

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395413</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/07/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>WESLEY ENHANCED LIVING PENNYPACK PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>8401 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19152</b>
STATE LICENSE NUMBER: <b>311202</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0626	<p>Based on an Abbreviated Survey in response to one complaint completed on April 7, 2025, it was determined that Wesley Enhanced Living Pennypack Park was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.</p>	F 0626		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0626  SS=D	Continued from page 1  483.15(e)(1)(2) Permitting Residents to Return to Facility  §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.  §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed	F 0626	The facility does and shall ensure to permit residents to return to the facility after hospitalization/therapeutic leave. The facility does and shall ensure to follow the bed hold policy permitting residents to return to the facility after hospitalization/therapeutic leave. The facility does and shall ensure to document conversations with the hospital and family regarding transfer back to the facility. Monitoring/random review will be conducted by admission director or Designee and social services 1 time weekly for 3 months with findings reported to the CQI Committee for a period deemed appropriate by the CQI Committee.	Completion Date: <b>05/02/2025</b> Status: <b>APPROVED</b> Date: <b>05/01/2025</b>

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F 0626  SS=D	Continued from page 2  there.  This REQUIREMENT is not met as evidenced by:	F 0626		

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F 0626  SS=D	Continued from page 3  Based on staff interviews, review of facility policy and review of clinical records, it was determined that the facility failed to re-admit a resident back into the facility after a change in condition for 1 out of 5 residents reviewed (Resident R1).  Findings include:  Review of the facility policy, "Transfer or Discharge, Facility-Initiated," with a revision dated of October 2022, indicated that if the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include, but not limited to: the specific resident needs that cannot be met; the facility's attempt to meet those needs; the receiving facility's service(s) that are available to meet those needs, and that an appropriate notice was provided to	F 0626		

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F 0626  SS=D	Continued from page 4  the resident and/or legal representative from the facility.  Review of the March 2024 physician orders for Resident R1 included the following diagnoses: morbid obesity; transient cerebral ischemic attack (a brief stroke-like attack); hypertension (high blood pressure); cognitive communication deficits; diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and a urinary tract infection. Resident was also being treated at the facility for anxiety (intense, excessive and persistent worry and fear about everyday situations); visual hallucinations (seeing people, places and things that do not exist), and disorientation.  Review of multidisciplinary notes from	F 0626		

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F 0626  SS=D	Continued from page 5  January 14, 2024 through March 3, 2025 documented various behaviors that included, but were not limited to, kicking staff, scratching staff, yelling, "screaming uncontrollably and unprovoked." Refusing meals and having a poor appetite, refusing medications, punching staff, hitting other residents; Resident noted with increased anxiety, trying to climb out of bed, taking his diaper and clothes off, and biting staff.  Review of nursing note dated March 3, 2025 at 7:13 p.m. described the resident as being very aggressive, trying to hit other residents in the common area, trying to get out of wheelchair, and making loud noises. The note indicated that staff tried to redirect him, and offered snacks, but the resident did not calm down. The nursing note indicated that physician was	F 0626		

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F 0626  SS=D	Continued from page 6  contacted and advised the facility to send the resident out to the hospital.  Review of a nursing note dated March 3, 2025 at 9:15 p.m. indicated that the resident when the transferred out to the hospital, was very combative and tried to bite the attendants who arrived to take him to the hospital.  Review of a nursing note dated March 3, 2025 at 4:13 a.m. indicated that the nurse spoke to the nurse at the hospital and was informed that the resident was admitted with Acute kidney injury.  Review of hospital records dated March 3, 2025 indicated that labs were performed on the resident and that he was being treated for a urinary track infection.	F 0626		

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F 0626  SS=D	Continued from page 7  Information provided by the hospital and reported to the State Survey Agency on March 14, 2025 indicated that the facility refused to accept the resident back after the facility reported to the hospital that the resident could not be admitted back to the facility if he was still required the use of Haldol (a medication that he was treated with during a a portion of his stay in the hospital) and if he still required the use of physical restraints. The hospital reported that upon the hospital's attempt to discharge the resident back to the facility on March 12, 2025, the resident no longer required the use of Haldol and had been off physical restraints for more that 60 hours prior to March 12, 2025.  Review of hospital records written by the hospital social worker on March 12, 2025 at 11:07 a.m. documented that the patient	F 0626		

