Pennsylvania
Department of Human Services

Sent via e-mail [redacted]
May 27, 2025

[redacted]
Director
Labor of Love, Inc.
[redacted]

RE: Labor of Love – Building 1
2029 North 62nd Street
Philadelphia, Pennsylvania 19151
License #: 14557

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on January 28, 2025 and March 7, 2025 of the above facility, we have determined that your submitted plan of correction for the December 18, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *LABOR OF LOVE BUILDING 1* **License #**: *14557* **License Expiration**: *07/22/2025*

Address: *2029 NORTH 62ND STREET, PHILADELPHIA, PA 19151*

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

Administrator

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

Legal Entity

Name: *LABOR OF LOVE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 3 SP* **Date**: *02/26/1987* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *9* **Waking Staff**: *7*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/18/2024*

Inspection Dates and Department Representative

12/18/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *11* **Residents Served**: *9*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *8* **Are 60 Years of Age or Older**: *9*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

12/18/2024 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *01/10/2025*

01/21/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/05/2025*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/26/2025*

01/28/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/05/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/14/2025*

03/07/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/05/2025*

Reviewer: [redacted] **Follow Up Type:**

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/18/2024, the home's resident medication administration record (MAR) binder was kept in a closet with a mirrored door which was unlocked, unattended, and accessible to anybody.

Plan of Correction ***Directed (- 01/28/2025)***

The MAR was moved to the locked room where the medications are kept at the time of the inspection. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. The administrator will check daily for future compliance. Director) conducted the Quality Management Meeting along with input from . We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Immediately, the administrator shall conduct weekly audits of the home to ensure records are secure for a period of 4 weeks, then monthly for 3 months.

Directed Completion Date: *02/14/2025*

Not Implemented (- 03/07/2025)

64a Admin Training

2. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.

Description of Violation

the home's administrator, does not have a document showing that staff completed an orientation program approved and administered by the Department.

Plan of Correction ***Accept (- 01/28/2025)***

I received my Administrators License in 2007 from P.E.P.P. Unlimited located in Doylestown, Pa. The training was paid for by the state. We did have an orientation when we arrived for training. If an orientation is still needed, even though I've been an administrator for 18 years then I will gladly take the orientation course. I just need to know

64a - Admin Training (continued)

where to sign up for the orientation. For Future Compliance, the Administrator will make sure that any new hires that are administrators have this orientation class. I signed up for the Administrators Orientation course scheduled for Feb. 21, 2025.

Proposed Overall Completion Date: 01/24/2025

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 03/07/2025)

123a - Exit Doors

3. Requirements

2600.
123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The 3rd floor middle room serves as an Exit in an emergency where a fire escape is present outside of the building. The door to the room, however, is lockable from the inside by the resident and needs a key to open when locked.

Plan of Correction ***Accept ([redacted] - 01/28/2025)***

The doorknob lock was replaced with a doorknob without a locking mechanism on 12/21/24. From now on, the Administrator will check weekly for future compliance.

Proposed Overall Completion Date: 01/24/2025

Licensee's Proposed Overall Completion Date: *01/24/2025*

Not Implemented ([redacted] - 03/07/2025)

132f - Alternate Exit Routes

4. Requirements

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

Description of Violation

Front/Rear was the only exit route used during the fire drills held from March to May 2024.

Repeat Violation: 12/11/2023

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

We explained to the inspector that sometimes we may say that the fire is at this stairway or that stairway on the second floor. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations including a discussion regarding the repetition of using the same exits. For future compliance, the administrator will check the fire drill log for drill times and exits weekly on Fridays from now on. [redacted] -Director) conducted the Quality Management Meeting along with input from [redacted] We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures.

132f Alternate Exit Routes (continued)

Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. [redacted] calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Immediately, the administrator shall review all fire drill logs at least once per month to ensure alternate exit routes are utilized and documented.

Directed Completion Date: *02/14/2025*

Implemented ([redacted] - 03/07/2025)

183c - Refrigerated Meds Locked

5. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 12/18/2024 at 02:30 PM, eye drops prescribed for the home's residents were unlocked and accessible in the kitchen refrigerator.

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

I didn't know that the eyedrops had to be locked up. This violation was corrected at the time of the inspection. The eyedrops were placed in a locked box in the refrigerator for storage. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. The administrator will check daily for future compliance. [redacted] Director) conducted the Quality Management Meeting along with input from [redacted] We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. [redacted] calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Immediately, the administrator shall audit the home for the proper storage of medications weekly for 4 weeks then monthly for 3 months.

Directed Completion Date: *02/14/2025*

Not Implemented ([redacted] - 03/07/2025)

183d - Prescription Current

6. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/18/2024 around lunch time, a resident [redacted] was observed asking staff A to give [redacted] lunch medications. Staff A administered medications to this resident.

