

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Wesley Enhanced Living Pennypack Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on review of facility documentation and staff interviews it was determined that the facility failed to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility for one of 22 residents reviewed (Resident R102). Findings include: Review of Resident R102's clinical records and admission documents revealed that upon admission to the facility on April 11, 2025, Resident R102 signed numerous admission, financial, consent, and resident right documents written in English. A review of facility documentation revealed numerous items with Resident R102's signature dated April 11, 2026, that included but were not limited to, the admission summary, insurance member responsibility forms, financial admission policy, physician authorization, advance directives power of attorney information, beneficiary notice of non-coverage, vaccine information, informed consent, informed consent for treatment, media release acknowledgement of private practices authorization for release of information, resident fund management services, laundry permission, privacy notice regarding the use and disclosure of medical information, grievance procedure, corporate compliance information, non-discrimination notice, abuse and zero tolerance information, visiting policy and resident rights and legal arbitration agreement .The majority of these documents were also signed by the facility admissions director, Employee E8, on April 11, 2025. Further review of Resident R102's clinical record revealed the resident's primary language is Spanish and that the resident does not speak, read or understand English. Continued review of facility documentation and Resident R102's clinical record revealed no documented evidence that the admission documents were translated into Spanish, and interpreted by a qualified medical interpreter, reviewed through a language assistance service, or otherwise communicated in a language and manner Resident R102 could understand prior to obtaining the resident signatures. There was no documentation identifying an interpreter, translator, bilingual staff member, or witness attesting to the contents of the document were accurately explained to the resident before signature. Review resident R102's comprehensive care plan revealed the resident has communication needs. The care plan documents that Resident R102 is Spanish speaking and, when spoken to in this native language answers appropriately follow commands and makes needs known. The care plan further indicated Resident R102 does not understand English and understands only a few basic English words and phrases. The care plan reveals staff should utilize nonverbal communication techniques, and that Resident R102 was provided a Spanish English communication board. Interventions directed staff to use verbal and visual cues, nonverbal techniques and gestures, and other communication strategies to facilitate understanding. Interview on July 23, 2026, with Admissions Director, Employee E8, revealed she does not speak Spanish and is unable to translate. When asked how Admissions Director, Employee E8, communicated the admissions agreement documents to Resident R102, Employee E8 reported using a tablet for translation. Admissions Director, Employee E8, acknowledged and (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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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that none of the admission documents contained any notation indicating that a translation method, including the tablet, or qualified translator was used. Admissions Director, Employee E8, further confirmed the paperwork was not provided in Spanish, and that there was no documentation to demonstrate that Resident R102 received translation assistance or understood the documents prior to signing them. Admissions Director, Employee E8, confirmed there was no independent witness present during the signing process and that she was the only individual present. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of clinical records, facility documentation, and staff interview, it was determined that the facility failed to ensure assessments accurately reflected the resident status for one of 22 residents reviewed (Resident R13). Findings Include: Review of Resident R13's clinical record revealed the resident has documented psychotic symptoms, including hallucinations, and was prescribed psychotropic medications (drugs that affect mood, behavior, and cognition), including Risperdal, Trazodone, and Depakote. Review of Resident R13's comprehensive care plan dated June 16, 2025, revealed the resident has a history of expressing feeling down/depressed/hopeless and has a diagnosis of Major Depressive Disorder (MDD - a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R13's Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 22, 2026, revealed depression was not checked as a diagnosis. Interview on July 22, 2026, at approximately 1:23 p.m., the Registered Nurse (RN) Assessment Coordinator (RNAC) acknowledged Resident R13 had a history of hallucinations and was receiving psychotropic medications. The RNAC confirmed the MDS did not accurately reflect Resident R13's diagnosis. 28 Pa. Code 201.14 (a) Responsibility of licensee.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies and staff interview it was determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed according to the resident assessment for one of 22 residents reviewed (Resident R13). Findings Include: The PASRR (Preadmission Screening Resident Review), created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA), has three goals: to identify individuals with mental illness and/or intellectual disability; to ensure they are placed appropriately, whether in the community or in a nursing facility; and to ensure they receive the services they require for their mental illness or intellectual disability. A Level I PASRR must be completed for all persons considering admission to a Medicaid-certified nursing facility. A Level II PASRR evaluation must be completed if the Level I PASRR determines that the person is a targeted individual with mental illness or an intellectual disability. The Level II PASRR determines whether placement or continued stay in the requested or current nursing facility is appropriate. Review of Resident R13's Minimum Data Set (MDS - federally mandated resident