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F 0626  SS=D	Continued from page 8  had been off restraints for over 48 hours and that the hospital social worker arranged transportation for the resident to return to the facility at 1:00 pm. on March 12, 2025. The hospital social worker's note also indicated that she notified the facility regarding the resident's return. "SW made pt team & facility aware."  Review of a hospital note written by the hospital social worker on March 12, 2025 at 1:23 p.m., documented that she was notified by the facility's admission director (Employee E4) that the facility Nursing Home Administrator (NHA) was not happy that the resident was coming back to the facility on the above referenced date due to the resident being on restraints and being treated with the medication, Haldol. Continued review of the hospital social worker's	F 0626		

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F 0626  SS=D	Continued from page 9  documentation indicated that the social worker informed the facility admission director that the information was untrue and asked the facility's admission director to review the chart again and to inform the hospital social worker of where it stated that the resident is currently being administered Haldol, and on physical restraints. The hospital social worker reported that the facility admission's director informed her that if the resident is returned to the facility, the facility will send him back to the hospital. Continued review of hospital documentation on March 12, 2025, at 1:23 p.m. indicated that the facility admission's director contacted the hospital social worker and reported that the facility's Director of Nursing (DON) did not think the resident was stable because the hospital did not have 3 nursing notes a day stating the	F 0626		

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F 0626  SS=D	Continued from page 10  resident was stable. The hospital social worker documented in her progress note that that the facility's admission director stated, "that's not good enough" when the hospital social worker informed the facility admission director that the resident was medically stable.  Review of a hospital's physician note dated March 13, 2025 at 8:31 a.m. documented, "Pt was medically stable for discharge for several days prior to DC Was off restraints >60 hours at time of discharge." The physician's continued documentation stated, "the director of nursing refused to re-admit the resident due to "inadequate documentation" of lack of restraints.  Review of the clinical record did not show evidence of any documentation, as	F 0626		

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F 0626  SS=D	Continued from page 11  required from March 3, 2025 through March 12, 2025 indicating that the facility was not able to meet the resident's needs or and what the needs were, if they were unable to meet them.  Continued review of the resident's clinical record at the facility did not show evidence of documentation from the facility indicating that the facility collaborated with the hospital related to the facility not be able to meet his needs.  During an interview with the Director of Nursing (DON) on March 27, 2025 at 4:34 p.m. the DON confirmed that she notified nursing staff to send the resident back to the hospital when the hospital transported the resident back to the facility on March 12, 2025. The DON reported during the above-referenced interview that she had	F 0626		

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F 0626  SS=D	Continued from page 12  hospital records for the resident(e.g. physician notes, social worker notes, other multi-disciplinary notes, etc), but that she wanted to see the hospital nursing notes and reported that she did not have access to the nursing notes.  During an interview with the NHA and the DON on April 7, 2025, at 2:15 p.m. it was discussed that the facility did not allow the resident to be re-admitted to the facility and had no documentation, as required to show that they collaborated with the hospital during the time that they resident was admitted prior to making the decision that he could not return to the facility.  28 Pa Code 201.18(a) Management  28 Pa Code 201.18(b)(1) Management	F 0626		

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F 0626  SS=D	Continued from page 13  28 Pa Code 201.18 (b) (2) Management  28 Pa. Code 201.24(b) Admission  28. Pa Code 201.29(a) Resident rights  28 Pa Code 201.29 (f) Resident rights  28 Pa Code 201.29 (g) Resident rights  28 Pa Code 201.29 (j) Resident rights  28 Pa Code 201.25 (a) Discharge policy	F 0626		
F 0656  SS=D		F 0656		

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F 0656  SS=D	Continued from page 14  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	The facility does and shall develop and implement comprehensive person-centered care plans for each resident, that includes measurable objectives and timeframes also consistent with the residents' rights to meet resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The facility does and shall ensure that comprehensive care plan is culturally competent. All residents comprehensive care plan will be reviewed, to ensure they are comprehensive and include any interventions deemed necessary. All nursing staff have/will be educated on proper comprehensive care planning and importance of ongoing care plan updates to ensure most effective and contemporary. Monitoring/random review of comprehensive care plans will be conducted 1 time weekly for 3 months with findings reported to the CQI Committee for a period deemed appropriate by the CQI Committee. Monitoring/random review of comprehensive care will be	Completion Date: <b>05/02/2025</b> Status: <b>APPROVED</b> Date: <b>05/01/2025</b>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=D	Continued from page 15  discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:	F 0656	conducted 1 time weekly for 3 months with findings reported to the CQI Committee for a period deemed appropriate by the CQI Committee	

