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

June 23, 2025

[redacted], CONTACT PERSON
PHILADELPHIA PROTESTANT HOME
6500 TABOR ROAD
BUILDING 5
PHILADELPHIA, PA, 19111

RE: PHILADELPHIA PROTESTANT HOME
6500 TABOR ROAD, MIDWAY MANOR
BUILDING 5, FLOORS 2,3,4
PHILADELPHIA, PA, 19111
LICENSE/COC#: 14450

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/28/2025, 05/29/2025 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PHILADELPHIA PROTESTANT HOME* **License #**: *14450* **License Expiration**: *01/25/2026*

Address: *6500 TABOR ROAD, MIDWAY MANOR, BUILDING 5, FLOORS 2,3,4, PHILADELPHIA, PA 19111*

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

Administrator

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

Legal Entity

Name: *PHILADELPHIA PROTESTANT HOME*

Address: *6500 TABOR ROAD, BUILDING 5, PHILADELPHIA, PA, 19111*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *01/20/2019* **Issued By**: *L&I*

Type: *I-2* **Date**: *03/30/2017* **Issued By**: *L&I*

Type: *I-1* **Date**: *10/28/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *144* **Waking Staff**: *108*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/29/2025*

Inspection Dates and Department Representative

05/28/2025 - On-Site: [redacted]

05/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *188* **Residents Served**: *97*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Chapters* **Capacity**: *23* **Residents Served**: *18*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *97*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *47* **Have Physical Disability**: *0*

Inspections / Reviews

05/28/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2025*

Inspections / Reviews *(continued)*

06/23/2025 - POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *06/23/2025*

Follow-Up Type: *Bypass Document Submission*

06/23/2025 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *06/23/2025*

Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 10/29/2024, resident #1 reported that staff did not get [redacted] out of bed until 4:30 pm and [redacted] incontinent product and sheets were soaked in urine. This allegation of neglect of care on 10/29/2024 was not reported to AAA.

Plan of Correction ***Accept ([redacted] - 06/23/2025)***

A grievance was reported 10/29/2024, resident #1 reported that staff did not get [redacted] out of bed until 4:30 pm and [redacted] incontinent product and sheets were soaked in urine. This allegation of neglect of care on 10/29/2024 was not reported to AAA.
Nurse notes did state that resident refused care several times and PCP aware of behaviors and consult for psychologist was requested at the time of the incident.
The Social Service Director, Grievance Officer, and PCHA reviewed and were educated on the reportable incident regulation and reporting to Older Adults Protective Services. The procedure for grievance review was updated to be reviewed by PCHA, Social Service Director, and Grievance Officer within 24 hours to ensure a reportable incidence is reported to the department and reporting to Older Adults Protective Services is completed in a timely manner. A log will be used to track that each grievance is reviewed (with investigation initiated) and reported within 24 hours in accordance with the regulation and policy and procedure, "Reportable Incidents 2600.16c and 2600.15a-PC". This tracking will be ongoing and reported to QAPI Committee quarterly. The in-service on the policy and procedure was conducted on 6/2/2025 with social services and on 5/30/2025 with PC staff. The revised policy and procedure for grievance review was initiated immediately after the in-service was completed on 6/2/2025 and will continue going forward. All reported grievances will be kept in a binder with the review log and readily available for surveyors to review upon request.

Licensee's Proposed Overall Completion Date: *06/13/2025*

Implemented ([redacted] - 06/23/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/29/2024, resident #1 reported that staff did not get [redacted] out of bed until 4:30 pm and [redacted] incontinent product and sheets were soaked in urine. This incident was reported to staff person A on 10/29/2024. On 3/24/2025, resident #2 reported that [redacted] asked for more bacon and was told there was none left, and the staff closed the pans, so the contents were no longer visible. This incident was reported to staff person A on 3/24/2025. On 4/6/2025, resident #3's family member reported that the resident's necklace that they wear everyday was missing and was last seen two weeks ago and was not found. This incident was reported to staff person B on 4/6/2025.

16c - Written Incident Report (continued)

The home did not report the incidents of neglect of care on 10/29/2024, the mistreatment of residents on 3/24/2025 and the alleged theft incident to the Department.

Plan of Correction ***Accept (- 06/23/2025)***

On 10/29/2024, resident #1 reported that staff did not get out of bed until 4:30 pm and incontinent product and sheets were soaked in urine. This incident was reported to staff person A on 10/29/2024. On 3/24/2025, resident #2 reported that asked for more bacon and was told there was none left, and the staff closed the pans, so the contents were no longer visible. This incident was reported to staff person A on 3/24/2025. On 4/6/2025, resident #3's family member reported that the resident's necklace that they wear everyday was missing and was last seen two weeks ago and was not found. This incident was reported to staff person B on 4/6/2025. The home did not report the incidents of neglect of care on 10/29/2024, the mistreatment of residents on 3/24/2025 and the alleged theft incident to the Department.
The Social Service Director, Grievance Officer, and PCHA reviewed and were educated on the reportable incident regulation and reporting to Older Adults Protective Services. The procedure for grievance review was updated to be reviewed by PCHA, Social Service Director, and Grievance Officer within 24 hours to ensure reportable incidents are reported to the Department in a timely manner. A log will be used to track that each grievance reviewed (with investigation initiated) and reported within 24 hours in accordance with the regulation and policy and procedure, "Reportable Incidents 2600.16c and 2600.15a-PC". This tracking will be ongoing. The tracking and reportable incidents will be reported to QAPI Committee quarterly. An in-service on the policy and procedure was conducted with social service on 6/2/2025 and 5/30/2025 with PC staff. The revised policy and procedure, "Reportable Incidents 2600.16c and 2600.15a-PC" was initiated immediately after the in-service was completed on 6/2/2025 and will continue going forward. All reported grievances will be kept in a binder with the review log. Reportable incidents will be kept in a binder as well and readily available for surveyors to review upon request.

