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

April 23, 2026

[redacted], EXECUTIVE DIRECTOR
EVANGELICAL MANOR, INC.
8401 ROOSEVELT BOULEVARD
PHILADELPHIA, PA, 19152

RE: WESLEY ENHANCED LIVING
PENNYPACK PARK
8401 ROOSEVELT BOULEVARD
PHILADELPHIA, PA, 19152
LICENSE/COC#: 17638

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/24/2026 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 PENNYPACK PARK* **License #**: *17638* **License Expiration**: *06/02/2026*

Address: *8401 ROOSEVELT BOULEVARD, PHILADELPHIA, PA 19152*

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

Administrator

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

Legal Entity

Name: *EVANGELICAL MANOR, INC.*

Address: *8401 ROOSEVELT BOULEVARD, PHILADELPHIA, PA, 19152*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *02/20/2023* **Issued By**: *Philadelphia L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *22* **Waking Staff**: *17*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/24/2026*

Inspection Dates and Department Representative

02/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *20*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *20*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

02/24/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/23/2026*

03/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/31/2026*

Inspections / Reviews *(continued)*

04/01/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/22/2026*

04/23/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/11/25, 7:00 am., resident 1 was administered insulin in error with subsequent low blood sugar. The home did not report this incident to the department.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

The Administrator re-educated the Wellness Nurse on 3/13/2026 along with the PC staff regarding reportable incidents and the requirement to report within 24 hours in accordance with Chapter 2600. The incident report would emailed to the Department of Human Services and/or faxed to confirm the incident report was submitted without any issues. Staff were instructed on identifying reportable incidents and the proper process for completing and submitting the report to the Department.
The Administrator or designee will review all incident reports daily to determine if the incident meets reportable criteria. A weekly audit of the incident log started on 3/13/2026 and will be conducted for four weeks to verify that all reportable incidents are submitted within the required timeframe. The weekly checks will conclude on 4/10/2026.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 04/23/2026)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2/24/26, at approximately 11:15 am, resident medical/care information to include shower schedules, level of care, and medical assessment due dates were unlocked, unattended, and accessible in an activity area.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

The Administrator immediately reviewed the circumstances related to the citation. The resident records were removed immediately and placed in a secured location to ensure that confidential information is accessible only to authorized personnel.
The Administrator re-educated all medication technicians and the Wellness Nurse on 3/13/2026 regarding confidentiality and procedures regarding resident records, including proper storage, handling, and access to protected information in accordance with Chapter 2600 requirements. Staff were instructed that resident records must remain secured at all times and only accessed by authorized personnel.
The Administrator or designee will conduct weekly checks of resident record storage areas and documentation practices. The audits tarted on 3/13/2026 and will take place over the course of four weeks to ensure records remain secured and confidentiality is maintained. The weekly checks will take place until 4/10/2026. Ongoing monitoring will be incorporated into routine administrative oversight.

17 Record Confidentiality (continued)

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 04/23/2026)

65f - Training Topics

3. 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 meeting the needs of the resident as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2025.

Repeat Violation: 03/31/2025

Plan of Correction ***Directed (- 04/01/2026)***

Direct Care Staff Person A received training on meeting the resident's needs as outlined in the preadmission screening form, assessment tool, medical evaluation, and Residential Service Plan (RASP) on January 24, 2025 conducted by the Administrator with documentation maintained in the personnel file. To address all staff, the Administrator and/or designee will provide training to all direct care staff on meeting resident needs as outlined in required assessments and plans. Meeting the resident's needs is currently outlined on the annual in service calendar for July 2026. Upon completion of training, documentation will be maintained in each personnel file. To prevent recurrence, a training tracking system will be implemented by the Administrator effective April 1, 2026 to ensure all required annual trainings are completed within the training year. The Administrator and/or designee will monitor compliance by reviewing training records monthly for a minimum of six months until October 31, 2026 and ongoing thereafter, and any staff found to be noncompliant will complete required training within five business days of identification.

Proposed Overall Completion Date: 10/31/2026

***Directed Plan of Correction (- 4/1/26)**:*

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/21/2026*

Implemented (- 04/23/2026)

65g - Annual Training Content

4. 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.

Description of Violation

Staff person A did not receive training in safety by fire expert during training year 2025.