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

The resident in question is in and out and usually away from [redacted] showed the inspector [redacted] med log which showed that [redacted] is sometimes away for weeks at a time. I explained to the inspector that [redacted] is a current addict, and that [redacted] was requesting to take all of [redacted] pain meds with [redacted] and that I couldn't give them to [redacted] to take with [redacted] The resident is always in a hurried and rushed state. [redacted] even wants [redacted] meals to go. I told the inspector that I only had [redacted] lunch meds with [redacted] because the resident called [redacted] and told [redacted] was coming to get them. I told [redacted] that I was currently going through a state inspection and to meet me at [redacted] home. For future compliance the administrator will leave the Inspection and administer the medications. I have counseled the residents on 12/19/24 about receiving their meds where they reside.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's medication administration procedures to ensure that the procedures include the setting in which residents of the home shall receive their prescribed medication administrations.

Within 15 days of the receipt of the acceptable plan of correction, all staff qualified in medication administrator shall be educated by the administrator on the home's medication administration policy and updates.

Directed Completion Date: *01/24/2025*

Not Implemented ([redacted] - 03/07/2025)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/18/2024, [redacted] prescribed for resident #1 were opened but not dated with an open/discard after date. According to the manufacturer's instructions, [redacted] should be discarded four weeks after opening.

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

[redacted] in the resident's drawer were disposed of. [redacted] were retrieved and the boxes were to be dated at the time that were to be opened. This violation was corrected at the time of the inspection. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. The administrator will check daily

183e - Storing Medications (continued)

for future compliance. [redacted] Director) conducted the Quality Management Meeting along with input from [redacted]. We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that [redacted] were dated and initialed once they were opened. [redacted] calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Immediately, the administrator or staff qualified to administer medications shall perform audits of medications in all medication storage areas weekly for 4 weeks then monthly for three months.

Directed Completion Date: *01/24/2025*

Implemented ([redacted] - 03/07/2025)

183f - Discontinued Medications

8. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Staff B who administered morning meds on 12/18/2024 stated that [redacted] accidently dropped resident #2's morning medications including [redacted] and that [redacted] trashed them since they fell on the floor. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

I told the inspector that we get rid of our discontinued meds by sending them back to the pharmacy or by placing them in the green box (for old drugs) located in the hospital. I thought that throwing away 3 or 4 pills that had fallen was ok. I directed my staff to do so, if a pill were to hit the floor. I was reminded by the inspector that I should had mixed the fallen meds with coffee grounds or with cat litter. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. The administrator will check daily for future compliance. [redacted] Director) conducted the Quality Management Meeting along with input from [redacted]. We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. [redacted] the glucometer to the

183f - Discontinued Medications (continued)

correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's medication administration procedures to ensure that the procedures include the proper disposal and destruction of medications to include a process by which narcotic medications destruction is witnessed and signed off on by at least 2 staff members qualified to administer medications.

Within 15 days of the receipt of the acceptable plan of correction, all staff qualified in medication administrator shall be educated by the administrator on the home's medication administration policy and updates.

Immediately, the administrator or staff qualified to administer medications shall perform audits of medications, to include narcotic medications, narcotic control records, and narcotic destructions logs weekly for 4 weeks then monthly for three months.

Directed Completion Date: *01/24/2025*

Not Implemented ([redacted] - 03/07/2025)

184a - Resident's Meds Labeled

9. 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] while the resident's medication administration record (MAR) read [redacted]

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

The resident in question was a new resident at Labor of Love. [redacted] said that [redacted] was only on the medication to help with [redacted] refused to take the [redacted] because [redacted] was fine. [redacted] PCP also said that they didn't see the need for it, since [redacted] was discharged and fine. [redacted] PCP said that it was just in case [redacted] needed it. It was not a PRN medication and I should have gotten a PRN or discontinue slip from [redacted] PCP. The administrator will contact [redacted] PCP for a new script and also check daily for future compliance. I took the resident to see [redacted] PCP on 1[redacted] went over all of [redacted] medications. [redacted] D/C some of [redacted] redundant meds. and at the end [redacted] gave us a current list of medications for [redacted] wasn't on the list. [redacted] said that [redacted] couldn't D/C it because it wasn't in [redacted] system.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

184a - Resident's Meds Labeled (continued)

Immediately, the administrator shall obtain a corrected physician's order or discontinue order for resident # 2's [redacted] medication.

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's medication administration procedures to include a process on clarifying and discontinuing medication orders.

Within 15 days of the receipt of the acceptable plan of correction, all staff qualified in medication administrator shall be educated by the administrator on the home's medication administration policy and updates.

Immediately, the administrator or staff qualified to administer medications shall perform audits of medications, to include narcotic medications, narcotic control records, and narcotic destructions logs weekly for 4 weeks then monthly for three months.

