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 January 9, 2025 and February 26, 2025 of the above facility, we have determined that your submitted plan of correction for the October 31, 2024 inspection is not implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

[redacted]
[redacted]

Enclosure
Licensing Inspection Summary

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

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:** *67* **Waking Staff:** *50*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *10/31/2024*

Inspection Dates and Department Representative

10/31/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served:** *48*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Bridges* **Capacity:** *30* **Residents Served:** *18*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *47*

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

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

Inspections / Reviews

10/31/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/07/2024*

Inspections / Reviews *(continued)*

12/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/23/2024*

02/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

02/26/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *02/26/2025*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1's current assessment and support plan dated [redacted], indicates that resident #1 has no needs relating to irritability, agitation, or aggression, but has a severe need for behaviors relating to judgement. The listed support for this need is for Direct Care Staff to redirect resident, and to "monitor and document for behaviors on every shift". On 10/9/24, the home initiated a task on the Direct Care assignment log, for staff to document behaviors of resident #1 on each shift. On October 11, 2024, resident #1 had a [redacted] at which time their doctor suggested that the resident be closely monitored due to behaviors and difficulty redirecting. The home did not update Resident #1's Support Plan and did not make changes to the monitoring tasks for direct care staff. From 10/9/24 through 10/25/24, the home has progress notes where it indicates that Resident #1 exhibited "a behavior" every day, However, the log does not always specify what specific behavior was observed by staff or what intervention were implemented to address the behaviors.

On October 25, 2024, two staff members were assigned to the secure dementia care unit. After breakfast, the SDCU residents were transferred from the dining room to the television room by staff however, Staff member A and Staff member B reported that they went back to cleaning up the dining room and completing computer work and thought all residents were in the TV room. Staff member A reported hearing a loud voice coming from the hallway. Staff member A reported looking toward the hallway and observing Resident #1 pushing Resident #2 with both hands, Resident #2 fell backwards and hit their head on the un-carpeted floor. Resident #2 was laying on the floor, screaming in pain, [redacted] Staff Member A called for the nurse to assess Resident #2 who complained of severe head, left shoulder, and back pain. The nurse called 911 and Resident #2 was transferred to the hospital for evaluation of injuries. Per hospital discharge records dated [redacted] Resident #2 sustained a hematoma on the right side of the head, and subsequently returned to the home with changes to [redacted] baseline ambulation needs. Staff A and B who were with resident #1 in the dining area prior to the incident, reported that the altercation appeared unprovoked, and that Resident #1 had not displayed any concerning behaviors that morning, but also reported that after the incident Resident #1 was very aggressive, agitated, and violent towards staff and other residents. Resident #1 was immediately assigned a 1:1 until a psychological evaluation could be held. Resident #1 was evaluated on 10/30/24, at which time the Doctor recommended continuing 1:1 from 7a-7p while resident is awake and until their next assessment.

Plan of Correction ***Do Not Accept ([redacted] - 12/19/2024)***

Any resident on our SDU comes in with a physician clearly stating that the individual has an issue as it relates to judgement. PCA and PC Admin will be in contact with the department for technical assistance. Some context to this particular resident, Resident was admitted on [redacted] to our SDU, saw psych on [redacted] resident sent out to ED on [redacted] admitted with TIA, [redacted] resident returned back with DX: of Covid, placed in Isolation, removed off Isolation [redacted] and the incident occurred. [redacted] resident admitted [redacted]. [redacted] resident returned back to facility. There are lots of miss points in verbiage above.

Licensee's Proposed Overall Completion Date: *12/20/2024*

Update: *12/19/2024*

Please indicate additional methods or steps that will be put in place to ensure long term quality and compliance improvement. Please identify specific actionable, measurable processes. This could include specific in-service trainings conducted for staff, reviews and/or updates to any policies/procedures, specific methods to audit

42b - Abuse (continued)

compliance and to prevent this violation from recurring. Please include specific detailed information including start and end dates for each step, frequency or duration of each step, method of documentation for each step and the title of the person responsible for each step.

