STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395413	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Enhanced Living Pennypack Park	8401 Roosevelt Boulevard Philadelphia, PA 19152

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on a review of facility policies, clinical records, incident/accident documents, staff training records as well as staff and resident interviews, it was determined the facility failed to ensure Resident R1 was free of neglect by failing to have sufficient staff during a mechanical lift transfer. This failure resulted in actual harm for Resident R1 who fell, sustaining multiple skin damage to the left forearm, experienced severe pain, and bruising to the head and face and required transfer to the hospital for one of five residents reviewed. (Resident R1). Findings include: Review of undated facility document, Use of a mechanical lifting machine revealed All C.N.As (Certified Nurse Aides) must read residents Kardex and get report from charge nurse prior to giving care to the residents. The Kardex will show level of care for residents, any special equipment and behavior issues. General Guidelines 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require: a. Lifting a resident from the floor; b. Transferring a resident from bed to chair; c. Lateral transfers; d. Lifting limbs; e. Toileting or bathing; or f. Repositioning. Make sure that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. Inspect sling for any damage or deterioration. If sling is damage do NOT use. Discard any worn, frayed or ripped slings. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's clinical record revealed diagnoses of Morbid (severe) Obesity, Dementia (progressive degenerative disease of the brain) and muscle weakness. Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident care needs) dated January 28, 2025, revealed Resident R1 had a BIMS (Brief interview of Mental Status) of 9 which indicated the resident's cognitive status was moderately impaired. Continued review of the MDS assessment revealed the resident was dependent for bed mobility and was dependent on staff for transfers to and from bed to chair. MDS assessment also revealed, dependent status coding indicates Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident R1's care plan dated June 11, 2024, revealed Resident R1 required extensive assistance of two staff with transfers via stand-up lift. Review of physician order for Resident R1 dated June 11, 2024, revealed an order for extensive assistance of two staff with transfers via stand-up lift. Review of facility investigation dated April 23, 2025, revealed Resident R1 had a fall while he/she was being transferred from the wheelchair to the bed, charge nurse found the resident lying on the floor in a supine position with hands on (his/her) sides and legs stretched out. Nurse Aide, Employee E3, reported the resident fell because the sling on the pad broke off. Additional review of facility investigation revealed the resident was found to have skin tear on the left elbow down toward the forearm measuring 14.5 x 4 (did not include a unit of measurement), and right foot 4th toe measuring 2 x 1 (did not include a unit of measurement) and there was fresh blood, steri strip applied on the left elbow, banded and wrapped with kerlix (type of gauze bandage). Continued review of the facility investigation revealed resident's event description as follows: I hold on to it, but I slide and fell. Review of Resident R1's progress note dated April 24, 2025, revealed that the Nurse Aide, Employee E3 reported the resident fell because the sling on the pad broke. Review of post fall investigation record for Resident R1 dated April 23, 2025, revealed the incident occurred during resident care and the resident fell while attempting to transfer from wheelchair to bed. Additional review of same document revealed action taken was staff would be able to complete all transfers with a stand-up lift and extensive assist of two staff member. Review of a employee corrective action form for Nurse Aide, Employee E3 dated April 23, 2025, revealed on April 23, 2025, employee used a stand-up lift with Resident R1 by himself. It was mandatory to have at least 2 people to use any lift. The sling broke during transfer. This resulted in a failed transfer and fall. The resident was hospitalized because of the fall. This is possible neglect and/or abuse of a resident. This is also a failure to follow resident's care plan, policy for mechanical lifts, and standard of nursing practice. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's nursing note dated April 24, 2025, revealed on April 24, 2025, at approximately 1: 30 p.m. resident complained of headache, neuro check at (his/her) baseline however bruising under right eye and at the back of head present. Physician assessed the resident and gave an order to send resident to emergency room for fall evaluation. Review of facility investigation documentation failed to reveal evidence a second staff member present during the mechanical lift transfer of Resident R1 on April 23, 2025 as per the facility policy, resident care plan, and physician order. Continued review of the facility investigation documentation and clinical record failed to reveal evidence the sling used for the resident transfer was examined by the facility staff and verified the sling was defective or broken prior to or after the incident. Interview with Nurse Aide, Employee E4 on April 29, 2025, at 1:00 p.m. revealed she examined the sling that was used during the transfer of Resident R1 on April 23, 2025, which resulted in fall of the resident the next day. Nurse Aide, Employee E3 revealed the pad was not broke or defective. Observation of Resident R1 skin conducted on April 29, 2025, at 1:10 p.m. with Employee E5, Licensed Practical Nurse revealed Resident R1 had skin damage sustained during the fall, to the left upper extremity from left knuckles to left elbow. Resident had a skin tear wound measuring 6.5 centimeter (cm) x 5.5 cm x 0. 