STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395715	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Enhanced Living at Stapeley	6300 Greene Street Philadelphia, PA 19144

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 06525 Based on clinical record review, interviews with staff and review of policies and procedures, it was determined that the facility failed to ensure that medications were administered according to professional standards of practice before and during dialysis treatment for one of two residents on hemodialysis.(Resident R1) Findings include: Review of the facility policy titled administering medication dated April, 2019 revealed that licensed nursing staff were required to administer medications to the residents in a safe and timely manner as prescribed by the physician. The policy also indicated that the administration of medications was supervised by the director of nursing services. This policy indicated that medications were required to be administered within on hour of their prescribed time. The policy said that a licensed individual administering the medication would be required to record in the medication administration record the date and time that the medication was administered. This administration would then require the signature of the licensed nurse that gave the drug. Review of Resident R1's physician's progress note dated April 4, 2024 revealed the diagnoses of end-stage renal disease (kidney failure) pseudoseizure disorder (epileptic seizures) and hypotension (low blood pressure) . The physician indicated that hemodialysis s(a machine that filters wastes, salts and fluids from the body when the kidneys are no longer able to do this) treatments were ordered routinely (three times a week). Clinical record review revealed that the physician had ordered medications to be administered during the months of March and April, 2024 for Resident R1. The physician had ordered Levetiracetam (used to treat pseudoseizure disorder) 500 milligrams (mg) twice a day at 8:00 a.m. and 9:00 p.m., daily and Carvedilol (used to treat cardiovascular disease) 6.25 mg to be administered at the breakfast and evening meal daily. The physician had also ordered that levetiracetam medication be sent with Resident R1 to the dialysis center on Tuesday, Thursday and Saturday for administration at the dialysis center. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing, Employee E2 and Licensed nursing staff, Employees E3 and E4, at 1:00 p.m., on April 9, 2024 confirmed that Resident R1 left the facility at 9:00 a.m., for the dialysis center on Tuesdays, Thursdays and Saturdays three times weekly for hemodialysis care. The nursing staff also reported that Resident R1 returned from the dialysis center after hemodialysis treatments at 3:00 p.m. weekly. Review of Resident R1's March, 2024 Medication Administration Record revealed that the nursing staff were administering medication (levetiracetam 500mg) at 9:00 a.m, on Tuesday, Thursday and Saturday for Resident R1. The medication administration record for March, 2024 also indicated that the nursing staff were giving Resident R1 500 mg of Levetiracetam to bring to dialysis for administration at the dialysis center on March 5, 7, 12, 14, 19, 21, 26, 28, and 30, 2024. The medication administration record for April, 2024 was reviewed and revealed that Resident R1 was administered medication Levetiracetam 500 mg at 9:00 a.m., on March 2, 2024. The medication administration record also indicated that Resident R1 was given 500 mg of Levetiracetam to bring with him to the dialysis center. Interview with Licensed nurse, Employee E3, at 10:30 a.m., on April 9, confirmed that Resident R1 was entrusted to bring the Levetiracetam 500 mg to the dialysis center three times a week to give to the dialysis staff. Further interview with Licensed practical nurse, Employee E3 confirmed that Resident R1 was entrusted with the safekeeping and transport of this medication from the nursing home to the dialysis unit three times a week. The licensed nurse, Employee E3 also confirmed that Resident R1 had not been assessed or care planned for the ability to self-administer medications or transport medications to the dialysis center three times a week. Nursing progress notes on March 19, 2024 indicated that Resident R1 was sent to the hospital in the morning from the dialysis unit because upon arrival to the dialysis center Resident R1 presented with experiencing a pseudoseizure. Nursing progress notes on April 5, 2024 indicated that Resident R1 refused to take all medications. There was no documentation to indicate that the director of nursing or the physician were notified of the resident's refusal of all medications. The resident refused the 9:00 a.m., levetiracetam (used to treat pseudo seizure disorder) and 9:00am., carvedilol (used to treat cardiovascular disease). Resident R1 was transported to the dialysis center on April 5, 2024 for hemodialysis treatment. Review of nursing note dated April 5, 2024 revelaed that the resident was transferred from the dialysis center to the hospital on April 5, 2024 due to signs and symptoms of unresponsiveness and syncope. Interview with Employee E2, Director of Nursing, at 10:00 a.m., on April 9, 2024 revealed that there were no policies and procedures collaborated with the dialysis center to ensure that Resident R1 was arriving to the dialysis center with the 500 mg of Levetiracetam. The Director of Nursing was not assured that Resident R1 was receiving this medication or holding on to the medication to use at another time . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Employee E2, Director of Nursing at 11:00 a.m., on April 9, 2024 revealed that the facility and dialysis center had no record of what was happening with the medication Levetiracetam that was supposed to be delivered by the resident to the dialysis center during the entire months of March and April, 2024. The Director of Nursing, Employee E2, confirmed during an interview at 11:30 a.m., that the facility failed to ensure that Resident R1 received medications as ordered by the physician during the months of March and April, 2024, according to professional standards of practice for safe administration and security of medications on hemodialysis days. 28 PA. Code 211.12(b)(c)(d)(1)(2)(3)(5) Nursing services 28 PA. Code 211.10(a)(c)(d) Resident care policies 28 PA. Code 211.9(a)(1)(b)(c)(d) Pharmacy services 28 PA. Code 201.21(c) Use of outside resources 28 PA. Code 201.18(b)(1)(3) Management