



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
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

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 January 8, 2026 until January 8, 2027,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **140170**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
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.



Pennsylvania Department of Human Services

Emailing Date: January 8, 2026

[REDACTED]
[REDACTED]
Stapeley Hall
[REDACTED]
[REDACTED]

RE: Wesley Enhanced Living at Stapeley
License #: 140170

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on August 18 and 19, 2025 and November 5, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

January 6, 2026

[REDACTED]
STAPELEY HALL
6300 GREENE STREET
PHILADELPHIA, PA, 19144

RE: WESLEY ENHANCED LIVING AT
STAPELEY
6300 GREENE STREET
PHILADELPHIA, PA, 19144
LICENSE/COC#: 14017

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/18/2025, 08/19/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WESLEY ENHANCED LIVING AT STAPELEY* License #: *14017* License Expiration: *09/21/2025*
 Address: *6300 GREENE STREET, PHILADELPHIA, PA 19144*
 County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED]

Legal Entity

Name: *STAPELEY HALL*
 Address: *6300 GREENE STREET, PHILADELPHIA, PA, 19144*
 Phone: [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: *60* Waking Staff: *45*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *08/19/2025*

Inspection Dates and Department Representative

08/18/2025 - On-Site: [REDACTED]
 08/19/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* Residents Served: *43*

Secured Dementia Care Unit

In Home: *Yes* Area: *Bridges* Capacity: *30* Residents Served: *16*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *42*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *17* Have Physical Disability: *0*

Inspections / Reviews

08/18/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/20/2025*

Inspections / Reviews (*continued*)

10/02/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/20/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/06/2025

10/31/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/06/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/03/2025

01/06/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/03/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

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]/2025, for resident #1 was not signed by the resident and there is no notation on why the resident did not sign.

Repeat Violation: 9/26/2024

Plan of Correction

Accept [REDACTED] - 10/02/2025)

Resident # 1 missed signature was obtained. It will be the practice going forward that Sales and Admission will pre-label Post it "sign here labels" prior to signing of any contract to assure there are no missed signatures. Sales and Admission has begun an audit of all contracts to assure there are no missed signatures on any contracts. This process will be completed by 10/31/2025.

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented [REDACTED] - 01/06/2026)

63b - Current First Aid Training

2. Requirements

2600.

63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

Staff person A was trained in CPR by National CPR foundation. This training source is not certified as a trainer by a hospital or other recognized health care organization.

Plan of Correction

Accept [REDACTED] 10/02/2025)

See attached. A complete audit was conducted by PCA to assure all staff CPR & FA was provided by a recognized health care organization. Staff person A was retrained on 9/16/2025. It will be the practice of WEL that all new staff will be trained by our team to assure compliance.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [REDACTED] - 01/06/2026)

64f - Record of Training

3. Requirements

2600.

64.f. A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

Description of Violation

The home's record of administrator training for staff person B does not include copies of certificates.

64f - Record of Training (continued)

Plan of Correction

Accept (█ - 10/02/2025)

After reviewing WEL's current training record and certificate, it will be the practice beginning 10/15/2025 all staff who attends any WEL Training will be provided with a certificate. A copy of the certificate will be placed in the staff training records as well. The staff and Development Team will be responsible to assure that we remain in compliance.

Licensee's Proposed Overall Completion Date: 10/15/2025

Implemented (█ - 01/06/2026)

86b - Bathroom

5. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in room 323, does not have an operable window or ventilation fan. The ventilation fan is inoperable and there is no window in the bathroom.

Plan of Correction

Accept (█ - 10/06/2025)

A spread sheet was created by DOF (Director of facility) identifying all bathrooms without windows and assured all vents are in clean and working order. Quarterly checks of the vents will be conducted by maintenance. DOF will retain records of completion in binder in his/her office. The bathroom vent in SH 323 was replaced, and two additional public bathrooms were found during the audit process to not have any exhaust fans. The maintenance team will have everything completed by 11/3/2025.

Licensee's Proposed Overall Completion Date: 11/03/2025

Implemented (█ - 01/06/2026)

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

On 8/18/2025, there were water stains on ceiling tiles in the music room and 1st floor common bathroom. The flooring in the memory care hallway, music room and kitchen is lifting and could cause a tripping hazard. Some areas of the floor that are lifting have been covered with duct tape. One ceiling tile on the 2nd floor hallway is hanging down.

On 8/19/2025, dark black stains were observed on the ceiling tiles in the 1st floor computer room.

Plan of Correction

Accept (█ - 10/02/2025)

All the identified stained ceiling tiles were replaced. beginning October 1st, 2025, maintenance will begin weekly checks of ceiling tiles as follows:

Week 1 4th Floor hallway and rooms

88a - Surfaces (continued)

Week 2 3rd Floor hallway and rooms

Week 3 2nd Floor hallway and rooms

Week 4 1st Floor hallway and rooms

Changes will be made as needed; documentation of completion will be kept by Director of facility.