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F 0656  SS=D	Continued from page 16  Based on staff interviews and the review of clinical records, it as determined that the facility failed develop a person-centered plan of care for behaviors and refusal of medications for 1 out of 2 residents reviewed (Resident R1).  Findings include:  Review of the March 2024 physician orders for Resident R1 included the diagnoses of morbid obesity; transient cerebral ischemic attack (a brief stroke-like attack); hypertension (high blood pressure); cognitive communication deficits; diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and a urinary tract infection. Resident was also being treated at the facility for anxiety (intense, excessive and persistent worry and fear	F 0656		

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F 0656  SS=D	Continued from page 17  about everyday situations); visual hallucinations (seeing people, places and things that do not exist), and disorientation.  Review of multidisciplinary notes from January 14, 2025 through March 3, 2025 documented various behaviors that included, kicking staff, scratching staff, yelling, "screaming uncontrollably and unprovoked." "Refusing meals and having a poor appetite, refusing medications, punching staff, hitting other residents; Resident noted with increased anxiety, trying to climbing out of bed, taking his diaper and clothes off, and biting staff."  Review of nursing notes date January 25, 2025 at 10:41 p.m. revealed that at 10:41 a.m the resident was anxious, making loud noises and shouted at staff.	F 0656		

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F 0656  SS=D	Continued from page 18  Nursing note dated January 27, 2025 at 10:15 p.m. revealed that the resident was confused and lethargic, and was sent out to the hospital at 10:15 p.m. Continued review of nursing notes dated January 28, 2025 p.m. at 4:44 a.m. revealed that the resident returned to the facility at 4:24 a.m. with no new orders.  Nursing note dated 1/30/2025 at 12:18 a.m. the resident was in the hallway yelling that he wanted to go home. On the same date at 12:36 a.m. the resident was still yelling, was anxious, and refused to go to bed. At 4:51 a.m. the administration of the resident's prn (as needed) medication used to help manage his anxiety was ineffective and nursing staff contact the resident's wife to assist with calming him down.	F 0656		

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F 0656  SS=D	Continued from page 19  Nursing note dated 2/1/2025 at 2:33 p.m. the resident refused all oral medications.  Nursing note dated 2/7/2025 at 2:47 a.m. the resident was anxious, unable to sit in the chair, would not to stay in bed and when he was in bed he was climbing out of bed and when nursing staff put him in his chair he want to go back to bed. "Very difficult to redirect." At 6:42 a.m. Resident continues on 1 hour checks due to multiple behaviors. Resident was noted as yelling out and screaming.  Nursing note dated 2/8/2025 at 12:45 a.m. - Resident noted with increased anxiety, Restlessness, climbing out of bed, staff talk and listen, toileting done. Staff members assisted him in to the w/c	F 0656		

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F 0656  SS=D	Continued from page 20  (wheelchair) and brought him out to the common area with staff supervision.  Nursing note dated 2/13/2025 at 2:36 p.m. - Resident had random outbursts of yelling and was hard to redirect at this time. At 4:52 a.m. Resident noted with behavior and had to be redirected Resident constantly tries to get up and move. He could not settle in bed to sleep. Staff brought him to the common area sat with him offered snacks Staff. Resident continues to scream uncontrollably and unprovoked.  Nursing note dated 3/3/2025 at 5:10 a.m. the resident was combative during care scratch staff. At 4:46 p.m. the resident was calling out and trying to get out of wheelchair. The resident wanted to go home and was	F 0656		

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F 0656  SS=D	Continued from page 21  making loud noises. At 7:13 p.m. the resident was described as being very aggressive, trying to hit other residents in the common area, trying to get out of wheelchair, and making loud noises. The note indicated that the staff tried to redirect him, and offered snacks, but the resident did not calm down. The physician was contacted and advised the facility to send the resident out to the hospital.  Review of the resident's person-centered plan of did not include a plan of care for the management of the resident's behaviors to ensure appropriate care and interventions are utilized to prevent behaviors from occurring and/or the management behaviors.  During an interview with the Unit Manager	F 0656		