Plan of Correction ***Directed ([redacted] - 04/01/2026)***

Staff Person A received fire safety training conducted by a Certified Fire Safety Instructor on August 29, 2025, and documentation of the training is maintained in the personnel file. To ensure compliance for all staff, the Administrator and/or designee will coordinate and ensure that all direct care staff receive annual fire safety training conducted by a qualified fire safety expert, with the next training scheduled to begin May 18, 2026 and be completed by May 29, 2026, with documentation maintained in each employee's personnel file. To prevent recurrence, the Administrator and/or designee will implement and maintain a training tracking system beginning April 1, 2026 to monitor all required annual trainings, including fire safety training by a qualified expert. The Administrator and/or designee will review training records monthly for a minimum of six months concluding on October 31, 2026 and ongoing thereafter to ensure compliance, and any staff identified as not having completed required fire safety training will be scheduled to complete the training within five business days of identification.

Proposed Overall Completion Date: 10/31/2026

Directed Plan of Correction ([redacted] - 4/1/26):

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/21/2026*

Implemented ([redacted] - 04/23/2026)

66b - Training Plan Content

5. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include safe management techniques in the annual training.

66b - Training Plan Content *(continued)*

Plan of Correction ***Directed (- 04/01/2026)***

The Personal Care Home's annual staff training plan was reviewed and updated on March 17, 2026 by the Administrator to include required training in safe management techniques in accordance with §2600.201 and §2600.202, and documentation of the updated training plan is maintained on file. To ensure all staff receive this required training, the Administrator and/or designee will provide training on safe management techniques to all direct care staff beginning March 26, 2026 and completed by April 10, 2026, with documentation maintained in each employee's personnel file. To prevent recurrence, the Administrator will review and update the annual training plan prior to the start of each training year to ensure all required topics, including safe management techniques, are included. The Administrator will monitor compliance by reviewing the training plan and training records monthly for a minimum of six months until October 31, 2026 and ongoing thereafter, and any identified deficiencies will be corrected within five business days.

Proposed Overall Completion Date: 10/31/2026

Directed Plan of Correction (- 4/1/26):

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/21/2026*

Implemented (- 04/23/2026)

94b - Non-Skid Surface

6. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The stairs in Manor stairwell (older side of the building) did not have a non-skid surface.

Plan of Correction ***Directed (- 04/01/2026)***

The Administrator and the Maintenance Director conducted a walk throughout of the Manor building stairwells. The facility shall ensure that non-skid treads will be installed in the Manor stairwell to create a safe walking area. The non-skid treads were installed on March 24, 2026 by the Maintenance Director .The Administrator and/or the Maintenance Director will conduct monthly environmental safety inspections of all stairwells, ramps, and surfaces to ensure compliance with nonskid requirements starting April 1, 2026. Monthly environmental safety inspections will take place over the course of six months until October 31, 2026. Any identified deficiencies will be addressed immediately with appropriate corrective measures (e.g., replacing worn treads or applying non-skid coatings).

Proposed Overall Completion Date: 04/10/2026

Directed Plan of Correction (- 4/1/26):

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/10/2026*

94b - Non-Skid Surface *(continued)*

Implemented ([redacted] - 04/23/2026)

100b - Removal Snow/Obstructions

7. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/24/26 at approximately 10:00am, there was an approximate 12 inches inch accumulation of snow. It last snowed on 2/23/25.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

The accumulation of snow on the emergency stairway observed on February 24, 2026, was immediately cleared by the Maintenance Department on the same day, and documentation of snow removal is maintained in the facility log. To ensure all exterior walkways, ramps, and emergency exits are safe and accessible, the Maintenance Director and/or designee will implement a daily snow and ice monitoring and removal schedule during inclement weather, beginning immediately and continuing through the end of the winter season, with staff assigned to specific pathways and emergency exits. Any snow or ice accumulation exceeding 2 inches will be cleared within 6 hours of the end of snowfall in compliance with City of Philadelphia requirements. The Administrator will review snow removal logs weekly for four weeks starting on March 13, 2026 and then concluding on April 10, 2026. Additional audits would then be conducted monthly thereafter to ensure compliance, and any deficiencies will be addressed immediately. All staff involved in snow removal, including the Maintenance Supervisor and designated support staff, are trained on pathway prioritization and emergency exit safety as part of this plan.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 04/23/2026)

103f - Refrigerator/Freezer Temps

8. 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 2/24/26 at approximately 11:00 am the temperature in the freezer was 20 degrees Fahrenheit and at approximately 2:15pm it was 8 degrees Fahrenheit.

