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

May 16, 2024

[redacted], DIRECTOR
CATHOLIC SOCIAL SERVICES

RE: WOMEN OF HOPE
251 NORTH LAWRENCE STREET
PHILADELPHIA, PA, 19106
LICENSE/COC#: 17594

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/08/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WOMEN OF HOPE* **License #**: *17594* **License Expiration**: *02/05/2024*

Address: *251 NORTH LAWRENCE STREET, PHILADELPHIA, PA 19106*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CATHOLIC SOCIAL SERVICES*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/01/1988* **Issued By**: *City of Phila.*

Staffing Hours

Resident Support Staff: *5* **Total Daily Staff**: *25* **Waking Staff**: *19*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *11/08/2023*

Inspection Dates and Department Representative

11/08/2023 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *20*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older**: *7*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

11/08/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/25/2023*

12/29/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/27/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/10/2024*

Inspections / Reviews *(continued)*

05/16/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *01/09/2024*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

05/16/2024 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *05/16/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

20b5 No Commingling

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
5. Commingling of resident funds and home funds is prohibited.

Description of Violation

The home had a practice of commingling residents' funds in one account. On [redacted], deposits of [redacted] each belonging to resident #1 were deposited into an account used for other residents.

Plan of Correction ***Directed ([redacted] - 12/29/2023)***

Plan of Correction

- *Program Director changed the process of managing resident funds as of 12/12/2023.*
- *Program Director requested from the bank, the checks are cashed ONLY, and NOT deposited and then withdrawn.*
- *The program director will cash the resident funds without depositing the funds first, effective immediately.*

Proposed Overall Completion Date: 12/31/2023

Directed Completion Date: *12/31/2023*

Implemented ([redacted] - 05/16/2024)

42q Compensation

2. Requirements

2600.
42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home.

Description of Violation

The home tells residents, including resident #2, to clean their rooms on Saturdays. The home says this is the residents' responsibility since the home does not have a cleaning service. Cleaning supplies, such as rags and furniture polish, are distributed.

Plan of Correction ***Accept [redacted] - 12/29/2023)***

Plan of Correction

- *The Program Director contacted the weekend staff on 12/16/2023 to inform them that the residents do not have to clean or organize their room/sleeping area.*
- *A follow-up discussion will occur during the January staff meeting on 1/19/2024.*
- *Staff will not direct residents to clean/organize their room/sleeping area.*
- *Staff will only provide assistance if the resident comes to them and requests it.*
- *The Women of Hope-Vine cleaning staff work Monday through Friday and not on the weekends.*

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 05/16/2024)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home did not provide a criminal background check for staff person A, who is the home's

Plan of Correction ***Accept (- 12/29/2023)***

Plan of Correction

• The program director resigned after maternity leave. "Staff person A" (program director) was temporarily overseeing the program until the new program director starts on January 8, 2024. "Staff person A" normally is in the administrative office which is the reason clearances were not on-site but in the Human Resources office.

• The program director retrieved the criminal clearance from HR and emailed the clearance to the monitor on 11/15/2023.

• The program director did an audit of all staff files on 12/15/2023 to ensure all clearances are present.

• The program director will perform quarterly staff file audits to ensure all staff clearances are filed, starting in January 2024.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented (- 01/17/2024)

64a - Admin Training

4. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
3. A Department-approved competency-based training test with a passing score.

Description of Violation

On 11/8/2023, staff person A, who is the home's had not taken the Department-approved competency-based training test.

Plan of Correction ***Accept (- 12/29/2023)***

Plan of Correction

• The program director (staff person A) was enrolled in Administrator's training program, while the certified program director was out on maternity leave. However, after the certified program director's maternity leave, she resigned.

• The program director (staff person A) completed competency-based training and is scheduled for the training test on January 13, 2024.

• However, the program's social work supervisor has completed and passed the department-approved competency training and test.

• A new program director has been hired and the new program director has completed and passed the department-approved competency training and test and will begin on 1/8/2024.

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented - 01/17/2024)

64a - Admin Training *(continued)*

107d - Procedure Emergency Management Agency Submission

6. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to a local emergency management agency since 1/1/2022.

Plan of Correction ***Directed - 12/29/2023)***

Plan of Correction

• In reviewing documentation of written emergency management procedures in the past several years, the previous program directors would always submit plans in January of each year. The program director resigned after her maternity leave so, the program director had to attempt to locate the plan.

• The program director did not locate the newest written emergency management plan so, a request will be emailed to the Office of Emergency Management on 12/27/2023 to inquire about the submission of the written emergency procedure for January 2023.

• As a precaution another request will be made to the local emergency management agency on 12/28/2023 to complete the written emergency procedures.

Proposed Overall Completion Date: 01/15/2024

Directed Plan of Correction (slw 12/29/23)

In addition to the plans noted above:

- *A copy of the homes emergency plan will be posted and a copy of the letter to the Philadelphia Emergency Management agecy will be maintained by the homes administrator following receipt by 1/10/24.*
- *The administrator or staff coordinator will conduct an annual training of the homes emergency plan every January, starting in January, 2024.*

Directed Completion Date: *01/15/2024*

Implemented - 01/17/2024)

132b - Safety Inspection/Fire Drill

7. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not produce documentation of a fire safety inspection or drill conducted by a fire safety expert.

