing new hire files shall continue monthly for three months or longer until compliance is maintained.
Documentation of in-service trainings, initial audits of employee files and ongoing audits shall be kept and made available to the Department upon request.

Directed Completion Date: *10/21/2024*

Not Implemented ([redacted] - 11/15/2024)

162c - Menus Posted

3. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's has a 4 week menu cycle which is posted in the home. However, there is no indication on the menu or anywhere nearby which week of the cycle the home is currently in. Residents of the home as well as staff of the home indicate they are unable to decipher which week/meal is to be served that day, or later in the week because there is no other calendar or date indications to inform them of what week in the cycle is the current week. On 9/26/24, which was in the fourth full week of the month of September the lunch meal being served did not match the menu for week 4. The home indicated that this was because they were not in the 4th week of the cycle but rather the 1st week of the homes menu cycle.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

The Dining Director has updated all the menu's to reflect the date and day on all the menus. This will be the process going forward.

Licensee's Proposed Overall Completion Date: *10/21/2024*

Implemented ([redacted] - 11/15/2024)

183b - Meds and Syringes Locked

4. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 9/26/2024 at 11:50 AM, a prescription tube of peri guard ointment was unlocked, unattended, and accessible in memory care room 321.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

Peri guard was removed from resident room. All residents on Bridges currently have an order for removal of poisonous materials which will occur on all shifts. All PC Staff attended a dementia course which outlined poisonous materials and the cause for safety in the elderly.

Directed Plan of Correction:

Within 5 calendar days of the receipt of this plan of correction, the administrator or designee shall audit a sample of at least 5 resident rooms/common areas in the the Secure Dementia Care Unit weekly to assess for unlocked/accessible poisons. The weekly audits shall continue weekly for 2 months, then monthly for 2 months or longer until compliance is maintained. Should any non-compliance be observed during the weekly/monthly audits, additional staff in-services shall be conducted and documented to prevent future re-occurrences.

Documentation of in-service trainings, initial and ongoing audits shall be kept and made available to the

183b - Meds and Syringes Locked (continued)

Department upon request.

Directed Completion Date: *10/22/2024*

Not Implemented (- 11/15/2024)

183e - Storing Medications

5. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 9/26/2024 a bottle of Brimo/Timolo eye drops for resident 2 was in the memory care medication cart. According to the manufacturer's instructions these expired 8/29/2024.

Repeat violation date: 2/23/23.

Plan of Correction ***Directed (- 10/23/2024)***

LPN continues to audit all carts, with documentation, of findings. The eye drop was removed immediately of the cart. Please see attached documentation for current month of audits.

Directed Plan of Correction:
Within 10 business days of the receipt of this plan of correction, a person qualified to provide medication training shall conduct an in-service for all staff persons who are qualified/certified to pass medications. The in-service shall include medication storage procedures and cart audit processes.
Additionally, a weekly audit of all medication carts shall be conducted starting immediately after the in-service training. Weekly audits of the medication carts shall continue for 2 months or longer until compliance is maintained. Should any areas of non-compliance be observed, additional in-service trainings with the staff working on those carts shall be conducted and documented. Monthly audits shall continue indefinitely in accordance with the homes established audit processes after the weekly audits have shown continued compliance.
Documentation of in-service trainings and ongoing audits shall be kept and made available to the Department upon request.

Proposed Overall Completion Date: 10/22/2024

Directed Completion Date: *10/22/2024*

Not Implemented (- 11/15/2024)