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F 0656  SS=D	Continued from page 22  (Employee E3) on March 27, 2025 at 3:25 p.m. the Unit Manager confirmed that there was no person-centered plan of care to address and management the resident's behaviors.  28 Pa Code 211.10(c) Resident care policies  28 Pa Code 211.10(d) Resident care policies  28 Pa Code 211.11(d) Resident care plan  28 Pa. Code 211.12(c)Nursing services  28 Pa. Code 211.12(d)(1) Nursing services  28 Pa. Code 211.12(d)(3) Nursing services	F 0656		

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F 0656  SS=D	Continued from page 23  28 Pa. Code 211.12(d)(5) Nursing services	F 0656			
F 0770  SS=D		F 0770			

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F 0770  SS=D	Continued from page 24  483.50(a)(1)(i) Laboratory Services  §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.  This REQUIREMENT is not met as evidenced by:	F 0770	The Facility does and shall ensure that routine and emergency Lab services were provided for all residents to meet their health needs. All residents will be reviewed for Lab orders to meet health needs.  Education has been done.  All nursing staff have/will be educated regarding timely lab services for all residents.  Monitoring and random check will be conducted by supervisors/Unit Managers. once a day for 2 weeks and 1 time a week for 6 weeks.  Findings and on-going monitoring will be reported to the CQI Committee for a period deemed appropriated by the CQI Committee.  Monitor: Unit Managers/shift Supervisor/DON	Completion Date: <b>05/02/2025</b> Status: <b>APPROVED</b> Date: <b>05/01/2025</b>

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F 0770  SS=D	Continued from page 25  Based on staff interviews and the review of clinical records, it was determined that the facility failed to ensure that physician orders were followed and recommendations were addressed regarding obtaining labs to ensure appropriate care and services could be provided for 1 out of 2 residents reviewed (Resident R1).  Findings include:  Review of a physician's note dated January 14, 2025 at 9:41 p.m. indicated that the resident was admitted to the facility on January 13, 2025 from a local hospital after being brought to the hospital by his wife after exhibiting signs of increased confusion at home. The resident was subsequently diagnosed with acute encephalopathy (damage or disease that	F 0770		

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F 0770  SS=D	Continued from page 26  affects the brain that lead to an altered mental status) and a urinary tract infection. The resident was transferred to the facility for rehabilitation services once discharged from the hospital.  Review of the March 2024 physician orders for Resident R1 included the following diagnoses: morbid obesity; transient cerebral ischemic attack (a brief stroke-like attack); hypertension (high blood pressure); cognitive communication deficits; diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and a urinary tract infection. Resident was also being treated at the facility for anxiety (intense, excessive and persistent worry and fear about everyday situations); visual hallucinations (seeing people, places and things that do not exist), and	F 0770		

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F 0770  SS=D	Continued from page 27  disorientation.  Review of multidisciplinary notes from January 14, 2025 through March 3, 2025 documented various behaviors that included, kicking staff, scratching staff, yelling, "screaming uncontrollably and unprovoked." Refusing meals and having a poor appetite, refusing medications, punching staff, hitting other residents; Resident noted with increased anxiety, trying to climbing out of bed, taking his diaper and clothes off, and biting staff.  During an visit with the psychiatric nurse practioner on January 24, 2025 at 4:06 p.m. the nurse practitioner reported that she was seeing the resident due to facility concerns with his behavior. The nurse practitioner indicated in her assessment that the resident had a history of UTI with	F 0770		

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F 0770  SS=D	Continued from page 28  delirium and presented to her with reports of visual hallucinations, agitation, anxiety, and restlessness. Recommendations made by the nurse practitioner included the facility obtaining labs on the resident for further assessment of the resident. "Collect U/A, CBC. CMP, to rule out infectious or metabolic cause of patient's mental status."  Review of nursing notes from January 24, 2025, through January 31, 2025 indicated that resident's behavior continued and included but was not limited to the following:  1/25/2025 at 10:41 p.m. nursing note indicated that at 10:41 a.m indicated that the resident was anxious, making loud noises and shouted at staff	F 0770		

