

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 01/08/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews with residents and staff, reviews of policies and procedures, nursing staffing assignments, pertinent human resource documents and the report form for investigation of alleged abuse, neglect, misappropriation of property (PB-22), it was determined that the facility failed to ensure that each resident was free from physical and mental abuse. (Resident R1) Findings include: A review of the facility policy titled abuse prevention program revealed that each resident at the facility had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicated that each resident had the right to be free from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. The policy indicated that the administrator was responsible for developing and implementing policies and procedures to prevent abuse, neglect or mistreatment of residents. The administrator was responsible for ensuring that staff were properly trained in abuse prevention, identification and reporting abuse and handling verbally or physically aggressive resident behavior. The administrator was also responsible for identifying and assessing all possible incidents of abuse. The administrator was also responsible for investigating and reporting any alleged allegations of abuse within required federal timeframes. A review of the policy titled procedure to conduct and report abuse revealed that all employees were mandated reporters and were required to report alleged abuse immediately to the supervisor on duty and a member of administration. The investigation was completed to determine the who, what, when, where, why and how the alleged abuse occurred. This abuse investigation was to be concluded within required timeframes. A documented summary of the finished investigation into the alleged abuse was filed at the facility and with the appropriate agencies according to protective services regulations. Clinical record review for Resident R1 revealed a comprehensive quarterly assessment (MDS-an assessment of care needs) dated September 28, 2025, that indicated this resident was understood (able to express ideas and wants) and had clear comprehension of others. The assessment indicated that Resident R1 had no functional limitations to upper and lower extremities. Resident R1 was using a manual wheelchair for mobility. The assessment indicated that Resident R1 was dependent on staff assistance to come to a standing position from sitting in a chair. The assessment also indicated that Resident R1 had diagnoses of cerebral vascular accident (stroke) and parkinsonism (a condition of symptoms of slowed movement, rigidity, tremor and balance issues). Clinical record review for Resident R1 revealed a physical therapy assessment dated [DATE], that indicated Resident R1 was not able to propel the wheelchair 150 feet. Interview with the physical therapist, Employee E3, at 10:00 a.m., on January 8, 2026, confirmed that due to the resident's decreased cognitive skills, Resident R1 was not capable of operating the wheelchair with full purpose. Clinical record review for Resident R1 indicated a care plan for the use of leg rests as needed for safe transportation with staff, while Resident R1 was seated in</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the wheelchair. Observations of resident R1 at 11:00 a.m., on January 8, 2026, revealed that this resident could propel herself in the wheelchair a short distance very slowly. A review of the Pennsylvania Department of Health report form for investigation of alleged abuse, neglect, misappropriation of property dated December 4, 2025, for the alleged abuse incident resulting in serious physical injury for Resident R1 revealed that this report contained a witness statement by a nursing assistant, Employee E5, that indicated Resident R1 was observed being pushed down the hallway on the back wheels of the manual wheelchair on December 2, 2025. The reportable event said that Resident R1 was removed from the common area/lounge during an activity for making disruptive foul statements during the planned activity. Interview with Employee E5, nursing assistant, at 10:30 a.m., on January 8, 2026, confirmed that Resident R1 was purposely angled backward in her wheelchair so that her feet were dangling and not able to touch the floor. The nursing assistant, Employee E6 had elevated the front two wheels of the chair in the air and reclined the wheelchair. Nursing assistant, Employee E6; restrained Resident R1 from normal use of the wheelchair with the hands and/or feet. Nursing assistant Employee E5 witnessed Resident R1 being wheeled down the hallway from the activities room at approximately 2:30 p.m., on December 2, 2024. Further interview with Employee E5 at 10:30 a.m., on January 8, 2026, revealed that Resident R1 was heard saying, while being pushed down the hallway by Employee E6 from the lounge/ activity area on December 2, 2025, that she did not want to go to her bedroom. Interview with Employee E5, nursing assistant, at 10:45 a.m., on January 8, 2026, revealed that after Resident R1 was placed in her room on December 2, 2025, by Employee E6. Nursing assistant, Employee E5 said that Resident R1 was found crying in her room at approximately 3:00 p.m., on December 2, 2025. The nursing assistant, Employee E5, also reported that Resident R1 told reported, at this time that that someone had bent her hand. Nursing assistant, Employee E5 also said that Resident R1 reported that if Employee E6, nursing assistant, comes back to take care of her, she was going to kill her with her gun. Interview with Employee E5 at 10:50 a.m., on January 8, 2026, confirmed that the event of alleged abuse of Resident R1 by Employee E6 on December 2, 2025, was not reported to the licensed or registered nurse on the 7 to 3 tours of duty or the 3 to 11 tours of duty as required by the facility's abuse prevention and investigation protocols. Clinical record review revealed that the registered nurse was called to assess Resident R1 with a painful and swollen left hand at 8:30 p.m., on December 2, 2025. The physician was notified and ordered an x-ray of the left hand and pain medication was administered at 8:30 p.m., on December 2, 2025. A review of the nursing schedules for December 3, 2025, revealed that Employee E6, was scheduled for work on the 7-to-3-day shift nursing assignment for the first-floor nursing unit. Resident R1 along with many other residents were living on the first-floor nursing unit. Clinical record review revealed that x-ray results were taken of Resident R1's left hand at 12:30 p.m. on December 3, 2025, and reported to the facility at 4:00 p.m., on December 3, 2025. Clinical record review revealed that on December 3, 2025, Resident R1 was sent to the hospital for further evaluation. The physician indicated being unaware that Resident R1 had fallen or sustained trauma. Observations and interview with Resident R1 at 11:30 a.m., on January 8, 2026, revealed that this resident was very upset and crying about her finger fracture. She said it was not painful right now, but it was painful. The resident reported that a staff member bent her hand backward causing the fracture. Resident R1 was not able to elaborate on the cause of the fracture in more detail. The registered nurse, Employee E11, told the resident that the person who was taking care of her when her finger was injured, no longer works at the facility. A review of the employee corrective action form for the nursing assistant Employee E6, revealed that the employee was discharged due to the severity of the infraction during resident care on December 4, 2025. Interview with the</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>administrator and director of nursing at 2:00 p.m., on January 8, 2026, revealed that the nursing assistant, Employee E6 was seen on camera footage on December 2, 2025, pushing Resident R1 from the lounge area at about 2:30 p.m., by improper use of the wheelchair without leg rests attached. The administrator and director of nursing reported that the camera footage showed Resident R1 trying to grab an object in the hallway to prevent herself from being wheeled into her room against her will. There was no documentation to indicate if Resident R1 was successful at grasping an object while being pushed unwillingly in the manual wheelchair down the hallway to her room. There was no documentation to indicate the probable cause of the serious injury (fractured left 4th proximal phalanx) of unknown origin that was sustained by Resident R1 under the care of the facility staff. 28 PA. Code 211.10 (a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(d)(1)(3)(5) Nursing services 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(d)(e)(1) Management</p>		