Plan of Correction ***Directed (- 01/09/2025)***

PC Admin and PC Admin assistant was educated by [an agent of the Department] in regard to the various meanings of "judgment "now that we have a better understanding of the meaning. We plan to review all resident's chart to be sure judgment is allocated correctly. This will be done by 1/17/25. Going forward this will be for all residents going forward.

Directed Plan of Correction: *In addition to the above plan of correction, with 14 calendar days of the receipt of this plan of correction, all staff members shall be in-serviced on prevention of abuse and neglect of residents by a provider qualified to provide this training. Additionally, an in-service training focusing on how to provide proper supervision of residents while direct care staff are attending to other ancillary duties shall be provided to all direct care staff within 30 calendar days. Training shall focus on maintaining supervision of residents in the SDCU and communication of supervision needs/changes when a staff person is assigned to other duties. The administrator or designee shall complete random observations of staff completing daily assigned tasks at various times, twice weekly for 1 month, then weekly for 1 month to ensure compliance with resident supervision needs. Documentation of all in-service trainings, training materials presented to staff and documentation of detailed observations shall be kept and made available to the Department upon request.*

Directed Completion Date: *01/16/2025*

Bypass Document Submission ***Not Implemented (- 02/26/2025)***

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation ***Withdrawn (- 01/09/2025)***

On 10/31/24 at 11am, a voice controlled electronic device was observed in resident #1's bedroom. The home has not established the required policies and procedures regarding resident owned electronic communication devices. At a minimum, the following standards are to be met:

Appropriate use of resident-owned devices in living units and common areas should be addressed, at a minimum, in the resident-home contract.

The facility's policies and procedures regarding use of these devices shall require compliance with local, state, and federal laws and regulations.

Residents must be advised, in writing, of the facility's policies and procedures for use of these devices.

187b - Date/Time of Medication Admin.

3. Requirements

187b - Date/Time of Medication Admin. *(continued)*

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Lorazepam Tab .5mg. Resident 1's October 2024 medication administration record does not include the initials of the staff person who administered this medication on 10/19/24 at 8:30am.

Resident #2 is prescribed Tramadol HCL Tab 50mg. Resident 2's October 2024 medication administration record does not include the initials of the staff person who administered this medication on 10/27/24 at 1:08pm , additionally, on 10/31/24 the residents Narcotic log for Tramadol 50mg- give 1 tablet by mouth every 8 hours as needed for severe pain has a notation that a dose was administered on 11/1/24 at 649am, a date and time which had not yet occurred at the time of inspection.

Plan of Correction ***Do Not Accept ([redacted] - 12/19/2024)***

All Staff person (Med Tech) will be retrained by 12/17/24 on Date/Time of Medication Admin.

Licensee's Proposed Overall Completion Date: *12/17/2024*

Update: *12/19/2024*

Please indicate additional methods or steps that will be put in place to ensure long term quality and compliance improvement. Please identify specific actionable, measurable processes. This could include specific in-service trainings conducted for staff, reviews and/or updates to any policies/procedures, specific methods to audit compliance and to prevent this violation from recurring. Please include specific detailed information including start and end dates for each step, frequency or duration of each step, method of documentation for each step and the title of the person responsible for each step.

Plan of Correction ***Directed ([redacted] - 01/09/2025)***

All Staff person (Med Tech) will be retrained by 12/17/24 on Date/Time of Medication Admin. All Employees were in service on proper documentation of narcotic administration. Narcotic administration logs will be audited by PCA weekly x 2 then monthly x 1 with results being reported to the ED and CQI committee as needed.

