STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395520	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Enhanced Living - Doylestown	200 Veterans Lane Doylestown, PA 18901

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observation, and staff interview, it was determined that the facility failed to store and serve food in a sanitary manner in the dietary department, the activities room kitchenette, and on one of three nursing units. (Nursing Unit N2) Findings include: Review of the facility policy entitled, Bare Hand Contact with Food and Use of Single-Use Gloves, last reviewed on October 29, 2025, revealed that staff were to change gloves as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, and any time a contaminated surface was touched. Observation of the meal service in the satellite kitchen on N2, on March 4, 2026, between 11:30 a.m. and 12:00 p.m., revealed a dietary employee, DE 1, was handling and cutting grilled sandwiches with gloved hands, then proceeded to touch the handle of the grill/oven and then handle the grilled sandwiches again without changing gloves. DE 1 was also observed preparing two slices of bread with peanut butter with gloved hands, then walked to another station, took two packs of jelly, and returned to preparing the sandwich without changing gloves. In an interview on March 4, 2026, at 12:00 p.m., the manager of dining services confirmed that DE 1 should have changed his gloves and performed hand hygiene between tasks. Review of the facility policy entitled, Foods Brought by Family/Visitors, last reviewed on October 29, 2025, revealed that food was to be labeled and stored in a manner that distinguished it from facility-prepared food and that staff were to discard any food that was passed the package expiration date. Observation of the activities room kitchenette refrigerator on March 4, 2026, at 2:00 p.m., revealed the following: An opened bottle of salad dressing that was not labeled. The shelving had debris and a dried light-yellow substance on it. Observation of the activities room kitchenette cabinets on March 4, 2026, at 2:00 p.m., revealed the following: A bottle of cinnamon sticks with an expiration date of December 29, 2020. A bottle of ground nutmeg with an expiration date of December 27, 2024. A bottle of a thick yellow substance that was not labeled or dated. A paper bowl with a lid on it that had a powdered substance inside and that was not labeled or dated. A bottle of cream of tartar that had an expiration date of November 20, 2024. A can of pumpkin puree that had an expiration date of December 29, 2025. Three packets of thickening powder that had an expiration date of November 3, 2025. Three packets of thickening powder that had an expiration date of April 10, 2025. Two packets of thickening powder that had an expiration date of October 11, 2024. One packet of thickening powder that had an expiration date of March 9, 2023. In an interview on March 4, 2026, at 1:23 p.m., the Nursing Home Administrator confirmed that the items in the activities room kitchenette refrigerator should have been labeled and dated, the shelving should have been clean, and the expired items in the kitchenette cabinets should have been discarded. 28 Pa. Code 201.14(a) Responsibility of licensee.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and review of electronic call bell logs, it was determined that the facility failed to answer call bells in a timely manner to provide care and services respectful of each resident's dignity and preferences to promote quality of life for five of 15 sampled residents. (Residents 3, 6, 8, 21, and 32)Findings include: Clinical record review revealed that Resident 3 had diagnoses that included heart failure and debility. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required assistance from staff for activities of daily living, such as toileting and dressing. In an interview on March 4, 2026, at 11:10 a.m., Resident 3 stated that staff took a long time to answer call bells. Clinical record review revealed that Resident 6 had diagnoses that included a recent femur fracture, difficulty walking, and obesity. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and required assistance from staff for activities of daily living, such as toileting and dressing. In an interview on March 3, 2026, at 1:20 p.m., Resident 6 stated that staff took a long time to answer call bells. Clinical record review revealed that Resident 8 had diagnoses that included heart failure, history of a stroke, difficulty with walking, and anxiety. The MDS assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and was dependent on staff for assistance with all activities of daily living such as toileting and dressing. In an interview on March 4, 2026, at 11:15 a.m., Resident 8 stated that staff took a long time to answer call bells. Clinical record review revealed that Resident 21 had diagnoses that included a recent femur fracture, diabetes, and chronic kidney disease. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and was dependent on staff assistance for all activities of daily living such as toileting and dressing. In an interview on March 3, 2026, at 11:15 a.m., Resident 21 stated that staff took a long time to answer call bells. Clinical record review revealed that Resident 32 had diagnoses that included Parkinson's disease and hypotension. The MDS assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and was dependent on staff assistance for all activities of daily living such as toileting and dressing. In an interview on March 3, 2026, at 11:48 a.m., Resident 32 stated that staff took a long time to answer call bells. Review of the facility form entitled, Status Solutions over 15 minutes Report, a report generated by the call bell system that indicates all call bell response times that exceeded 15 minutes, for Residents 3, 6, 8, 21, and 32 revealed that from February 3 through March 3, 2026, there were 65 incidents when the call bell response time exceeded 19 minutes which included: On February 28, 2026, at 8:14 p.m., Resident 3 waited 36 minutes, and on March 1, 2026, at 7:56 a.m., Resident 3 waited 30 minutes. On February 13, 2026, at 4:46 p.m., Resident 6 waited 29 minutes, and on that same day at 6:45 p.m., Resident 6 waited 31 minutes.On February 7, 2026, at 10:29 a.m., Resident 21 waited 28 minutes, and February 21, 2026, at 9:57 a.m., Resident 21 waited 27 minutes.On February 5, 2026, at 6:57 p.m., Resident 32 waited 25 minutes, and on February 12, 2026, at 8:21 a.m., Resident 32 waited 27 minutes. During an interview on March 5, 2026, at 10:35 a.m., the Nursing Home Administrator confirmed that report accurately measured the response times for call bells, and that the aforementioned residents waited more than the expected response time of 15 minutes for assistance. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on a clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for one of 15 sampled residents. (Resident 32)Findings include:Clinical record review revealed that Resident 32 had diagnoses that included hypotension (low blood pressure) and Parkinson's disease. A physician's order dated December 6, 2024, directed staff to administer 5 mg of a blood pressure medication (midodrine) three times daily. The physician ordered that staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was higher than 140 millimeters of mercury (mm/Hg). Review of Resident 32's Medication Administration Record (MAR) for December of 2025, and January of 2026, revealed that the staff administered midodrine three times in December of 2025, and twice in January of 2026, when Resident's 32's SBP was higher than 140mm/Hg.A physician's order dated January 2, 2026, reduced the dose of midodrine to 2.5 mg, three times daily. The physician ordered that staff were not to administer the medication if the resident's SBP was higher than 140 mm/Hg. Review of Resident 32's Medication Administration Record (MAR) for January and February of 2026, revealed that the staff administered 2.5 mg of midodrine twice in February 2026, when Resident's 32's SBP was higher than 140mm/Hg.In an interview on March 5, 2026, at 10:13 a.m., the Director of Nursing confirmed orders by the physician for resident 32 were not followed and medications were administered outside of the ordered parameters.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on clinical record review and observation, it was determined that the facility failed to ensure that adaptive equipment was provided to one of 15 sampled residents. (Resident 4)Findings include: Clinical record review revealed that Resident 4 had diagnoses that included Parkinson's Disease. Occupational therapy documentation dated August 25, 2025, indicated the resident was to use weighted utensils with meals to increase independence with self-feeding. A review of the resident's care plan indicated that the resident was to use a weighted fork and spoon at all meals. On April 8, 2025, a physician order directed staff to have adaptive equipment in place according to the resident's care plan. Observations on March 4, 2026, from 12:15 p.m. to 12:45 p.m., revealed Resident 4 was eating her lunch in the dining room. She was using regular (not weighted) utensils. On March 5, 2026, from 9:00 a.m. to 9:15 a.m., Resident 4 was observed eating breakfast in her room. The resident did not have weighted utensils. The resident was observed using regular utensils and there were scrambled eggs that had fallen onto the floor. In an interview, at that time, the resident stated that she was having difficulty using her utensils.In an interview on March 5, 2026, at 10:30 a.m., the Director of Nursing confirmed the adaptive equipment as indicated in the care plan should have been in place. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.