

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

April 1, 2026

[REDACTED], EXECUTIVE DIRECTOR  
SIMPSON HOUSE INC  
[REDACTED]

RE: SIMPSON HOUSE  
BELMONT AVENUE & MONUMENT  
ROAD  
PHILADELPHIA, PA, 19131  
LICENSE/COC#: 18921

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/02/2025 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: *SIMPSON HOUSE* License #: *18921* License Expiration: *06/14/2026*  
 Address: *BELMONT AVENUE & MONUMENT ROAD, PHILADELPHIA, PA 19131*  
 County: *PHILADELPHIA* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *SIMPSON HOUSE INC*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *06/17/1996* Issued By: *Philadelphia L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *52* Waking Staff: *39*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal, Incident* Exit Conference Date: *10/02/2025*

**Inspection Dates and Department Representative**

*10/02/2025 - On-Site* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *84* Residents Served: *31*

**Secured Dementia Care Unit**  
 In Home: *Yes* Area: *Comfort Haven* Capacity: *10* Residents Served: *5*

**Hospice**  
 Current Residents: *0*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *31*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *21* Have Physical Disability: *0*

**Inspections / Reviews**

**10/02/2025 - Full**  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/09/2025*

**11/19/2025 - POC Submission**  
 Submitted By: [REDACTED] Date Submitted: *12/25/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/24/2025*

Inspections / Reviews *(continued)*

12/08/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 12/25/2025

04/01/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/25/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

16c - Written Incident Report

1. 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 [redacted] Resident #1 passed away unexpectedly. The home did not report this incident to the Department until [redacted]

Plan of Correction

Directed ([redacted] - 12/04/2025)

Starting 11/20/2025, LPN supervisors will be provided education regarding reportable incidents as they will be responsible for completing and accurately reporting incidents. This education will have an emphasis on the regulation as well as correct spelling and dating. All reportable incidents moving forward will be audited within 24hours by the administrator or designee for accuracy and resubmitted as needed. this audit will begin 11/20/2025 it will be completed weekly for 4 weeks. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving compliance.

Proposed Overall Completion Date: 12/20/2025

Directed Plan of Correction ([redacted] - 12/8/25)

To clarify the above plan of correction, within 10 days of the receipt of the plan of correction, the administrator shall provide education to all staff of the requirements to time report incidents and conditions.

Directed Completion Date: 12/20/2025

Implemented ([redacted] - 04/01/2026)

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for Resident #2 was not signed by the administrator or designee and was not resident.

Plan of Correction

Accept ([redacted] - 12/08/2025)

2600.25 b Resident #2 Reviewed and signed the contract with [redacted] present. The PCHA educated marketing personnel and the move in coordinator on regulation 2600.25B. Thereafter, all other resident contracts were audited by the administrator and the Move -In Coordinator, and all unsigned contracts were reviewed and signatures obtained. Starting 11/17/2025, each new resident contract will be audited within the first thirty days of admission by the administrator. This will be an ongoing audit. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

Implemented ([redacted] - 04/01/2026)

41e - Signed Statement

3. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept ( [redacted] ) - 12/08/2025)

The unsigned contract was reviewed with the resident then signed with [redacted] present. The PCHA educated marketing personnel and the move in coordinator on regulation 2600.41e. Starting 10/6/2025, the marketing assistant (Move in Coordinator will audit all personal care charts review the information and obtain the appropriate signatures and/ or document if the resident is unable to sign by 11/14/2025. Starting 11/17/2025, The PCHA or designee will audit any new charts for signatures within the first 30days of admission This will be an ongoing audit. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

Implemented ( [redacted] ) - 04/01/2026)

66b - Training Plan Content

4. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan includes the projected date for all required trainings as December 31, 2025. The home's staff training plan does not include times for these trainings.

Repeat Violation Date: 11/7/24

Plan of Correction

Accept ( [redacted] ) - 12/08/2025)

On 11/7/2025 the PCHA in-serviced the Human Resources Generalist on regulation 66b. The community training plan has been updated to include dates, times, and the location of the training. Starting 12/2/2025, the Human Resources Generalist will audit all new employee training plans. Results of the audits will be discussed during quarterly QI meeting on 1/9/2026. The QI Committee will determine if continued auditing is necessary to ensure on-going compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

Implemented ( [redacted] ) - 04/01/2026)

103f - Refrigerator/Freezer Temps

5. Requirements

103f - Refrigerator/Freezer Temps (continued)

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 10/2/25 at 10:10am, there was no thermometer in the Carson freezer.

