

Department of Human Services  
Bureau of Human Service Licensing

September 30, 2021

██████████ ASSISTANT REGIONAL DIRECTOR  
CARELINK COMMUNITY SUPPORT SERVICES OF PENNSYLVANIA  
605 EAST BALTIMORE PIKE  
MEDIA, PA 19063

RE: CARELINK COMMUNITY SUPPORT  
SERVICES-TORREY HOUSE  
3520 DARBY ROAD  
HAVERFORD, PA, 19041  
LICENSE/COC#: 10007

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/14/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Mia Johnson

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services  
Bureau of Human Service Licensing

August 24, 2021

██████████ ASSISTANT REGIONAL DIRECTOR  
CARELINK COMMUNITY SUPPORT SERVICES OF PENNSYLVANIA  
605 EAST BALTIMORE PIKE  
MEDIA, PA 19063

RE: CARELINK COMMUNITY SUPPORT  
SERVICES-TORREY HOUSE  
3520 DARBY ROAD  
HAVERFORD, PA, 19041  
LICENSE/COC#: 10007

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 06/14/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,  
Mia Johnson

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services  
Bureau of Human Service Licensing  
LICENSING INSPECTION SUMMARY - PUBLIC**

**Facility Information**

**Name:** CARELINK COMMUNITY SUPPORT SERVICES TORREY HOUSE    **Licence #:** 10007    **Licence Expiration Date:** 08/08/2021  
**Address:** 3520 DARBY ROAD, HAVERFORD, PA 19041  
**County:** DELAWARE    **Region:** SOUTHEAST

**Administrator**

**Name:** [REDACTED]    **Phone:** 6105277131    **Email:** [REDACTED]

**Legal Entity**

**Name:** CARELINK COMMUNITY SUPPORT SERVICES OF PENNSYLVANIA  
**Address:** 605 EAST BALTIMORE PIKE, MEDIA, PA, 19063  
**Phone:** 6105277131    **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C-2 LP    **Date:** 03/03/1986    **Issued By:** Commonwealth of Pennsylvania

**Staffing Hours**

**Resident Support Staff:** 0    **Total Daily Staff:** 10    **Waking Staff:** 8

**Inspection**

**Type:** Partial    **Notice:** Unannounced    **BHA Docket #:**  
**Reason:** Complaint    **Exit Conference Date:** 06/14/2021

**Inspection Dates and Department Representative**

06/14/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 17    **Residents Served:** 10

**Secured Dementia Care Unit**

**In Home:** No    **Area:**    **Capacity:**    **Residents Served:**

**Hospice**

**Current Resident:** 0

**Number of Residents Who:**

**Receive Supplemental Security Income:** 4    **Are 60 Years of Age or Older:** 4  
**Diagnosed with Mental Illness:** 10    **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 0    **Have Physical Disability:** 0

Inspections / Reviews

06/14/2021 - Partial

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow-Up Date: *08/02/2021*

8/13/2021 POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/16/2021*

8/24/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/26/2021*

9/30/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Not Required*

187a - Medication Record

1. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

**Description of Violation**

*Resident 1 is prescribed Omeprazole DR 20 MG Capsule by mouth in the morning. However, resident s June 2021 medication administration record (MAR) does not indicate diagnosis or purpose for the medication, including pro re nata (PRN). The MAR does not indicate diagnosis or purpose for any of the medications on the MAR.*

*Resident 2 is prescribed Lisinopril 10 MG Tablet take one by mouth every day. However, resident s June 2021 medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN). The MAR does not indicate the diagnosis or purpose for any of the medications on the MAR.*

**Plan of Correction**

**Accept**

*The purpose for the medications has been added to the medication fields on the MAR's for the residents. I have attached their MAR's for your review.*

**Completion Date:** 08/16/2021

**Document Submission**

**Implemented**

*Please see attached document.*