1 cm to the left hand, with active bleeding from the wound and the dressing was sticking to the wound. Resident had a skin tear wound measuring 1.5 cm x 1cm to the left forearm hand. There was another skin tear wound right below the above-mentioned area to the left forearm measuring 2.4 c.m. x 1.5 c.m. Resident had a skin tear wound measured 2.4 cm x 1.5 c.m. to the wrist area. There was a scabbed area above the elbow measuring all together 6.5 c.m. x 5.5 c.m. Interview with Resident R1 on April 29, 2025, revealed Resident R1 experienced severe pain of the left arm which (he/she) revealed was a result of the fall a week prior. Resident R1 indicated (his/her) pain level at the time of the interview was 8 on a scale of 10. Resident R1 revealed the worst pain (he/she) experienced to the area was 10 on a scale of 10. Interview with the Employee E2, Director of Nursing, on April 24, 2025, at 1:30 p.m. revealed Nurse Aide, Employee E3, used the mechanical lift to transfer Resident R1 by himself without other staff assistance which resulted in an injury to Resident R1 when the resident fell out of the mechanical lift. Director of Nursing, Employee E2 indicated there was no issues with the mechanical lift sling after it was inspected by the staff. Director of Nursing, Employee E2 confirmed facility policy required two staff for all lift transfers. Employee E2 confirmed the injury was sustained when Employee E3 independently transferred Resident R1 using the mechanical lift. The facility failed to ensure Resident R1 was free of neglect by ensuring facility staff followed safety protocols of having two staff during a mechanical lift transfer. This failure resulted in actual harm to Resident R1 who sustained multiple skin damage to the left forearm, experienced severe pain, and bruising to the head and face and required transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on a review of facility policies, clinical records, incident/accident documents, staff training records as well as staff and resident interviews, it was determined the facility failed to ensure resident's environment remained free of accident hazards and failed to ensure safe transfer techniques were used during a transfer via mechanical lift. This failure resulted in actual harm for Resident R1 who sustained multiple skin damage to the left forearm, experienced severe pain, and bruising to the head and face and required transfer to the hospital for one of five residents reviewed. (Resident R1) Findings include: Review of undated facility document Use of a mechanical lifting machine, revealed All C.N.As (Certified Nurse Aides) must read residents Kardex and get report from charge nurse prior to giving care to the residents. The Kardex will show level of care for residents, any special equipment and behavior issues. General Guidelines 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require: a. Lifting a resident from the floor; b. Transferring a resident from bed to chair; c. Lateral transfers; d. Lifting limbs; e. Toileting or bathing; or f. Repositioning. Make sure that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. Inspect sling for any damage or deterioration. If sling is damage do NOT use. Discard any worn, frayed or ripped slings. Review of Resident R1's clinical record revealed diagnoses of Morbid (severe) Obesity, Dementia (progressive degenerative disease of the brain) and muscle weakness. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident care needs) dated January 28, 2025, revealed Resident R1 had a BIMS (Brief interview of Mental Status) of 9 which indicated the resident's cognitive status was moderately impaired. Continued review of the MDS assessment revealed the resident was dependent for bed mobility and was dependent on staff for transfers to and from bed to chair. MDS assessment also revealed, dependent status coding indicates Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident R1's care plan dated June 11, 2024, revealed Resident R1 required extensive assistance of two staff with transfers via stand-up lift. Review of physician order for Resident R1 dated June 11, 2024, revealed an order for extensive assistance of two staff with transfers via stand-up lift. Review of facility investigation dated April 23, 2025, revealed Resident R1 had a fall while he/she was being transferred from the wheelchair to the bed, charge nurse found the resident lying on the floor in a supine position with hands on (his/her) sides and legs stretched out. Nurse Aide, Employee E3, reported the resident fell because the sling on the pad broke off. Additional review of facility investigation revealed the resident was found to have skin tear on the left elbow down toward the forearm measuring 14.5 x 4 (did not include a unit of measurement), and right foot 4th toe measuring 2 x 1 (did not include a unit of measurement) and there was fresh blood, steri strip applied on the left elbow, banded and wrapped with kerlix (type of gauze bandage). Continued review of the facility investigation revealed resident's event description as follows: I hold on to it, but I slide and fell. Review of Resident R1's progress note dated April 24, 2025, revealed that the Nurse Aide, Employee E3 reported that the resident fell because the sling on the pad broke off. Review of post fall investigation record for Resident R1 dated April 23, 2025, revealed the incident occurred during resident care and the resident fell while attempting to transfer from wheelchair to bed. Additional review of same document revealed action taken was staff would be able to complete all transfers with a stand-up lift and extensive