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	05/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, facility policies, facility documents, observations, and staff interviews, it was determined that the facility failed to ensure the safety and adequate supervision and ensure that safety devices were in place for five of six residents reviewed for risk of wandering and elopement. (Residents 122, R21, and R39).Findings include: Review of facility policy titled Elopement of a Resident, last revised 12/17/2025, outlines procedures to ensure resident safety and prevent elopement, particularly for residents with dementia or cognitive impairment. The policy requires elopement risk assessments upon admission, family interviews, resident photographs in the medical record, Wander Guards for at-risk residents, and individualized care plans to address wandering behaviors. The policy also establishes procedures for responding to a missing resident, including staff search assignments, use of resident photographs, notification of leadership, police, SEPTA (public bus transportation system), and family members, and completion of required documentation and state reporting. The revised policy further identifies assigning staff-specific responsibilities during an elopement event, such as contacting hospitals and coordinating search efforts. Record review for Resident R122 revealed the resident was admitted on [DATE] with diagnoses including dementia, (a progressive decline in memory and cognitive functioning; probable Alzheimer's disease, a neurodegenerative brain disorder affecting memory, thinking, and behavior) Nursing documentation dated 07/02/2025 identified Resident R122 as having a history of elopement while at home. Additional nursing documentation dated 07/03/2025 indicated the resident required frequent redirection and was being monitored by nursing staff due to elopement risk. Documentation dated 07/04/2025 noted a Wander Guard was applied to the resident's ankle for safety monitoring. Review of the resident's Minimum Data Set (MDS- assessment of resident's care needs) dated July 2, 2026, revealed the resident was admitted to the facility on [DATE], and discharged to the hospital on July 7, 2026. The resident was assessed with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment and significant loss of cognition. Diagnoses included anxiety disorder. Further review of the resident's clinical record revealed additional diagnoses including suicidal ideation (thoughts of self-harm or suicide); and unsteadiness on feet, (impaired balance or gait instability increasing risk for falls). Review of July 2025 physician's order revealed an order dated July 4, 2026, for the use of a Wander Guard (device placed on a person's wrist or ankle which activates the door locking mechanism to the outside) to resident's right ankle for safety monitoring. Review of the investigation revealed that on July 7,2025 at approximately 6:30 p.m. staff became aware that the resident was missing from the unit after last being observed at approximately 6:20 p.m. sitting in the second-floor lounge. The receptionist reviewed security cameras and observed the resident walking toward a trail located near the parking lot. At approximately 7:30 p.m., the resident was found by nursing staff sitting in bushes along the trail and was escorted safely back to the facility. No injuries were noted and vital signs were stable. Staff interviews indicated that once the resident was discovered missing, an alert was initiated and staff began searching the facility and surrounding grounds. The receptionist identified the resident on camera and reported seeing the resident walking (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

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	05/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toward the trail. A nurse located the resident sitting on the ground between trees, where the resident stated she shouldn't have done this and asked for help. Review of investigation statement of nurse aid Employee E18, stated the resident had been walking freely on the unit prior to the incident and that no alarms sounded despite the resident reportedly having a wander guard sensor device. Documentation reviewed indicated the resident was placed on one-to-one monitoring following the incident. Review of door and stairwell alarm checklists indicated alarms were documented as on and functioning at the time of review. The investigation did not identify how the resident exited the facility. Top of Form Bottom of FormReview of the Resident R21's quarterly MDS dated [DATE], revealed the resident was admitted to the facility on [DATE]. The resident was assessed with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment and significant loss of cognition. The resident utilized both a wheelchair and walker for mobility and had diagnoses including Dementia, and depression (a mood disorder characterized by persistent sadness, loss of interest, and decreased functioning). The assessment further indicated the resident had a Wander Guard elopement alarm in place for resident safety. Review of Resident 39's quarterly MDS dated [DATE], revealed the resident was admitted to the facility on [DATE]. The resident was assessed with a Brief Interview for Mental Status (BIMS) score of 6 indicating indicates severe cognitive impairment. The resident utilized a walker for ambulation and had diagnoses including Alzheimer's disease dementia, a progressive neurodegenerative disorder causing worsening memory loss, cognitive decline, and impaired daily functioning, and psychotic disorder (a mental health condition characterized by a loss of contact with reality, which may