assessment and care screening) revealed the resident was admitted to the facility on [DATE], and has a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Per the MDS, Resident R13 has a diagnosis of Cognitive Impairment (problems with memory and thinking). Review of Resident R13's clinical record revealed the resident has documented psychotic symptoms, including hallucinations, and was prescribed psychotropic medications (drugs that affect mood, behavior, and cognition), including Risperdal, Trazodone, and Depakote. Review of Resident R13's comprehensive care plan dated June 16, 2025, revealed the resident has a history of expressing feeling down/depressed/hopeless, has a diagnosis of Major Depressive Disorder (MDD - a mood disorder that causes a persistent feeling of sadness and loss of interest), and was evaluated by psychiatry on 4/29/2026. Review of Resident R13's PASRR dated June 3, 2025, revealed the assessment did not include Resident R13's documented hallucinations or diagnosis of major depressive disorder. Interview on July 22, 2026, at 2:00 p.m. the social worker confirmed Resident R13's PASRR was not updated with Resident R13's hallucinations or diagnosis of depression. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident records and interview with staff it was determined that the facility failed to review and revise a care plan for two of 22 residents reviewed (Resident R66 and R117). Findings include: Review of clinical records revealed Resident R66 was admitted to the facility on [DATE], with diagnoses including, but not limited to, muscle weakness, abnormalities of gait and mobility, and dementia. Review of the resident's most recent MDS (minimum Data Set, a periodic assessment of resident care needs) completed on May 29, 2026, revealed in Section C: Cognitive Patterns, that the resident was unable to complete a BIMS assessment (Brief Interview for Mental Status, an assessment of cognitive abilities). The Staff Assessment of Mental Status revealed that the resident had both short term and long term memory problems, and that their decision making abilities were moderately impaired-decisions poor; cues/supervision required. A review of the resident's care plan revealed a history of falls with fractures, with risk factors for future falls including anti-hypertensive medication use, change in safety awareness, gait dysfunction and [the resident] self-transfers without using assistive device. Continued review of Resident R66's care plan revealed that it included numerous repeated interventions and/or interventions inappropriate for a resident with the above cognitive deficits. These interventions included, but were not limited to, the following: [the resident] should be reminded frequently to call/wait for assistance to complete tasks/ADLs (Activities of Daily Living). There were 14 variations on educating or reminding the resident of safety measures or to call for assistance, which is ineffective given the resident's cognitive status. These interventions were initiated on dates ranging from June 26, 2021, to September 29, 2025. Aide or nurse monitoring resident for help to get out of bed or use call bell. There were 7 variations on monitoring the resident for safety initiated on dates ranging from March 14, 2024, to March 24, 2026. Encourage participation in activities that minimize the potential for falls while providing diversion and distraction. There were 5 variations on encouraging the resident to socialize and/or participate in activities. These interventions were initiated on dates ranging from October 1, 2022, to April 17, 2025. Offer assistance to transfer when [the resident is] seated in the common area, initiated February 14, 2026, and Frequently ask if resident needs assistance while in the common area, initiated July 13, 2026. Removed from situation and made comfortable in bed, initiated September 2022, and resident toilet, assessed for pain and neuro-checks, assist resident from floor, initiated December 21, 2025, are the immediate actions taken following actual falls, and are not appropriate as care planned interventions. Interview with Employee E2, Director of Nursing, on July 24, 2026 at 1:45 p.m. confirmed that reminders and education are not appropriate for a cognitively impaired resident, that immediate actions taken after a fall should not be entered into the care plan, and that numerous repetitions existed in interventions initiated over the course of several years. Director of Nursing, Employee E2, also confirmed that interventions should be appropriate and up to date. Review of Resident R117 clinical record revealed an admission Minimum Data Set (MDS- a federal mandated resident assessment tool) dated May 30, 2026, documented a brief interview for mental status (BIMS) score of three (severe impaired cognition), and a diagnosis of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) and moderate impairment and decision making. Review of facility documentation submitted to the State Survey Agency revealed on June 9, 2026, the facility reported allegations of physical abuse against Resident R117's family member. Review of the facility documentation/investigation revealed that on June 9, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, Resident R117's family became verbally and physically aggressive towards staff. Resident R117's son became aggressive pushing two nursing assistants out of the way, and while attempting to demonstrate care for Resident R117, the resident fell and hit his/her head against the wall. The facility's investigation substantiated the above incident. Review of Resident R117's comprehensive care plan revealed no documented evidence the care plan was reviewed/ revised to include individualized interventions addressing the residents newly identified safety needs, including interventions to protect the resident from further abuse, or staff instructions regarding supervision or monitoring of visits with family member. Findings were discussed via an interview with the Director of Nursing, Employee E2, on July 23, 2026. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 201.14 (a) Responsibility of licensee		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, and staff interview it was determined that the facility failed to ensure one resident environment was free from accident/hazards for one of 22 residents reviewed (Resident R63). Findings include: Review of facility documentation submitted to the State Survey Agency revealed on November 28, 2025, Resident R63 was seated in his/her reclining wheelchair while a maintenance employee performed repairs to the chair. While performing repairs, the wheelchair unexpectedly reclined backwards causing Resident R63 to hit the side of his/her head against the wall. Resident R63 was subsequently transferred to the emergency room for evaluation. Review of Resident R63's Minimum Data Set (MDS- federally mandated resident assessment and care screening) dated July 28, 2026, revealed the resident was admitted to the facility on [DATE], with diagnosis including traumatic brain injury, deep being thrombosis (blood clot) diabetes, and cerebral vascular accident (stroke). The MDS documented a brief interview for mental status (BIMS) score of nine indicating moderate cognitive impairment. Review of resident R63's comprehensive care plan revealed the resident has multiple safety related risk factors including an above the knee amputation, cognitive impairment with short term memory deficits, dependence on staff for transfers using a Hoyer left, and a risk for falls. Resident R63's care plan directed staff to observe and monitor the resident's environment for fall and trip hazards, ensure the safe use of the resident's wheelchair and other assistive devices, consult physical and occupational therapy as indicated, and utilize adaptive equipment and positioning devices to promote the resident safety. Review of facility documentation revealed a work order dated November 26, 2025, for Resident R63's wheelchair that the anti-tippers (Anti tip device or safety devices attached to the back lower frame of a wheelchair their purpose is to prevent the wheelchair from tipping backwards) are not stable. The work order asked for new anti-tippers be placed or somehow be fixed so they don't move. Review of facility documentation and internal investigation revealed Resident R63 was in his/her wheelchair while Maintenance Director, Employee E9, performed repairs on the wheelchair. While repairs were being performed, the chair suddenly reclined backwards, causing Resident R63 to strike the right side of his/her head against the wall. Resident R63's spouse, who was present in the room at the time of the incident, notified nursing staff. Nursing assessment revealed a skin tear to the resident R63's right forearm with small amount of bleeding. Interview on July 23, 2026, with Maintenance Director, Employee E9, confirmed responding to a work order to fix Resident R63's wheelchair. Maintenance Director, Employee E9, stated the repair involved tightening the anti-tip mechanism located underneath the wheelchair and believed it was a minor adjustment that only required a tightening a nut. Maintenance Director, Employee E9, stated he did not believe it was necessary to remove the resident from the wheelchair while the repair was being performed. Maintenance Director, Employee E9, reported Resident R63 remained seated in the wheelchair, while the Maintenance Director, Employee E9, positioned himself under the chair to complete the repair. During the repair the reclining back of the wheelchair suddenly released, causing Resident R63 to recline backward and strike his/her head against the wall. Interview on July 23, 2026, Maintenance Director, Employee E9, acknowledged that the component of the wheelchair that released was the reclining mechanism, not the anti-tip mechanism that was intended to be repaired, and suspected the recliner had not fully secured or locked into place. Maintenance Director, Employee E9, reported that following this incident, residents will not be seated in equipment while repairs are being made. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29 (a) Resident Rights		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation staff interview the facility failed to ensure medications were stored in a secure manner for one of two medication rooms observed (First Floor). Findings include: Review the facility policy titled Medication Labeling and Storage revealed that all medications in biologicals are to be stored in a locked compartment under appropriate temperature humidity and light conditions. Access to medication storage areas is limited to authorized personnel. Nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy further requires that medication drawers, cabinets, rooms, refrigerators, and carts containing medications or biologicals remain locked when not in use and that medication trays or carts are not left unattended when open or otherwise accessible to unauthorized individuals. Observation of nursing station on first floor on July 21, 2026, at 11:05 a.m. revealed the medication room door was open and unattended allowing unrestricted access to medications and medication supplies. Interview at the time of observation with licensed nurse, employee E5, confirmed medication room was open and accessible. Licensed nurse, employee E5, acknowledged the medication room should have remained secured when unattended. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview it was determined the facility failed to implement enhanced barrier precautions for one of 22 residents reviewed (Resident R69). Finding include: Review of the facility policy titled Enhanced Barrier Precautions dated August 2022 revealed that enhanced barrier precautions (EBPs) are implemented to reduce the transmission of multidrug resistant organisms (MDROs). The policy requires staff to wear gown and gloves when performing high contact resident care activities, including urinary catheter care. Observation on the first-floor nursing unit on July 21, 2026, at approximately 10:45 am Resident R69 was observed seated in the hallway, in his/her wheelchair, appearing upset. Resident R69 reported waiting for staff assistance with his/her urinary catheter. Further observation on July 21, 2026, at approximately 10:45 am revealed licensed nurse, employee E4, responding to Resident R69's request and escorting the resident into his/her room and closed the door to provide catheter care. Continued observations on July 21, 2026, revealed Licensed nurse, Employee E4, exiting Resident R69's room and removing her gloves. Interview on July 21, 2026, with licensed nurse, Employee E4, confirmed the employee just got done assisting Resident R69 with his/her urinary catheter. When asked what personal protective equipment (PPE) was worn, Licensed Nurse, Employee E4, acknowledged required PPE (such as a gown) was not worn and should have been. 28 Pa. Code 211.12 (d)(5) Nursing services.		