Plan of Correction

Accept ( ) - 12/08/2025

Plan of correction: On 10/3/2025, the facilities director installed a thermometer in the refrigerator immediately. Starting 10/4/2025 the PCHA or designee will (spot) Randomly check the refrigerator and freezer for working thermometers during weekly rounds for one month then for two months. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 12/04/2025

Implemented ( ) - 04/01/2026

105g - Lint Removal and Duct Cleaning

6. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 10/2/25 at 9:42am, there was an approximate 1 inch accumulation of lint in the lint trap of the Wesley Commons third floor laundry room dryer. At 10:12am, there was an approximate 1/2 inch accumulation of lint in the lint trap of the Carson second floor laundry room dryer. There were no clothes in the dryers at that time.

Plan of Correction

Directed ( ) - 12/08/2025

Starting 10/3/2025 All care staff were in-serviced on the hazards of not cleaning the dryer lint traps after each load. In addition, a lint check sheet will be added to the laundry room, Direct care staff members will be responsible for initialing the sheet each shift. The PCHA or designee will randomly check the dryers and the sign off sheet on a weekly basis. The random checks will occur for 4 weeks, then for two months. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving two months of compliance.

Proposed Overall Completion Date: 12/09/2025

Directed Plan of Correction ( ) - 12/8/25

To clarify the above plan of correction, within 10 days of the receipt of the plan of correction, the administrator shall provide education to all staff of the requirements of 105g.

Directed Completion Date: 12/09/2025

Implemented ( ) - 04/01/2026

141b1 - Annual Medical Evaluation

7. Requirements

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on [REDACTED] The resident's previous medical evaluation was completed on [REDACTED].

Repeat Violation Date: 11/7/24

Plan of Correction

Accept [REDACTED] - 12/08/2025)

Starting 10/4/2025 The PCHA or designee will audit each resident record for two-years consecutive DME's and ensure all 2025 DMEs are completed and up to date by 11/14/2025. Effective 11/17/2025, the family members for all residents with outside will be given copy of a DME 30 days prior to due date, LPN Supervisors will also call, fax and email the provider notification of a due DME. Lpn Supervisors will also audit DME's monthly for six months. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving six consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

Implemented [REDACTED] - 04/01/2026)

183e - Storing Medications

8. 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 10/2/25, Resident #4's Potassium Chloride 20mg tab was observed to have a punctured blister foil with the medication still present in the spot, exposing it to contamination or improper sanitation.

On 10/2/25, two half white round pills were observed loose in the Comfort Haven medication cart.

On 10/2/25, one half oblong white pill, two oblong yellow pills, one round white pill and one round yellow pill were observed loose in the Carson #2 medication cart.

Repeat Violation Date: 11/7/24

Plan of Correction

Accept [REDACTED] - 12/08/2025)

10/4/2025 The LPN supervisor audited each medication cart was and cleaned of any loose pills or unlabeled medications. Beginning 10/8/2025 medication tech was educated to clean the medication carts of loose pills and debride. Starting 10/22/2025The PCHA or designee will audit one medication cart biweekly for two months, then randomly check a cart monthly. This will be an ongoing audit. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

183e - Storing Medications (continued)

Implemented ( ) - 04/01/2026

184c - Sample Prescription Meds.

9. Requirements

2600.

184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

On 10/2/25, the sample prescription dimethyl fumarate belonging to resident #5 was observed in the home's medication cart. The label for this sample did not include the date the prescription was issued, the prescribed dosage and instructions for administration or the name and title of the prescriber.

Plan of Correction

Accept ( ) - 12/08/2025

10/4/2025 The LPN Supervisor audited each medication cart for unlabeled medications and requested a label from the pharmacy. Starting 10/22/2025 The PCHA or designee (the LPN supervision will audit one medication cart per biweekly for two months, then randomly check a cart monthly for two months, then ongoing monthly. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving compliance.