include hallucinations, delusions, or disorganized thinking). The assessment further indicated the resident had a Wander Guard in place for resident safety. Observations conducted on May 5, 2026, at 2:00 p.m. in the second-floor resident lounge during an activity revealed Resident R21 and Resident R39 were observed without a Wander Guard device in place. This finding was confirmed by Nurse aides, Employees E15 and E16 who stated they were unable to locate the Wander Guards. Observation on May 5, 2026, at 02:45 p.m. identified multiple unsecured exit points within the facility. In the first-floor lounge, a glass sliding door was observed unsecured and without a lock or alarm system. This observation was confirmed by the Nursing Home Administrator (NHA) at the time of the observation. The NHA acknowledged that anyone could enter or exit through the door without restriction, he stated he was unaware the door opened. The stairwells accessible from the resident floors, including areas housing residents with dementia, were also observed to be unsecured. These stairwells provided direct access to the first-floor lobby area, where supervision consisted of a receptionist present only until 9:00 p.m. Further observation on May 6, 2025 at 10:00 am on the first-floor nursing unit there was a wheelchair observed with a Wander guard but Resident R22 was not seen. Identified a resident's walker with a Wander Guard attached; however, the resident was not within sight at the time. Staff confirmed the residents were independently ambulatory. Interview with The Director of Nursing (DON), Employee E2 on May 7, 2026, at 10:25 a.m. revealed that Resident R 22 stated the Wander Guard attached to the walker was not intended for elopement tracking purposes, but rather served only as a reminder device for the resident. 28 Pa. Code 211.10 (c)Care Plan Policies 28 PA Code 211.12(d)(1)(5) Nursing services

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on policy review and record review, the facility failed to implement an effective and comprehensive water management program necessary to identify, monitor, control, and reduce hazardous conditions supporting the growth and spread of Legionella within the facility water system and failed to ensure proper infection control practices during the administration of eye drops for one of one resident observed. (Resident R101)Findings inlcude: Review of the CDC (Center for Disease Control and Prevention- a major public health agency in the United States that works to: Monitor and track diseases (like flu, COVID-19, etc.) ,Prevent outbreaks and health threats ,Provide health guidelines and research ,and Respond to emergencies (pandemics, natural disasters, bioterrorism) recommends that healthcare facilities implement a water management program to reduce the risk of Legionella growth and prevent Legionnaires' disease. The program should include a multidisciplinary team, identification of all water systems, and assessment of conditions that may promote bacterial growth such as stagnant water, improper temperatures, and low disinfectant levels. Facilities must establish control measures, monitor water systems regularly, and document temperatures, disinfectant levels, flushing, and maintenance activities. When issues are identified, corrective actions such as flushing, disinfection, or system adjustments should be taken promptly. The program should also include routine verification and review to ensure effectiveness, staff education, and updates following system changes or outbreaks, with special attention to high-risk populations such as elderly or medically vulnerable residents. Review of the facility's revised January 2024 Water Management Program policy showed the program was intended to reduce the risk of Legionella and other waterborne pathogens. The policy identified a water management team, recognized the facility's high-risk resident population, and listed potential sources and conditions that could promote Legionella growth. However, the facility failed to implement a comprehensive operational program. The policy did not establish measurable control limits for temperature, disinfectant levels, pH, or other monitoring parameters, and it lacked defined corrective actions for abnormal findings or positive Legionella results. The facility also failed to provide evidence of routine monitoring, maintenance records, water quality testing, flushing schedules, or completed logs. In addition, there was no evidence of program validation or verification activities such as audits, environmental testing, trend analysis, or annual evaluations. The facility also failed to demonstrate staff training, assigned responsibilities, or competency related to water management procedures. Lastly, the program lacked a detailed hazard analysis and building-specific risk assessment identifying high-risk areas and control points within the water system. Interview with the Maintenance Director and Regional Director on May 7, 2026, confirmed that the current program did not meet required standards. Both individuals acknowledged understanding of the requirements moving forward but were unable to describe the building's water system, identify potential high-risk hot spots, or explain what testing and preventive measures are in place to monitor and control Legionella risk. Observation on Resident R101 conducted on March 4, 2026, at 10:23 AM during medication administration revealed Licensed Nurse, Employee E4 administered the eye medication Muro 128 Ophthalmic Solution 2% (Sodium Chloride Hypertonic), 1 drop into the resident's left eye while wearing gloves. Further observation revealed Licensed Nurse, Employee E4 did not remove gloves or perform hand hygiene prior to obtaining the resident's blood pressure, touching the blood pressure machine with the same gloves. No hand hygiene was performed between administering the eye drops and use of the blood pressure equipment. Licensed Nurse E4, placed Resident R101 eyeglasses back on the resident's face wearing the same gloves. Further observation revealed Licensed Nurse, Employee E4 continued medication administration, including oral medications, while wearing the same gloves used for eye drop administration and blood pressure measurement. Interview with Licensed Nurse E4 confirmed she/he did not change gloves during the medication administration process. 28 Pa. Code 204.19 Plumbing, heating, Ventilation, air condition and electrical 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 211.12 (d)(1) Nursing services