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F 0770  SS=D	Continued from page 29  1/27/2025 at 10: 15 p.m. the resident was noted with confused and was lethargic, and was sent out to the hospital at 10:15 p.m. and per a nursing note dated returned on 1/28/2025 p.m. at 4:44 a.m. the resident returned to the facility at 4:24 a.m. with no new orders.  1/30/2025 at 12:18 a.m. the resident was in the hallway yelling that he wanted to go home.  1/30/2025 at 12:36 a.m. the resident was still yelling, was anxious, and refused to go to bed.  1/30at 4:51 a.m. - the administration of the resident's prn (as needed) medication used to help manage his anxiety was ineffective and nursing staff contact the resident's wife to assist with calming him	F 0770		

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F 0770  SS=D	Continued from page 30  down.  Review of the nurse practitioner's note on January 31, 2025 at 1:30 p.m. after her visit with the resident, the nurse practitioner documented that the urine analysis lab work that she recommended during her January 24, 2025 visit had not been done. "U/A not collected per previous recommendation- can reconsider to rule out that this is not a delirium related to an unresolved UTI." The nurse practitioner's recommendation for the January 31, 2025 visit included completing a urine analysis on the resident. "Reconsider collecting U/A."  Review of a note dated February 14, 2025 at 9:43 p.m. by the psychiatric nurse practitioner who visited with the resident indicated that the residents assessment	F 0770		

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F 0770  SS=D	Continued from page 31  remains unchanged from her last visit (January 31, 2025).....The nurse practitioner also asked the facility to reconsider obtain a urine analysis on the resident. "Reconsider collecting U/A to rule out all possible causes of patient's current mental status."  Review of nursing notes from February 14, 2025, through March 3, 2025 when resident was discharged to the hospital, indicated that the resident's behaviors continued as follows:  3/3/2025 at 5:10 a.m. the resident was combative during care scratch staff.  3/3/2025 at 4:46 p.m. the resident was calling out and trying to get out of wheelchair. The resident wanted to go home and was making loud noises.	F 0770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395413</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/07/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>WESLEY ENHANCED LIVING PENNYPACK PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>8401 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19152</b>		
STATE LICENSE NUMBER: <b>311202</b>				
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F 0770  SS=D	Continued from page 32  3/3/2025 at 7:13 p.m. the resident was described as being very aggressive, trying to hit other residents in the common area, trying to get out of wheelchair, and making loud noises. The note indicated that the staff tried to redirect him, and offered snacks, but the resident did not calm down. The physician was contacted and advised the facility to send the resident out to the hospital.  3/3/2026 at 9: 15 p.m. the resident was transferred out to the hospital, was very combative and tried to bite the attendants who arrived to take him to the hospital.  3/4/2025 at 4:13 a.m. a follow up call to the spoke ER nurse indicated that the resident was admitted with Acute kidney injury.	F 0770		

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NAME OF PROVIDER OR SUPPLIER: <b>WESLEY ENHANCED LIVING PENNYPACK PARK</b>  STATE LICENSE NUMBER: <b>311202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>8401 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19152</b>		
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F 0770  SS=D	<p>Continued from page 33</p> <p>Review of hospital records dated 3/3/4 indicated that labs were performed on the resident and that he was being treated for a urinary trac infection.</p> <p>Review of the January 2025 physician's order dated January 21, 2025 included a physician's order for the resident to have urine analysis/culture and sensitivity related to symptoms of a urinary trac infections. "u/a C&amp;S dx uti symptoms. 1/21/25.</p> <p>Continued review of the clinical record did not show evidence that this was completed, as ordered.</p> <p>Review of the resident's clinical record did not show evidence that the facility addressed the nurse practitioner's</p>	F 0770		

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F 0770  SS=D	Continued from page 34  recommendations of obtaining the above referenced labs on the resident when she visited on January 24, 2025, January 31, 2025 and February 14, 2025.  During an interview on March 27, 2025 at 2:53 p.m. with the Unit Manager it was confirmed that the urine analysis that was ordered on January 21, 2025 by the physician was not completed. It was also confirmed that the urine analysis that was recommended by the nurse practitioner on January 24, 2025, January 31, 2025 and February 14, 2025 were not addressed by the facility.  28 Pa. Code 211.12(d)(1) Nursing services  28 Pa. Code 211.12(d)(3) Nursing services	F 0770		

