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

January 9, 2026

[redacted] ADMINISTRATOR
CARELINK COMMUNITY SUPPORT SERVICES OF PENNSYLVANIA
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/03/2025 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: *CARELINK COMMUNITY SUPPORT SERVICES-TORREY HOUSE* **License #**: *10007* **License Expiration**: *08/08/2026*

Address: *3520 DARBY ROAD, HAVERFORD, PA 19041*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CARELINK COMMUNITY SUPPORT SERVICES OF PENNSYLVANIA*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/03/1986* **Issued By**: *cwopa*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *13* **Waking Staff**: *10*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/03/2025*

Inspection Dates and Department Representative

11/03/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* **Residents Served**: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *7*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

11/03/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/13/2025*

12/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/22/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2025*

Inspections / Reviews *(continued)*

12/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/22/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/24/2025*

01/09/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/22/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

89b - Hot Water Temperature

1. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 11/3/2025 at 9:45 am, the hot water temperature at the 3rd floor bathroom B measured 130.6 degrees Fahrenheit.

On 11/3/2025 at 9:47 am, the hot water temperature at the 3rd floor bathroom A measured 128.1 degrees Fahrenheit.

On 11/3/2025 at 9:55 am, the hot water temperature at the 2nd floor bathroom D measured 126.6 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 12/10/2025)***

A maintenance work order was placed on 11/3/25 while the department representative was on site. Budget Maintenance technicians arrived to the site and addressed the issue the same day and was observed by the department representative. Additionally, a new water thermometer was purchased on 12/5/25 and was delivered on 12/7/25. The Administrator will check the water temperature each week from at least 2 faucets on different floors of the home and document them in a water temperature log. If the water temperature falls out of the acceptable range, an adjustment will be made to the hot water heater and the temperature will be re-checked the following day. Attached is a copy of the work order, receipt for thermometer and copy of the new water log sheets.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented ([redacted] - 01/09/2026)

130g - Smoke Detector Repair

2. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 10/27/2025 at 11:42 am, the home's fire alarm and smoke detectors were found to be inoperative. The system was not repaired until 11/3/2025 at 10:54 am.

Plan of Correction ***Accept ([redacted] - 12/10/2025)***

A call in to have the system was previously placed on 10/27/25, but moving forward, all repairs needed will require a work order to be formally placed through the Budget Maintenance website with an emergency tag so that they get addressed withing 24-48 hours. The Program Administrator or Assistant Program Administrator will be responsible for this.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented ([redacted] - 01/09/2026)

132c - Fire Drill Records

3. Requirements

2600.

132c - Fire Drill Records *(continued)*

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted on 11/26/2024, 12/18/2024, 1/20/2025, 2/17/2025, 3/21/2025, 4/16/2025, 5/23/2025, 6/21/2025, 7/20/2025, 8/21/2025, 9/19/2025, and 10/16/2025 do not include whether the fire alarm or smoke detector was operative.

Plan of Correction ***Accept ([redacted] - 12/10/2025)***

The fire drills that occur at Torrey House will be recorded on the state's document for fire drill records: 55 Pa. code 2600.132(c). This will specifically address whether or not the fire alarm system was operative. The form that we were formerly using only asked if there were problems with the system used. Attached is a copy of the new fire drill log sheet. The Administrator will collect the completed fire drill sheets and keep their record.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented ([redacted] - 01/09/2026)

132f - Alternate Exit Routes

4. Requirements

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

Description of Violation

The main entrance was the only exit route used during the fire drills held for these dates: 11/26/2024, 1/20/2025, 2/17/2025, 4/16/2025, 5/23/2025, 8/21/2025, 9/19/2025 and 10/16/2025.

Plan of Correction ***Accept ([redacted] - 12/10/2025)***

Torrey House will rotate the route of egress each month so that the same exit is not utilized in consecutive months in order to educate the residents on all the ways they can locate the closest emergency exit in an emergency situation. A copy of the 2026 fire drill schedule is attached. All fire drills will be documented and those sheets will be collected by the Administrator and kept in the annual record.

Licensee's Proposed Overall Completion Date: *12/08/2025*

Implemented ([redacted] - 01/09/2026)

183e - Storing Medications

5. 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 11/3/2025 Anora Ellipta belonging to Resident 1, was open with no open date on the label. According to the manufacturer's instructions this medication expires 6 weeks after opening..

183e - Storing Medications *(continued)*

Plan of Correction ***Accept (- 12/12/2025)***

This was discussed at the staff meeting held on 11/20/25 and the proper way to hold, administer and store medications was reviewed with staff. Attached is the group supervision that was relayed to all staff so that we can prevent this error from occurring in the future. All medication certified staff will be responsible for this moving forward. A full audit of the medication boxes for each resident will also occur twice a month to ensure that everything is accurate and accounted for. One of these audits will be performed by the third shift supervisor and the other audit is to be performed by the second shift supervisor. This will happen during the 2nd and 4th weeks of the month respectively. This will start in December 2025 as well.

Licensee's Proposed Overall Completion Date: *12/10/2025*

Implemented (- 01/09/2026)

185a - Implement Storage Procedures

6. 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

On 10/30/2025, Resident 1's Medication Administration Record had a reading of 119 for the after lunch glucose check. This reading was not located in the glucometer.

Plan of Correction ***Accept (- 12/12/2025)***

At the staff meeting held on 11/20/25, a group supervision was provided to the entire staffing team that outlined the proper manner in which a resident's blood sugar reading was to be collected. Staff were educated on how to assist, when to document the reading and what to do if a mistake is made and how to correct that. All staff certified in medication administration will be responsible for this moving forward. Additionally, the Program Supervisor and Assistant Program Supervisor will check this monthly to ensure accuracy. This will begin in December 2025.

Licensee's Proposed Overall Completion Date: *12/10/2025*

Implemented (- 01/09/2026)

227d - Support Plan Medical/Dental

7. Requirements

2600.
227.d. Each home shall document in the resident’s support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident’s physician, physician’s assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident 1, dated indicates the resident has needs for Agitation and Irritability. The resident's support plan dated does not document how these needs will be met.

Plan of Correction ***Directed (- 12/12/2025)***

The Administrator is responsible for the completion and storage of the home's RASPs for each resident. Each existing RASP will be used to assist in completing the following RASP, along with the DME to gauge a resident's overall progress in the areas contained within the RASP. Attached is a revised page where the error occurred. These will

227d - Support Plan Medical/Dental (continued)

be reviewed annually by Careink's Quality Management team and also spot checked by the Administrator quarterly. These checks will begin in December 2025.

Proposed Overall Completion Date: 12/10/2025

Directed POC:

In addition to the above-mentioned steps:

Within 10 days of receipt of the plan of correction: *The administrator or designee shall review all current completed support plans for accuracy and completion including the care and services the home and any other agency will provide. Documentation of the review shall be kept.*

Directed Completion Date: *12/22/2025*

Implemented ([redacted] - 01/09/2026)