Licensee's Proposed Overall Completion Date: *06/13/2025*

Implemented (- 06/23/2025)

17 - Record Confidentiality

3. 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 5/28/25, at approximately 9:27am, resident records were unlocked, unattended, and accessible in the memory care nurse station.
On 5/28/25, at approximately 9:37am, two treatment carts were left open, unattended in the hallway near the personal care dining room.

Plan of Correction ***Accept (- 06/23/2025)***

On 5/28/25, at approximately 9:27am, resident records were unlocked, unattended, and accessible in the memory care nurse station. On 5/28/25, at approximately 9:37am, two treatment carts were left open, unattended in the

17 - Record Confidentiality (continued)

hallway near the personal care dining room.
This was corrected immediately. Carts and nurses' stations were locked. All med techs and nurses were reeducated on keeping the treatment/medication carts, and nurses station locked while unattended. Random lock checks/observations of the treatment cart and memory care nurses' station will be conducted weekly by the PCHA to ensure compliance for 12 weeks and will be discontinued if 100% compliance is achieved for the last two months. The audit will be extended monthly until 100% compliance is achieved. Audit results will be reported to the quarterly QAPI Committee. The audits sheets will be kept for 12 weeks in a binder and readily available for surveyors to review upon request. The in-service/staff education for PC med techs /nurses/memory care staff was completed on 5/30/2025. Weekly lock checks/observations were initiated on June 5, 2025, and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *06/13/2025*

Implemented (- 06/23/2025)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/29/25, at 9:15 am, staff person C, was observed using bare, ungloved fingers to remove medication from blister cards and placing the medication into small cups during the medication pass for residents near the memory care dining hall.

Plan of Correction ***Accept (- 06/23/2025)***

On 5/29/25, at 9:15 am, staff person C, was observed using bare, ungloved fingers to remove medication from blister cards and placing the medication into small cups during the medication pass for residents near the memory care dining hall.
Med tech was educated immediately after receiving this report and successfully demonstrated proper hand hygiene. Med tech stated the use of hand sanitizer prior to the med pass. All med techs and nurses were reeducated on completion of proper hand hygiene during medication pass per the Policy and Procedure. Weekly, random hand hygiene observations will be conducted by the PCHA to ensure compliance. Hand hygiene observations will be extended monthly until 100% compliance is demonstrated if not achieved during the first 12 weeks. Audit results will be reported to the quarterly QAPI Committee. The audits sheets will be kept for 12 weeks in a binder and readily available for surveyors to review upon request. The in-service/staff education for PC med techs /nurses was completed on 5/30/2025. Weekly hygiene observations were initiated on June 5, 2025, and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *06/13/2025*

Implemented (- 06/23/2025)

103g - Storing Food

5. Requirements

2600.

103g - Storing Food *(continued)*

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/28/2025, the following food items in the walk-in freezer were opened and unsealed:

A bag of roasted garlic loaf, a bag of frozen waffles, and a bag of sausage links.

Plan of Correction ***Accept (█ - 06/23/2025)***

2600.103(g) - Food shall be stored in closed or sealed containers.
On 5/28/2025, the following food items in the walk-in freezer were opened and unsealed: A bag of roasted garlic loaf, a bag of frozen waffles, and a bag of sausage links.
This was corrected immediately and removed by dining staff. Weekly audits will be conducted by the dining designee for 12 weeks to ensure food items are placed in sealed containers. Once weekly audits are completed, staff will sign the audit sheet. Audits sheets will be reviewed by the Dining Management monthly to ensure compliance. After 12 weeks these audits will be discontinued if 100% compliance is achieved, otherwise they will be extended monthly until this goal is met. Audit results will be reported to the quarterly QAPI Committee. The audits sheets will be kept for 12 weeks in a binder and readily available for surveyors to review upon request. The in-service/staff education for dining staff was completed on 6/2/2025. The weekly dining audit sheets were initiated on June 2, 2025, and will be reviewed on July 1, 2025, and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented (█ - 06/23/2025)

162c - Menus Posted

6. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of May 25, 2025, and the upcoming week's menu were not posted in memory care and personal care dining hall.

Plan of Correction ***Accept (█ - 06/23/2025)***

2600.162(c) - Menus, stating the specific food being served at each meal, shall be prepared one week in advance and shall be followed. Weekly menus shall be posted one week in advance in a conspicuous and public place in the home.

The home's menu for the week of May 25, 2025, and the upcoming week's menu were not posted in memory care and personal care dining hall.

This was corrected immediately by dining staff. Weekly audits will be conducted by dining designee to ensure that the menus are items are correct. Once weekly audits are completed, staff will sign the audit sheet. Audits sheets will be reviewed by Dining Management monthly to ensure compliance. After 12 weeks these audits will be discontinued if 100% compliance is achieved, otherwise, they will be extended monthly until this goal is met. Audit results will be

162c - Menus Posted (continued)

reported to the quarterly QAPI Committee. The audits sheets will be kept for 12 weeks in a binder and readily available for surveyors to review upon request. The in-service/staff education for dining staff was completed on 6/2/2025. The weekly dining audit sheets were initiated on June 2, 2025, and will be reviewed on July 1, 2025, and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented (- 06/23/2025)