Please see attached communication for flooring work.

Licensee's Proposed Overall Completion Date: 10/15/2025

Implemented [REDACTED] 01/06/2026)

100a - Exterior - Free of Hazards

7. 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 that could possibly create a tripping hazard.

Repeat Violation: 5/20/2024, et al.

Plan of Correction

Accept [REDACTED] - 10/02/2025)

Current quotes are being obtained by Facility Director by various contractors. The repair of the ramp will be completed by 10/31/2025. Monthly inspection will be completed by Director of facility and documentation of completion will also be retained by DOF.

Licensee's Proposed Overall Completion Date: 10/31/2025

Implemented [REDACTED] - 01/06/2026)

101j5 - Bedside Table/Shelf

8. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 2's bed in bedroom 407A.

Plan of Correction

Accept [REDACTED] - 10/02/2025)

A bedside table was placed by resident #2 bed. Resident #2 was educated as to why a bedside table is needed near the bed. Resident #2 states [REDACTED] will no longer remove his bedside table. DCS will monitor on a daily basis that bedside table remains in place.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [REDACTED] - 01/06/2026)

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 8/18/2025, at 10:48 am, the thermometer in the refrigerator in memory care was not reading the temperature.

Plan of Correction

Accept [redacted] - 10/02/2025)

on 8/18/25 a new thermometer was placed in the refrigerator, which read correctly. The temp log sheet has been updated to reflect when there is a defective device, when the temperature is out of range who was it reported to, and the course of action taken. This will be the responsibility of utilities, cooks and dining aide. The management team will oversee compliance of this process.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

121a - Unobstructed Egress

10. 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 8/18/2025, at 10:01 am, stairwell #3 was covered with leaves and blocked by a patio table, and chair.

Repeat Violation: 5/20/2024, et al.

Plan of Correction

Accept [redacted] - 10/02/2025)

A thorough cleaning was performed on 9/1/2025 of all egress, housekeeping will conduct a monthly inspection/cleaning. Documentation of completion will be left in binder in housekeeping office.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

125a - Combustible Storage

11. Requirements

2600.

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

Description of Violation

On 8/18/2025, at 11:27 am, united laboratories dry spray was stored in the boiler room with a warning sign that read "extremely flammable vapor harmful."

Repeat Violation: 8/1/2024

Plan of Correction

Accept [redacted] - 10/02/2025)

The can of spray was immediately removed from boiler room. A monthly check of boiler room will be conducted by

125a - Combustible Storage (continued)

maintenance; they will also oversee all contractors. A sign off sheet will be provided/left in the boiler room for documentation.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

131f - Fire Extinguisher Inspection

12. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the vehicle used to transport residents has not been inspected by a fire safety expert since 7/2024.

Plan of Correction

Accept [redacted] - 10/02/2025)

Fire extinguisher was serviced by Cintas on 8/27/2025. The buses will be scheduled off hours monthly and also yearly by Cintas to assure the vehicles are available for service when they arrive for service. Director of Facility will oversee the completion of service.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

162c - Menus Posted

13. 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 menu for the week of 7/20/2025 through 8/16/2025 was posted. However, the current week of 8/17/2025 and the following week was not posted in memory care or the 2nd floor.

Repeat Violation: 9/26/2024

Plan of Correction

Accept [redacted] - 10/02/2025)

On 8/17/2025The menu was updated to reflect the current week and also the following week's menu. It will be the responsibility of the dining managers to post the menu a month at a time. The new month's menu will be posted 3 days prior to the start of a new month to assure it is posted on time.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

181f - Record of Medication

14. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

Resident #3 self-administers [redacted] medication. On 8/19/2025, resident #3's record did not include a current list of medications. The following medications were on the resident's medication list that he/she is no longer prescribed:

- Methylphenidate HCl ER capsule extended release 24-hour 40 mg
- Vitamin D3 tablet 50 mcg 2000 UT

Plan of Correction

Accept [redacted] - 10/02/2025)

See attached.

A recap was conducted on resident #3 medication, PCP was contacted by LPN to review current medication list, per PCP resident is still currently on both medications. LPN will continue to monitor and recap resident #3 medications on a PRN/ monthly basis to assure accuracy of orders.

Licensee's Proposed Overall Completion Date: 09/20/2025

Implemented [redacted] - 01/06/2026)

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

Resident #4 is prescribed acetaminophen 325 mg. On 8/19/2025, the blister pack had a tear on pill number 6. The pill was still in the package.

Plan of Correction

Accept [redacted] 10/06/2025)

The identified pill was discarded on 8/19/2025. Pharmacy was notified of the concern regarding the slit.



183e - Storing Medications (continued)

Purpose:

To ensure the safety, cleanliness, and integrity of all blister-packed medications by verifying that no packaging damage (including punctures, tears, or compromised seals) is present prior to administration and at the end of each shift.