Licensee's Proposed Overall Completion Date: 12/09/2025

Implemented ( ) - 04/01/2026

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 #6 is prescribed blood sugar readings once per day on Monday, Wednesday and Friday. On 9/15/25, Resident #6's medication administration record indicated that a reading of 120 was taken at 6:30am; however, no corresponding reading was found in Resident #6's glucometer.

Repeat Violation Date: 11/7/24

Plan of Correction

Directed ( ) - 12/08/2025

Beginning 10/8/2025 the LPN supervisor will perform weekly Glucometers and MARS comparisons with weekly cart audits (ongoing). The PCHA will enroll all medication technicians in diabetes education classes. The PCHA will audit one diabetic record biweekly for one month, then monthly for two months, then monthly this will be an ongoing audit. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving satisfactory compliance.

Proposed Overall Completion Date: 12/09/2025

Directed Plan of Correction ( ) - 12/8/25):

To clarify the above plan's timeframes, within 15 days of the receipt of the acceptable plan of correction, the

185a - Implement Storage Procedures (continued)

administrator shall ensure that all staff qualified to administer medications are educated by a certified diabetes educator within the past year.

Directed Completion Date: 12/24/2025

Implemented ( ) - 04/01/2026

191 - Resident Right to Refuse

11. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted ( ) has not been educated on the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Directed ( ) - 12/08/2025

Starting 10/6/2025, the marketing assistant (move-in coordinator) will audit all personal care charts and obtain the appropriate signatures and/ or document if the resident is unable to sign by 11/9/2025. starting 11/17/2025 The PCHA or designee will audit any new charts for signatures within the first 30days of admission for the next three months. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving three consecutive months of compliance.

Proposed Overall Completion Date: 12/09/2025

Directed Plan of Correction ( ) - 12/8/25

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate resident #2 of their rights to refuse medications if they believe that there may be a medication error.

Directed Completion Date: 12/24/2025

Implemented ( ) - 04/01/2026

227g -Support Plan Signatures

12. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of his/her support plan on 7/15/25; however, the resident did not sign the support plan.

Repeat Violation Date: 11/7/24

Plan of Correction

Directed ( ) - 12/08/2025

Starting 10/4/2025 The PCHA or designee will audit all 2025 support plans for signatures, review plans and obtain omitted signatures, and/ or document the resident's inability to sign. The PCHA or designee will then audit any new initial, annual or significant change plans for 4 weeks then monthly for two months. Audit results will be reviewed

227g -Support Plan Signatures (continued)

during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving two consecutive months of compliance.

Proposed Overall Completion Date: 12/09/2025

**Directed Plan of Correction (█ - 12/8/25)**

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall review the RASP with Resident #1 and request the resident to sign. If the resident refuses to sign, multiple attempts to offer to sign must be made and documented. If the resident is unable to sign, the home shall indicate this on the RASP and maintain documentation of the reason for which the resident is unable to sign.

Directed Completion Date: 12/09/2025

Implemented (█ - 04/01/2026)

231e - No Objection Statement

13. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident’s designated person have not objected to the resident’s admission or transfer to the secured dementia care unit.

**Description of Violation**

Resident #7 was admitted to the Secure Dementia Care Unit (SDCU) on █. The home has no documentation that the resident has not objected to the admission.

**Plan of Correction**

Directed (█ - 12/08/2025)

on 10/3/2025 The unsigned contract was reviewed with resident # 7, █ was unable to sign and it was documented. Starting 10/6/2025, the marketing assistant audited all personal care SDCU charts and began reviewing and obtaining signatures and/ or document if the resident is unable to sign by 11/9/2025. Starting 11/17/2025 The PCHA or designee will audit any new charts for signatures within the first 30days of admission for the next three months. Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will evaluate whether continued audits are necessary based on achieving three consecutive months of compliance.

Proposed Overall Completion Date: 12/09/2025

**Directed Plan of Correction (█ - 12/8/25)**

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall review the no objection statement with the resident and the resident's designated person(s) and indicate in the resident's file that this was completed. The resident shall acknowledge via signature on the document, If the resident refuses to sign, multiple attempts shall be made and documented prior to indicating a refusal. If the resident is unable to sign, the administrator shall indicate this and include documentation of the reasons why the resident is unable to sign in the resident's record.

Directed Completion Date: 12/09/2025

Implemented (█ - 04/01/2026)