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	05/07/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, clinical records and staff interviews, it was determined that the facility failed to ensure an appropriate, safe, and properly documented discharge process for 1 of 2 residents reviewed for discharge practices (Resident R 118). Findings include:Review of facility policy titled Transfer or Discharge Documentation dated December 2016, stated residents have the right to remain in the facility unless discharge is necessary because the facility cannot meet the resident's needs, the resident's condition has improved sufficiently, the resident poses a danger to the safety or health of others, nonpayment occurs, or the facility ceases operation. The policy further requires documentation supporting the reason for discharge, physician documentation related to safety concerns or unmet needs, documentation of attempts to meet resident needs, and communication of all necessary information to ensure a safe and effective transition of care. Review of the Resident R 118's Minimum Data Set (MDS- assessment of resident's needs) dated March 28, 2026, revealed the resident was admitted to the facility on [DATE], following hospitalization for acute on chronic congestive heart failure (condition in which the heart does not pump blood effectively causing fluid buildup and fatigue). Continued review of the MDS revealed that the resident was diagnosed was Alzheimer's disease, (a progressive brain disorder affecting memory, thinking, and daily functioning); congestive heart failure; atrial fibrillation, (an irregular and often rapid heart rhythm that increases the risk of stroke); hypertension, (high blood pressure); hyperlipidemia (elevated cholesterol or fat levels in the blood); obstructive sleep apnea, (a sleep disorder causing repeated interruptions in breathing during sleep); ventricular tachycardia (potentially serious rapid heart rhythm originating in the lower chambers of the heart); and prostate cancer. The resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment and required partial assistance with transfers, mobility, toileting, dressing, bathing, and bed mobility. The resident was receiving physical and occupational therapy services. The MDS documented physical behavioral symptoms directed toward others occurring 1-3 days during the assessment period. Review of the social service note dated March 27, 2026, revealed plans for discharge home on March 28, 2026 with home care services and family transportation. Review of the discharge plan dated March 27, 2026 revealed referral information for community services and visiting nurse services; however, the form was not signed by the resident or responsible party. Review of the physician discharge summary revealed the resident was discharged on March 28, 2026 after a four-day stay with diagnoses including acute on chronic systolic congestive heart failure, hypertension, Alzheimer's disease, atrial fibrillation, and prostate cancer. The discharge summary stated the resident completed his stay and would return home; however, there was no documentation explaining why the resident's skilled rehabilitation stay ended after four days, no evidence the resident met therapy goals, and no physician documentation indicating the resident posed a danger to others or required involuntary discharge. Review of nursing documentation dated 3/28/26 revealed the resident was discharged home with family transportation and medication reconciliation completed. Review of the clinical record failed to identify documentation that the resident or representative requested discharge, failed to identify documentation that the resident was informed of appeal rights, and failed to identify evidence supporting that discharge criteria outlined in facility policy were met. During staff interview, Social Services employee E 11 stated the resident was discharged due to behavior. However, the facility failed to document that the behaviors endangered the health or safety of others, failed to demonstrate attempts to manage the behaviors within the facility, and failed to provide physician documentation supporting discharge related to behavioral concerns. The facility's documentation describing the resident as cooperative, stable, and adjusting well conflicted with interview statements indicating the resident was discharged due to behaviors. Interview with the Nursing Home (continued on next page)

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	05/07/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator Employee E1 on May 7, 2026, at 12:20 p.m. revealed that the resident was discharged due to aggressive behaviors; however, the administrator confirmed there was no documentation in the clinical record to support this stated reason for discharge. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18 (1)(e) Management