Directed Completion Date: *02/14/2025*

Not Implemented ([redacted] - 03/07/2025)

185a - Implement Storage Procedures

10. Requirements

2600.
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

Resident [redacted] glucometer was not calibrated to correct time. On 12/18/2024 at 02:55 PM, the glucometer displayed 10:54. Resident [redacted] glucometer reading was 94 on 12/09/2024 but it was documented as 90.

Plan of Correction ***Directed ([redacted] - 01/28/2025)***

The glucometer has been calibrated to the correct time and date. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. All glucometer readings are to be double checked from now on. The administrator will check daily for future compliance. [redacted] -Director) conducted the Quality Management Meeting along with input from [redacted]. We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. [redacted] calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Corrections:

Immediately, the administrator or staff person qualified to administer medications and who has completed diabetic education shall audit all glucometers weekly for 1 month then monthly for 3 months.

185a Implement Storage Procedures *(continued)*

Directed Completion Date: *02/14/2025*

Not Implemented (- 03/07/2025)

11. Requirements

2600.
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

Resident #2 is prescribed . According to the controlled medication log of this medication, the remaining balance was 78 while the actual pill count was 77 at 02:30 PM on 12/18/2024. The home explained that staff B dropped one pill in the morning of 12/18/2024 and that the pill was trashed and a new pill was administered without being documented on the decreasing controlled medication log. The home's medication procedures state that controlled medications should be disposed by two staff persons and documented properly. Staff B did not follow these steps.

Plan of Correction ***Directed (- 01/28/2025)***

I told the inspector that had called me twice that morning to let me know that had dropped a few pills. I even told that I was in the middle of a State Inspection and that I would talk with latter while the inspector was right there. I thought that throwing away 3 or 4 pills that had fallen was ok. I directed my staff to do so, if a pill were to hit the floor. We had a staff quality Management Meeting on Dec. 19, 2024 to discuss all of the current violations. My staff that administer meds were instructed that if any more meds were dropped to hold them so that I could witness the pills and then they are to be logged and disposed of by mixing them with coffee grounds or with cat litter. The administrator will check daily for future compliance. -Director) conducted the Quality Management Meeting along with input from . We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed the alternating the Day Of The Week and Routes for the Fire Drill, and Controlled Substance Procedures and Disposal Procedures. Making sure that the Med Log and eye drops were both being kept in a locked area daily and that the eye drops were dated and initialed once they were opened. calibrated the glucometer to the correct date and time on 12/18/24 and we now do a 2 person check on glucometer readings. The meeting lasted approx. an hour and a half.

Proposed Overall Completion Date: 01/24/2025

<u>Directed Plan of Correction:</u>

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall review and update the home's medication administration procedures to ensure that the procedures include the proper disposal and destruction of medications to include a process by which narcotic medications destruction is witnessed and signed off on by at least 2 staff members qualified to administer medications.

Within 15 days of the receipt of the acceptable plan of correction, all staff qualified in medication administrator shall be educated by the administrator on the home's medication administration policy and updates.

Immediately, the administrator or staff qualified to administer medications shall perform audits of medications, to

185a - Implement Storage Procedures (continued)

include narcotic medications, narcotic control records, and narcotic destructions logs weekly for 4 weeks then monthly for three months.

Directed Completion Date: *02/14/2025*

Not Implemented (- 03/07/2025)

187b - Date/Time of Medication Admin.

12. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 12/18/2024 at 11:40 AM, resident #1 was administered scheduled at 12:30 PM. Staff person A did not document the administration until 01:58 PM.

Plan of Correction ***Directed (- 01/28/2025)***

The med was administered to the resident. When asked confirmed that had gotten the medication. I was a little flustered because of the Inspection. The inspector would ask for something and before the item(s) could be retrieved was calling out my name throughout the house for 3 more items. This went on for hours. For future compliance from now on, I will definitely have an alternate person certified in medication administration administer resident medication at the correct time in the even the scheduled person is not available.

Proposed Overall Completion Date: 01/24/2025

Directed Plan of Correction:

Immediately, the administrator shall review the staff schedule weekly to ensure sufficient staff qualified to administer medications are scheduled in the home to complete the administration and documentation of medication, and provide additional staff as required by resident assessment and support plans/resident needs.

Directed Completion Date: *02/14/2025*

Not Implemented (- 03/07/2025)

224a - Preadmission Screen Form

13. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #4 was admitted to the home on however, the resident's preadmission screening form has not been completed.

Plan of Correction ***Accept (- 01/28/2025)***

The Resident was admitted . We were called by DHS on that

224a - Preadmission Screen Form (continued)

date and asked to come out immediately to help with [redacted]. All of our resident files were checked and we have Pre-Admission Screenings for all of our residents, except those that came to us for the [redacted]. The Administrator will continue to do Preadmission Screenings for all incoming [redacted] to our facility. For Future Compliance, as of Sept. 27, 2024 the Administrator will request in the case [redacted] that the resident be [redacted] to our facility the following day so that we can stay in compliance with the regulations.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Not Implemented ([redacted] - 03/07/2025)