assist of two staff member. Review of a employee corrective action form for Nurse Aide, Employee E3 dated April 23, 2025, revealed on April 23, 2025, employee used a stand-up lift with Resident R1 by himself. It was mandatory to have at least 2 people to use any lift. The sling broke during transfer. This resulted in a failed transfer and fall. The resident was hospitalized because of this fall. Review of nursing note dated April 24, 2025, revealed on April 24, 2025, at approximately 1: 30 p.m. resident complained of headache, neuro check as (his/her) baseline however bruising under right eye and at the back of head present. Physician assessed the resident and gave an order to send resident to emergency room for fall evaluation. Review of facility investigation documentation failed to reveal evidence a second staff member was present during the mechanical lift transfer of Resident R1 on April 23, 2025 as per the facility policy, resident care plan, and physician order. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Continued review of the facility investigation documentation and clinical records failed to reveal evidence the sling used for the resident transfer was examined by the facility and verified that the sling was defective or broken prior or after the incident. Interview with Nurse Aide, Employee E4 on April 29, 2025, at 1:00 p.m. revealed she examined the sling that was used for the transfer of Resident R1 on April 23, 2025, and resulted in the resident fall the next day. Nurse Aide, Employee E3 revealed the pad was not broke or defective. Observation of Resident R1 skin was conducted on April 29, 2025, at 1:10 p.m. with Employee E5, Licensed Practical Nurse revealed the resident had skin damage sustained during the fall on April 23, 2025, to the left upper extremity from left knuckles to left elbow. Resident had a skin tear wound measured 6.5 centimeter (cm) x 5.5 cm x 0.1 cm to the left hand, there was active bleeding from the wound and the dressing was sticking to the wound. Resident had a skin tear wound measured 1.5 cm x 1cm to the left forearm hand. There was another skin tear wound right below the above-mentioned area to the left forearm measured 2.4 c. m. x 1.5 c.m. Resident had a skin tear wound measured 2.4 cm x 1.5 c.m. to the wrist area. There was a scabbed area above the elbow measured all together 6.5 c.m. x 5.5 c.m. Interview with Resident R1 on April 29, 2025, revealed Resident R1 experienced severe pain on the left arm which (he/she) revealed was a result of a fall at the facility a week prior. Resident R1 indicated (his/her) pain level at the time of the interview was 8 on a scale of 10. Resident R1 revealed the worst pain (he/she) experienced to the area was 10 on a scale of 10. Interview with the Employee E2, Director of Nursing, on April 24, 2025, at 1:30 p.m. revealed Nurse Aide, Employee E3, used the mechanical lift to transfer Resident R1 by himself without other staff assistance which resulted in injury to Resident R1 when the resident fell out of the mechanical lift. Director of Nursing, Employee E2 indicated there was no issues with the mechanical lift sling after it was inspected by the staff. Director of Nursing, Employee E2 confirmed facility policy required two staff for all Hoyer lift transfers. Employee E2 confirmed the injury was sustained when Employee E3 independently transferred Resident R1 using the mechanical lift. The facility failed to ensure resident's environment remained free of accident hazards and failed to ensure safe transfer techniques were used during a transfer via mechanical lift. This failure resulted in actual harm for Resident R1 who sustained multiple skin damage to the left forearm, experienced severe pain, and bruising to the head and face and required transfer to the hospital 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on the review of facility documentation, review of personnel files and interview with staff, it was determined that the facility failed to complete performance review of every nurse aide at least once every 12 months for one of one staff educational records reviewed. (Employee E3). Finding include: Review of facility investigation dated April 23, 2025, revealed Resident R1 had a fall while he/she was being transferred from the wheelchair to the bed, charge nurse found the resident lying on the floor in a supine position with hands on (his/her) sides and legs stretched out. Nurse Aide, Employee E3, reported the resident fell because the sling on the pad broke off. Interview with the Employee E2, Director of Nursing, on April 24, 2025, at 1:30 p.m. revealed Nurse Aide, Employee E3, used the mechanical lift to transfer Resident R1 by himself without other staff assistance which resulted in injury to Resident R1 when the resident fell out of the mechanical lift. Director of Nursing, Employee E2 indicated there was no issues with the mechanical lift sling after it was inspected by the staff. Director of Nursing, Employee E2 confirmed facility policy required two staff for all Hoyer lift transfers. Employee E2 confirmed the injury was sustained when Nurse Aide, Employee E3 independently transferring Resident R1 using the mechanical lift. A request was made to the facility Nursing Home Administrator for Employee E8's annual training records on April 16, 2023, at 12:00 p.m. Review of Nurse Aide, Employee E3's personnel files revealed no documented evidence that Nurse aide, Employee E3, had a performance evaluation completed for the year 2024 and 2025. Interview with the Director of Nursing on April 29, 2024, at 1:30 p.m. confirmed that the facility did not have process of completing performance evaluation of the employees and did not have performance evaluation of Nurse Aide, Employee E3. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. 211.12(c) Nursing services