Plan of Correction ***Directed ([redacted] - 04/01/2026)***

The Administrator and/or the Dining Manager will ensure that all freezers and refrigerators maintain proper temperatures in accordance with regulation 2600.103(f). On February 24, 2026, it was identified that the freezer temperature was 20°F at approximately 11:00 AM and 8°F at approximately 2:15 PM, exceeding the required maximum of 0°F for frozen food. Immediate corrective action took place to rectify the concern. To prevent any recurrence, Atlantic Refrigeration Company was onsite on 3/18/2026 to assess the freezer door. The Administrator, Dining Manager and/or designee will implement a twice-daily monitoring schedule for all refrigerators and freezers, documenting temperatures each shift starting on March 30, 2026 for four weeks ending April 24, 2026. Any deviations from required temperatures will be addressed immediately, including food relocation, corrective

103f - Refrigerator/Freezer Temps (continued)

maintenance, or disposal if necessary. Staff have been re-educated on proper food storage protocols, temperature monitoring, and documentation procedures. The Administrator, Dining Manager and/or designee are responsible for ongoing monitoring and review of temperature logs to ensure continued compliance with refrigeration and food safety standards.

Proposed Overall Completion Date: 04/24/2026

Directed Plan of Correction (- 4/1/26):

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/21/2026*

Implemented (- 04/23/2026)

132h - Designated Meeting Place

9. 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 the fire drill on 3/21/25 at 6:04am, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. The residents stayed in their rooms during the drill.

Plan of Correction ***Accept (- 04/01/2026)***

Upon discovery of the violation, the Administrator reviewed the fire drill procedures as well as attended a fire safety & emergency preparedness class on 3/11/2026.
The facility has reinforced the fire drill policy requiring that all residents evacuate to the designated meeting location or fire-safe area during each fire drill. Staff will be re-educated on proper evacuation procedures and documentation requirements by a certified fire safety instructor. The staff re-education started to take place on March 27, 2026 and will be completed by April 10, 2026.
The Administrator and/or Maintenance Director will review all fire drill documentation monthly to ensure that all residents are evacuated to the designated meeting location and that drills are conducted in compliance with regulation 2600.132(h).

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 04/23/2026)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141a 1 10 Medical Evaluation Information *(continued)*

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 3's medical evaluation did not include the ability to self administer medications.

Plan of Correction ***Directed ([redacted] - 04/01/2026)***

The resident identified in the citation has received a completed medical evaluation from the nurse practitioner on the Department required medical evaluation form. The completed form has been placed in the resident's record.
The Administrator or designee conducted an audit on all resident's charts on 3/27/2026 to ensure compliance with PA state regulations.
The Administrator and/or designee will audit resident records monthly for compliance with medical evaluation requirements starting April 1, 2026 and will take place over the course of six months. Results will be documented and corrective action will be taken immediately if deficiencies are identified.

Proposed Overall Completion Date: 10/31/2026

Directed Plan of Correction ([redacted] - 4/1/26):

The overall completion date has been directed to 4/21/26.

Directed Completion Date: *04/21/2026*

Implemented ([redacted] - 04/23/2026)

185a - Implement Storage Procedures

11. 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

Resident 2 is prescribed Tums as needed. On 2/24/26 Tums medication(s) were not available in the home.

Repeat violation: 03/31/2025

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

The medication cart for the resident identified in the citation was reviewed. All prescribed medications were verified to be present, correctly labeled, and documented on the Medication Administration Record (MAR). Staff responsible for the missing or unverified medication were immediately instructed on February 25, 2026 by the Administrator

185a - Implement Storage Procedures (continued)

ensuring medication availability prior to administration.
The Administrator and/or designee conducted a department wide audit of all medication carts to ensure that all resident medications are present, properly labeled, and accurately documented on each MAR on a weekly basis for four weeks starting on March 13, 2026. Audits will conclude by April 10, 2026. Additional audits will remain in place monthly thereafter. Any discrepancies were corrected immediately, and missing medications were obtained from the pharmacy and placed on the appropriate cart.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 04/23/2026)

187d - Follow Prescriber's Orders

12. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed Lorazepam 0.5mg 2 times a day. However, resident 2 was administered Lorazepam 0.5mg 1 time on 2/22/26 at 8 am.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

Immediate corrective action included reviewing the MAR for accuracy, confirming that the medication was administered as prescribed, and providing re-education to the medication technician on proper documentation procedures, including accurate date and time notation. To prevent recurrence, all medication administration staff will be re-trained on MAR documentation requirements and the importance of complete and accurate charting in accordance with prescriber orders. The Administrator and/or designee will educate all staff by April 10, 2026.
The Administrator or designee will conduct weekly random cart audits for 30 days starting March 13, 2026, followed by routine monthly audits for the next six months to ensure ongoing compliance. Any discrepancies identified will be addressed promptly with additional training or corrective action as needed. The Administrator is responsible for the implementation and monitoring of this plan to ensure continued compliance with medication administration and documentation standards.

Licensee's Proposed Overall Completion Date: *04/13/2026*

Implemented ([redacted] - 04/23/2026)