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F 0770  SS=D	Continued from page 35  28 Pa. Code 211.12(d)(5) Nursing services	F 0770		
F 0840  SS=D		F 0840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395413</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/07/2025</b>
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F 0840  SS=D	Continued from page 36  483.70(f)(1)(2) Use of Outside Resources  §483.70(f) Use of outside resources. §483.70(f)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.  §483.70(f)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.  This REQUIREMENT is not met as evidenced by:	F 0840	The Facility does and shall ensure that endocrinologist services were provided for all residents to meet their spatialized health needs.  All nursing staff have/will be educated regarding timely dental services for all residents.  Monitoring and random check will be conducted by supervisors/Unit Managers. once a day for 2 weeks and 1 time a week for 6 weeks.  Findings and on-going monitoring will be reported to the CQI Committee for a period deemed appropriated by the CQI Committee.  Monitor: Unit Managers/shift Supervisor/DON	Completion Date: <b>05/02/2025</b> Status: <b>APPROVED</b> Date: <b>05/01/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395413</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/07/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>WESLEY ENHANCED LIVING PENNYPACK PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>8401 ROOSEVELT BOULEVARD PHILADELPHIA, PA 19152</b>		
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F 0840  SS=D	Continued from page 37  Based on staff interviews and review of clinical records, it was determined that the facility failed to ensure that a recommendation for a resident to be seen by an endocrinologist was addressed for 1 out of 2 residents reviewed (Resident R1).  Findings include:  Review of multi-disciplinary notes indicated that the resident had a visit that the resident had with the facility endocrinologist (a physician who specializes in the treatment of diagnosis, such as diabetes) on January 27, 2025 at 1:06 p.m. Recommendations to the residents current treatment plan were made. Continued review of the clinical notes from the endocrinologist indicated that the endocrinologist would follow up with the resident in 2-4 weeks and that the facility could contact the endocrinologist sooner with any questions, concerns, or any changes in the resident's health care status related to diabetes. "Will follow up in 2-4 weeks. Please email [name of office] sooner with any questions,	F 0840		

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F 0840  SS=D	Continued from page 38  concerns or changed in the pts's DM (Diabetes Melittus) control."  Review of multidisciplinary notes from January 14, 2025 through March 3, 2025 documented various behaviors that included, kicking staff, scratching staff, yelling, "screaming uncontrollably and unprovoked." Refusing meals and having a poor appetite, punching staff, hitting other residents; Resident noted with increased anxiety, trying to climbing out of bed, taking his diaper and clothes off, biting staff and refusing his medications, including medication related to the management of his diabetes.  Review of a note dated February 14, 2025 at 9:43 p.m. by the psychiatric nurse practitioner who visited with the resident indicated that staff reported to her that the resident is worse when his blood sugars are low. The nurse practioner recommended that the facility consult endocrinology, as low blood sugars may be the cause of the resident's behavior." Advisable to consult endocrinology as it is possible	F 0840		

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F 0840  SS=D	<p>Continued from page 39</p> <p>this may be leading to patient's presentation. Frequent checking of patient's blood sugar is advisable as medications that address patient's AMS (altered mental status) may mask symptoms of hypoglycemia. Continue to rule out medical causes of patient's AMS as you are." The nurse practitioner also asked the facility to reconsider obtain a urinal analysis on the resident. "Reconsider collecting U/A (urinalysis) to rule out all possible causes of patient's current mental status."</p> <p>Review of the clinical record did not show evidence that this recommendation was addressed by nursing staff, as there was no appointment scheduled for Resident R1 to see the endocrinologist or any other indication that nursing staff contacted the endocrinologist.</p> <p>During a interview with the Director of Nursing (DON) on April 7, 2025 at 2:10 p.m. regarding the recommendation made by the psychiatric nurse practitioner on February 13, 2025 and no evidence that the recommendation was addressed, or the</p>	F 0840		

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F 0840  SS=D	Continued from page 40  endocrinologist contacted regarding concerns related to the resident's diabetes management. The DON reported that the endocrinologist was not at the facility every day, and only comes to the facility on certain days.  28 Pa. Code 211.10(c) Resident care policies  28 Pa. Code 211.12(d)(1)(3)(5) Nusing services	F 0840			



# Certified End Page

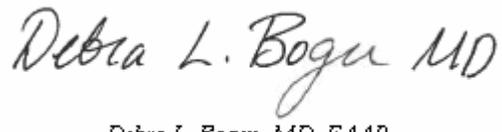
**WESLEY ENHANCED LIVING PENNYPACK PARK**

**STATE LICENSE NUMBER: 311202**

**SURVEY EXIT DATE: 04/07/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY