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

July 13, 2026

[redacted], EXECUTIVE DIRECTOR
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 06/08/2026, 06/09/2026 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**: *01/25/2027*

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**: *11/20/2019* **Issued By**: *City of Philadelphia*

Type: *I-2* **Date**: *03/30/2017* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *127* **Waking Staff**: *95*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/09/2026*

Inspection Dates and Department Representative

06/08/2026 - On-Site: [redacted]

06/09/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *188* **Residents Served**: *85*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Floor* **Capacity**: *23* **Residents Served**: *20*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *85*

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

Have Mobility Need: *42* **Have Physical Disability**: *1*

Inspections / Reviews

06/08/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/02/2026*

Inspections / Reviews *(continued)*

07/02/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/10/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/12/2026*

07/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/10/2026*

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

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 6/8/26, at 9:57 A.M., medication information including names of medications and dosage were unlocked, unattended, and accessible on the side of the third floor medication cart.

Repeat Violation: 1/6/26, 5/28/25 et al

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

This was corrected immediately and removed from the cart. Staff removed the top of the medication blister pack to place in the HIPPA bin. However, left it on the cart visible if up close to medication cart. All med techs, CNAs, nurses were reeducated on keeping this information confidential. Also reviewed with staff other confidential records to maintain resident privacy. Random privacy observations to check for any breach of resident records 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. In-service/education for Personal Care staff was conducted on June 12, 2026. Weekly privacy observations were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/13/2026)

65g - Annual Training Content

2. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year January 1, 2025 to December 31, 2025.

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

After identifying incomplete annual training the dining staff member was removed from working in Personal Care on 6/8/2026. HR will ensure ancillary staff have the required annual training hours for the year to meet the requirements (see attached new policy). In-person and online training will be checked periodically throughout the year by HR, and all departments will be notified of staff's progress. All annual training will be readily available for surveyors to review upon request. Inservice conducted with dining staff 6/15/26-6/30/26 to educated on the importance/requirement of completing the annual training to continue to work in the Personal Care department. HR will report training progress during the quarterly QAPI Committee meeting.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 07/13/2026)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of Staff Person A and Staff Person B's training does not include the trainer, source, and length of training on orientation.

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

During inspection this information was provided related to the staff orientation which included the required details. Please see attached. The PCHA will ensure all training and in-services throughout the year includes the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept. (See attached records)

Licensee's Proposed Overall Completion Date: *06/29/2026*

Implemented ([redacted] - 07/13/2026)

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Crest Optic White Toothpaste, with a manufacture's label indicating "if more than is used for brushing is ingested, contact a Poison Control Center.", was unlocked, unattended, and accessible to residents in bedroom 3500. Not all the residents of the home, including Resident # 1, have been assessed capable of recognizing and using poisons safely.

McKesson Hand Sanitizer, with a manufacture's label indicating "in case of accidental ingestion, contact a Poison Control Center.", was unlocked, unattended, and accessible to residents on the 3rd floor medication cart. Not all the residents of the home, including Resident # 1, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction ***Accept (- 07/02/2026)***

Items were moved immediately, and staff members were educated on safe storage of poisonous materials. Random poisonous material observations to ensure proper storage 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. In-service/education for Personal Care was conducted on June 12, 2026.Weekly privacy observations were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 07/13/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 6/8/26 at 9:15 A.M., Resident # 2's urinal uncovered with 1/2 inch of urine was present on the bathroom floor.

Plan of Correction ***Accept (- 07/02/2026)***

This resident empties own urinal and will alert staff to check with output for documentation. However, the resident left for appointment before telling the staff that emptied the urinal. Personal Care staff were educated to check the room through the shift to ensure the urinals are empty to maintain sanitary conditions. Weekly, random room check observations will be completed to ensure sanitary conditions are maintained. This will be conducted 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. In-service/education for Personal care staff was conducted on June 12, 2026. Weekly room check observations were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented (- 07/13/2026)

96b - First Aid Location

6. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff Person C and Staff Person D, did not know the location of the first aid kit.

96b - First Aid Location *(continued)*

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

Personal care/housekeeping staff were educated on the location of all first aide kits. In-service/education for location of the first aide kits was then conducted on June 12, 2026 for Personal Care staff. Housekeeping staff in-service/education for location of the first aide kits was conducted on June 26, 2026 for housekeeping staff working in PC. This information will be reviewed annually during in-personal fire safety training.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/13/2026)

101j3 - Bed/Linens/Pillows/Blankets

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for Resident # 3 had a dried black stain on the mattress cover near the pillow.

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

This was corrected immediately and the sheets/mattress cover were removed and replaced. Weekly, random room check observations will be completed to check that linens are in good repair 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 staff was completed on 6/12/2026 and laundry's staff in-service was completed on 6/19/2026. Weekly room check observations were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/13/2026)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 6/8/26 at 9:15 A.M., a mechanism at the top of the door allows on the left side of the double doors to open first or both doors at the same time and blocked egress from the home's emergency exit near the library.

On 6/8/26 at 9:37 A.M., a mechanism at the top of the door allows only the left side of the double doors to open first or both doors at the same time and blocked egress from the home's emergency exit labeled south near the activities kitchenette.

On 6/8/26 at 9:50 A.M., a mechanism at the top of the door allows on the left side of the double doors to open first or both doors at the same time and blocked egress from the home's emergency exit labeled north.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

Upon maintenance's inspection of the doors, it was noted that the metal astragal on one side of door was preventing the doors from opening on both side unless pushed together. Consulted with the Fire Safety Expert and recommended a soft brush astragal to replace the existing metal. This was removed from the door on 2nd floor. On the 3rd floor (memory care) staff were unable to remove it as the other door does not have the magnetic lock to keep both door secured once the metal astragal is removed. Requested CMS building Solution for an appointment for a quote for additional magnetic locks. Appointment was on 6/23/2026. Estimated received that evening and was approved. Awaiting parts to be delivered with next 2 weeks for exact date of installation. Once installed the metal astragal will be replaced with the soft brush astragal. See pictures of a metal astragal and estimate from CM3 for additional magnetic locks.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 07/13/2026)

125a - Combustible Storage

9. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Cardboard boxes were stored 6 inches from the hot water heater.

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

This was corrected immediately and boxes removed. Staff educated on ensuring combustible and flammable materials may not be located near heat sources or hot water heaters. Weekly, audits will be conducted by the maintenance department's designee/manager. The maintenance director or manager will review the audits sheet at the end of the month 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 maintenance staff was completed on 6/19/2026. Weekly audits were initiated on June 15, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/02/2026*

Implemented ([redacted] - 07/13/2026)

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 # 4 is prescribed Pregabalin 75 mg 2 tablets twice daily. Resident # 4 was given both doses on 6/7/26 and 6/8/26. The narcotic control log has Pregabalin documented as administered 6/8/26 at 9:00 P.M. twice and 9:00 A.M. once and 6/7/26 administered once at 9:00 A.M. The home's medication policy states " When staff assist the resident with a Narcotic, the staff must sign and date the individual narcotic sheet and deduct the previous total."

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

The Med Tech transcribed the incorrect date on the narcotic sheet. This staff member was re-educated on proper documentation. Weekly record checks will be conducted 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 Staff was completed on June 12, 2026. Weekly record checks were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/13/2026)

187d - Follow Prescriber's Orders

11. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident # 5 is prescribed Metoprolol Succinate ER Oral Tablet Extended Release 25 mg 1 tablet by mouth at bedtime hold is Systolic Blood Pressure is lower than 110 and heart rate is lower than 60. However, Resident #5 was administered Metoprolol Succinate ER Oral Tablet Extended Release 25mg on 6/2/26 but did not include the blood pressure and heart rate.

Plan of Correction ***Accept ([redacted] - 07/02/2026)***

Upon investigation it was identified that the medication was not administered as per EMAR it was documented "hold for parameter. The EMAR software allowed staff to save the medication as "hold for parameter". However, did not require blood pressure results before saving the documentation. Blood pressure result for that date were not saved in the EMAR. All Med Techs educated on this issue and nursing staff added an additional order as per PCPs for residents with parameters to have a standing blood pressure order in place to be taken before medication given. This will ensure the results are saved in the EMAR system. Weekly random record checks will be completed to check that parameter results are documented. The PCHA will conduct audits weekly for 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 Staff was completed on June 12, 2026. Weekly record checks were initiated on June 19, 2026 and will continue for 12 weeks as noted above.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented ([redacted] - 07/13/2026)