

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Wesley Enhanced Living at Stapeley		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46993</p> <p>Based on review of clinical record, review of facility documentation and interview with staff, it was determined that the facility failed to ensure that one of six residents reviewed receive the required assistance via mechanical lift during a bed to chair transfer. This failure resulted in actual harm to Resident R1 whose left leg got twisted during transfer and sustained a fracture of the left femur (thigh bone). (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy 'Using a Mechanical Lifting Machine,' revised July 2017, states the following:</p> <p>4. Prepare the environment: a. clear an unobstructed path for the lift machine;</p> <p>b. ensure there is enough room to pivot;</p> <p>c. position the lift near the receiving surface; and</p> <p>d. place lift at correct height.</p> <p>Further review of policy instructs staff to 13. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. 14. Check the resident's comfort level by asking or observing for signs of pinching or pulling of the skin.</p> <p>Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE] with the diagnosis of legal blindness, muscle weakness, dementia (progressive degenerative disease of the brain), Poly osteoarthritis, age-related osteoporosis without current pathological fracture.</p> <p>Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated August 17, 2024, revealed that the resident was visually impaired. The resident was assessed with cognitive impairment and required substantial to maximum assistance with transfer from bed to chair.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R1's care plan revised September 12, 2024, revealed that up until the date of incident the resident was care planned for exhibiting factors related to falls such as impaired cognition and visual deficit. Interventions included for the resident to be transferred via mechanical (hoyer) lift with the assistance of 2 persons. The resident was also care planned for impaired vision as evidence of blindness.</p> <p>Review of Resident R1's nursing notes dated October 13, 2024, at 12:23 p.m., revealed that primary nurse reported incident occurrence during patient transfer from bed to chair. Complained of pain to left lower extremity noted, PRN (as needed) Tylenol given, skin intact, with no redness observed. on call provider notified, 2 views stat (immediate) ordered.</p> <p>Continued review of nursing notes revealed that on October 13, 2024 at 2:42 p.m. care nurse reported that [Resident R1] complaining of leg pain. PRN (as needed) Tylenol administered for pain. left hip down to femur tender to touch. no swelling no redness observed. on call provider notified. 2 views stat (immediate) ordered.</p> <p>Nursing note date October 14, 2024, revealed x-ray of the left tibia-fibula demonstrate no acute fracture. Continued review of nursing notes revealed that on October 14, 2024 at 3:01 p.m. resident is monitored for left leg pain. On left knee is swollen and resident is complaining when the leg is moved. I called [physician] and she ordered an x-ray of left hip, left femur and left knee.</p> <p>Further review of nursing note dated October 14, 2024, at 8:33 p.m. revealed Technician during x-ray stated resident has Fracture and displacement of L (left) femur in multiple areas and requested to not transfer resident from bed to chair, should ensure she stays in bed when turning to be very careful.</p> <p>Continued review of nursing notes dated October 15, 2024 at 7:33 a.m. stated that the resident was admitted to the hospital with the diagnosis of left femur fracture.</p> <p>Review of physician notes from Resident R1's outpatient office visits on October 24, 2024, revealed that upon physical examination Resident R1 was noted to have an abrasion over the anterior aspect of her left knee she also has an abrasion over her left lateral ankle.</p> <p>Review of facility investigation revealed a written statement from Nurse aide, Employee E2 [Nurse aide Employee E3] gave care to [Resident R1] while I gave care to . When the time came to get [Resident R1] up into her chair we lifted her, and put her into her chair. It wasn't until [Resident R1] said It hurts! that we noticed her leg bent. [Employee E3] made sure Resident R1 was safe and secured in her chair.</p> <p>Review of Nurse aide, Employee E3's written statement revealed while transferring [Resident R1] with another CNA [nurse aide, Employee E2] to her chair her left leg bent to her side.</p> <p>Interview with Nurse aide, Employee E2, on November 4, 2024, at 1:12 p.m., revealed that at the time of incident, Employee E2 was on orientation and unfamiliar with Resident R1's care related to transfers. Per Employee E2's report - she helped another nurse aide with transfer of Resident R1 from bed to geriatric chair during which time there were no incident, however Resident R1 started to complain of pain on left lower extremity immediately after transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nurse aide, Employee E3, on November 4, 2024, at 1:20 p.m., revealed that Employee E3 was not familiar with Resident R1's care related to transfers since she is not her regular nurse aide; per Employee E3's report Resident R1's left leg twisted inward during transfer from bed to chair.</p> <p>The facility failed to ensure that Resident R1 with a diagnosis of Osteoporosis was transferred in accordance with the resident's care plan via mechanical lift from bed to chair. This failure resulted in actual harm to Resident R1's whose left leg got bent and twisted and sustained a fracture of the left femur.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		