Plan of Correction ***Directed (- 12/29/2023)***

Plan of Correction

132b - Safety Inspection/Fire Drill (continued)

• The program director had scheduled a Fire Safety Training and Inspection on 9/15/2023 but the trainer did not confirm, and staff were unable to reach him.
• Program Director has been attempting since 9/15/2023 to have the trainer from previous years come out and perform the training.
• The Program Director had to find a new trainer to conduct training since the previous trainer was not responding.
• Training has been scheduled for 12/28/2023.

Proposed Overall Completion Date: 01/15/2024

Directed Plan of Correction (slw 12/29/23):
In addition to the POC steps noted above:

- *The Program Director will review the fire safety results with the staff following the fire drill held in January, 2024 and monthly thereafter.*
- *The Program Director will maintain a copy of the fire safety letter dated 12/28/23 for the Departments review.*

Directed Completion Date: *01/15/2024*

Implemented █ - 05/16/2024)

132d - Evacuation

8. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home took more than 2 minutes and 30 seconds to evacuate on consecutive monthly fire drills. During the fire drill on 11/20/2022 at 8:41pm, the home took 4 minutes and 16 seconds to evacuate. During the fire drill on 12/25/2022 at 6:20pm, the home took 4 minutes and 6 seconds to evacuate. The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert.

Plan of Correction ***Directed (█ - 12/29/2023)***

Plan of Correction
• Women of Hope staff was utilizing the maximum safe evacuation time, writing in previous years recommending 7 minutes and 52 seconds from the resident area to the exterior of the building.
• The program director provided verbal education to staff on 11/17/2023 regarding the importance of evacuating residents quickly and consistently.
• To follow up with the verbal education, an additional Fire drill training is scheduled for 12/28/2023.
• An updated writing maximum safe evacuation time will follow the training on 12/28/2023.

Proposed Overall Completion Date: 01/15/2024

132d - Evacuation (continued)

Directed Plan of Correction (slw 12/28/23):
In addition to the above Plan of Correction steps:

- *The Program Director will ensure all fire drills are completed in accordance with the fire safety letter instructions if the evacuation time exceeds 2.5 minutes.*
- *In the event the fire drill exceeds the recommended time for evacuation, the Program Director will hold a second drill later in the month to ensure the residents can evacuate in the prescribed time, starting January, 2024.*
- *The Program Director will review the fire drill logs to determine the staff are able to assist the residents to evacuate in the prescribed time, at least monthly, starting January 2024.*

Directed Completion Date: *01/15/2024*

Implemented (█ - 05/16/2024)

132f - Alternate Exit Routes

9. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The 4th Street exit was the only exit route used during the fire drills held from July through November of 2023.

Plan of Correction ***Directed (█ - 12/29/2023)***

Plan of Correction
• Program director provided verbal education to staff on 11/17/2023 regarding the use of alternative exits when conducting fire drills.
• To follow up with the verbal education, an additional Fire drill training is scheduled for 12/28/2023.
• A writing maximum safe evacuation time will be requested at the training on 12/28/2023.

Proposed Overall Completion Date: 01/31/2024

Directed Plan of Correction (slw 12/29/23):
In addition to the Plan of Correction steps noted above:

- *The Program director will develop a poster and place the poster at an exit that cannot be used alternating it monthly to ensure residents understand where all exits are located in the building by January 15, 2024..*
- *The Program director will review the fire drill logs to ensure the residents are using alternative exits during the monthly drill, starting January 2024.*
- *The Program director will meet with staff and residents explaining the importance of alternating exits during fire drills at the next monthly meeting by January 15, 2024and bi-annually thereafter. Documentation of the sign in will be maintained for the Departments review.*

Directed Completion Date: *01/15/2024*

Implemented (█ - 05/16/2024)

141b1 - Annual Medical Evaluation

10. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 1's most recent medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 12/29/2023)***

Plan of Correction
• The social work supervisor met on 11/9/2023 with case managers to review state standard 2600.141.(b) to ensure each resident has a scheduled annual medical examination.
• The social work supervisor did an audit on 11/9-16/2023- of resident files to ensure the DMEs are current.
• The social work supervisor will perform quarterly audits of 30% of files to ensure updated DMEs starting in January 2024.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented ([redacted] - 01/17/2024)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #2's [redacted] read "please see attached instructions," but the instructions were no longer attached.

Plan of Correction ***Accept ([redacted] - 12/29/2023)***

Plan of Correction
• The social work supervisor was able to locate the detached instructions on 11/9/2023 and reattached the instructions.
• The social work supervisor reviewed all the pharmacy labels on 11/10/2023 to ensure all labels were attached.
• The social work supervisor will conduct quarterly audits of 30% of medication labels, starting in January 2024.
• Social Work Supervisor (trained medication trainer) provided a medication refresher training for staff on 11/17/2023.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented ([redacted] - 01/17/2024)

185a - Implement Storage Procedures

12. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Several readings from residents' glucometers were transcribed inaccurately in the home's logs. On 1 at , resident #1 had a blood glucose reading of but the log stated . On , resident #2 had a blood glucose reading of but this was logged as . On , resident #2 had a blood glucose reading of but this was logged as

Plan of Correction ***Accept (- 12/29/2023)***

Plan of Correction

• Social Work Supervisor (trained medication trainer) provided a medication refresher training for staff involved in the error on 11/17/2023 to ensure glucose levels readings are logged properly.

• Social Work Supervisor will conduct quarterly audits of medication equipment and logs starting in January 2024.

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented (- 05/16/2024)