Directed Plan of Correction: *All medication/narcotic audits shall begin within 3 calendar day of the receipt of this plan of correction unless already started. Documentation of completed trainings and detailed audits shall be kept and made available for Department review upon request.*

Directed Completion Date: *01/16/2025*

Bypass Document Submission ***Not Implemented ([redacted] - 02/26/2025)***

234d - Support Plan Revision

4. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #1 was completed on [redacted] The residents assessed need for aggression and agitation were listed as no problem, however, from 10/9/24 through 10/25/24, the home has documented that resident #1

234d - Support Plan Revision (continued)

exhibited several different behaviors every day on various shifts. On 10/25/24, resident #1 exhibited a change in aggressive behaviors and had an altercation with resident#2. Prior to the incident and as of 10/31/24, Resident #1's support plan had not been revised to reflect these changes in behaviors or needs.

A support plan for resident #2 was completed on [redacted] the residents assessed needs for ambulation, transferring, and toileting are listed as no problem. However, on 10/25/24, resident #2 exhibited a change in need related to ambulation, transferring, and toileting. As of 10/31/24, the resident's support plan has not been revised to reflect this change.

Plan of Correction ***Do Not Accept ([redacted] - 12/19/2024)***

Resident 1 and resident number 2 has an addendum that was added to their support plan. The addendum reflects any necessary changes to date. PCA and Admin assistance will reach out to BHS for technical assistance in regard to this particular regulation to prevent this from occurring again.

Licensee's Proposed Overall Completion Date: *12/20/2024*

Update: *12/19/2024*

Please indicate additional methods or steps that will be put in place to ensure long term quality and compliance improvement. Please identify specific actionable, measurable processes. This could include specific in-service trainings conducted for staff, reviews and/or updates to any policies/procedures, specific methods to audit compliance and to prevent this violation from recurring. Please include specific detailed information including start and end dates for each step, frequency or duration of each step, method of documentation for each step and the title of the person responsible for each step.

Plan of Correction ***Accept ([redacted] - 01/09/2025)***

Resident 1 and resident number 2 has an addendum that was added to their support plan. The addendum reflects any necessary changes to date. PCA and Admin assistance will reach out to BHS for technical assistance in regard to this particular regulation to prevent this from occurring again. PC admin assistant will audit all residents' charts to assure compliance of support plan revision. This will be done by 1/17/25

Licensee's Proposed Overall Completion Date: *12/23/2024*

Bypass Document Submission ***Not Implemented ([redacted] - 02/26/2025)***

236 - Staff Training

5. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 4 hours of training in dementia care during the January 2023 to December 2023 training year.

Plan of Correction ***Do Not Accept ([redacted] - 12/19/2024)***

Learning and Development Director ran an audit to identify no other employees' hours were dropped by Relias. Those employees were assigned additional hours to make up any missed hours. The Learning Center will no longer utilize that specific Dementia Training that drops off courses that was previously taken, previous years.

Licensee's Proposed Overall Completion Date: *12/10/2024*

236 - Staff Training *(continued)*

Update: *12/19/2024*

Please indicate the date of the initial audit.

Please indicate additional methods or steps that will be put in place to ensure long term quality and compliance improvement. Please identify specific actionable, measurable processes. This could include specific in-service trainings conducted for staff, reviews and/or updates to any policies/procedures, specific methods to audit compliance and to prevent this violation from recurring. Please include specific detailed information including start and end dates for each step, frequency or duration of each step, method of documentation for each step and the title of the person responsible for each step.

Plan of Correction ***Directed ([redacted] - 01/09/2025)***

Learning and Development Director ran an audit to identify no other employees' hours were dropped by Relias. Those employees were assigned additional hours to make up any missed hours. The Learning Center will no longer utilize that specific Dementia Training that drops off courses that was previously taken, previous years.
Training records for all Employees were audited to assure compliance with required training. Our system was corrected to always include the required hours and modules. Training records for all new Employees will be audited for compliance x three month with results reported to ED and CQI Committee as require.

Directed Plan of Correction: *All training record audits shall begin within 14 calendar day of the receipt of this plan of correction unless already started. Documentation of completed trainings and detailed audits shall be kept and made available for Department review upon request.*

Directed Completion Date: *01/16/2025*

Bypass Document Submission ***Not Implemented ([redacted] - 02/26/2025)***