Policy Statement

All blister-packed medication cards must be visually inspected at the end of each shift to confirm that packaging integrity is intact. Any evidence of damage—such as tears, holes, peeling foil, or moisture intrusion—must be reported and documented immediately.

This process is required to maintain compliance with FDA cGMP standards (21 CFR 211.94) and USP <659> Packaging and Storage Requirements, which require medication packaging to provide adequate protection from contamination and environmental factors.

Procedure

1. Timing

- Each medication technician (or nurse administering medications) must perform a blister pack inspection at the end of their shift.
- Inspections should also occur before medication administration when removing doses from storage.

2. Inspection Criteria

- Verify that:
 - All foil and plastic blisters are fully sealed and free of punctures or tears.
 - No moisture, residue, or powder is present inside the card.
 - Labels and expiration dates remain legible.
 - No tablets/capsules are missing, crushed, or partially exposed.

3. Documentation

- Complete the Blister Pack Integrity Log.
- Record findings as:
 - "Pass" – No defects observed.
 - "Fail" – Packaging compromised or product exposed.
- For any "Fail" entries:
 - Remove and destroy tablet/capsule.
 - Notify the supervising nurse or pharmacist immediately.

4. Follow-Up

- Recurrent or patterned defects should be logged for QA review.

Training and Accountability

All medication technicians must be trained on this policy during orientation and annually thereafter. Supervisors are responsible for random audits and reinforcement of compliance.

References

- 21 CFR 211.94 – Drug product containers and closures.
- USP <659> Packaging and Storage Requirements.
- Facility Medication Handling SOPs.

Revision History

183e - Storing Medications (continued)

Revision Date Description of Change Approved By

11/03/2026 Initial policy creation [REDACTED]

Proposed Overall Completion Date: 09/20/2025

Proposed Overall Completion Date: 11/03/2025

Licensee's Proposed Overall Completion Date: 11/03/2025

Implemented [REDACTED] - 01/06/2026)

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

January 6, 2026

[REDACTED]
STAPELEY HALL
6300 GREENE STREET
PHILADELPHIA, PA, 19144

RE: WESLEY ENHANCED LIVING AT
STAPELEY
6300 GREENE STREET
PHILADELPHIA, PA, 19144
LICENSE/COC#: 14017

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/05/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WESLEY ENHANCED LIVING AT STAPELEY* License #: *14017* License Expiration: *09/21/2025*
 Address: *6300 GREENE STREET, PHILADELPHIA, PA 19144*
 County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED]

Legal Entity

Name: *STAPELEY HALL*
 Address: *6300 GREENE STREET, PHILADELPHIA, PA, 19144*
 Phone: [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: *66* Waking Staff: *50*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Monitoring* Exit Conference Date: *11/05/2025*

Inspection Dates and Department Representative

11/05/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *79* Residents Served: *46*
Secured Dementia Care Unit
 In Home: *Yes* Area: *Memory Care Unit* 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: *46*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *20* Have Physical Disability: *0*

Inspections / Reviews

11/05/2025 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/29/2025*

12/05/2025 - POC Submission
 Submitted [REDACTED] Date Submitted: *12/23/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/08/2025*

Inspections / Reviews *(continued)*

12/09/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/23/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 12/25/2025

01/06/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/23/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

*The bathroom in bedroom 407 had a liquid substance on the floor around the base of the toilet.
The pipe leading into the wall over the bed in room 401 had a black substance on it that appeared to be mold.*

Plan of Correction **Accept** (████) - 12/05/2025)

Housekeeping will conduct an inspection during their cleaning process once a week. The housekeeping manager or DOF will oversee completion of inspections. A log will be kept identifying any findings.

Housekeeping will inspect pipe coverings once a week during the cleaning process and report any necessary repairs. Maintenance has scheduled a full inspection of all PC rooms and common areas by 12/5 and will complete all repairs by 12/25/25. Inspection sheet will be stored in DOF office in PC binder once completed.

Licensee's Proposed Overall Completion Date: 12/15/2025

Implemented (████) - 01/06/2026)

103i - Outdated Food

2. Requirements

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

Description of Violation

There was an unlabeled, undated cup of what appeared to be rice pudding in the 3rd-floor kitchenette refrigerator.

Plan of Correction **Accept** (████) - 12/09/2025)

*See attached.
The rice pudding was immediately discarded. Unopened foods will no longer be stored in PC kitchenette refrigerator, all applesauce, pudding, and juices will now be self-stable PCs. (portion control) Once the item comes out of the refrigerator, it will be thrown away. All dining staff has been Inservice on labeling and storage of food. Dining managers checks all kitchen area after every meal and another staff members signs off to assure nothing is missed. Once the item comes out of the refrigerator, it will be thrown away.
Anytime we save food for a resident the proper sticker with the resident's initials, room number and date for three days. The dining managers, pc staff will be responsible for the prevention of this violation from recurring.*

Licensee's Proposed Overall Completion Date: 12/15/2025

Implemented (████) - 01/06/2026)