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

August 5, 2026

[redacted], CEO
HOLY REDEEMER HEALTH SYSTEM
8580 VEREE ROAD
PHAILDALPHIA, PA, 19111

RE: THE LAFAYETTE
8580 VERREE ROAD, 2ND&3RD FLRS
PHILADELPHIA, PA, 19111
LICENSE/COC#: 10192

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2026 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: *THE LAFAYETTE* **License #**: *10192* **License Expiration**: *07/16/2027*

Address: *8580 VERREE ROAD, 2ND&3RD FLRS, PHILADELPHIA, PA 19111*

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

Administrator

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

Legal Entity

Name: *HOLY REDEEMER HEALTH SYSTEM*

Address: *8580 VEREE ROAD, PHAILDALPHIA, PA, 19111*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/20/1985* **Issued By**: *Philadelphia L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/08/2026*

Inspection Dates and Department Representative

07/08/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *50*

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

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

Inspections / Reviews

07/08/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/04/2026*

07/28/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/29/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/08/2026*

Inspections / Reviews *(continued)*

08/05/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/29/2026*

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

65g - Annual Training Content

1. 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:

Description of Violation

Staff persons A and B did not receive the following trainings during training year 2025:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Plan of Correction ***Directed ([redacted] - 07/28/2026)***

Administrator was told by Fire Safety Expert that 15 day grace period applied to training because it is an annual requirement and not listed under the regulations in the RCG that the grace period doesn't apply to. Fire Safety & Emergency Preparedness training for the 2025 calendar year was completed outside of calendar year for some staff because the previous fire safety expert who provided our education resigned and there were staff members who were unable to attend the scheduled training with newly established fire safety expert that occurred in December of 2025. As an ongoing measure, Administrator completed the Fire Safety and Emergency Preparedness Train the Trainer course on 1/14/2026 so that the Administrator can complete the training going forward therefore allowing for more training dates and flexibility to ensure all Redeemer direct and non-direct care staff complete the training within calendar year beginning with calendar year 2026.

Proposed Overall Completion Date: 07/28/2026

Directed Plan of Correction (slw 7/28/26):
In addition to the steps submitted in the Plan of Correction, the administrator will insure the following steps are implemented:
1. The administrator will ensure all staff have completed the Fire Safety and Emergency Preparedness training within the next 30 days of receipt of this plan of corretion.
2. Staff A and B will be trained on Fire Safety and Emergency Preparedness within the next 10 days.
3. Documentation of the fire safety training will be maintained for the Departments review.
4. At least bi-annually, the administrator will review all staff training to ensure the required topics have been completed or are scheduled annually, starting immediately.

Directed Completion Date: *07/28/2026*

Implemented ([redacted] - 08/05/2026)

130a - Smoke Detector 15 ft Bedroom

2. Requirements

2600.
130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

From 6/6 to 7/8/2026, there were no smoke detectors within 15 feet of rooms 318, 367, 372, and 377.

Plan of Correction ***Accept ([redacted] - 07/28/2026)***

On 7/8/26 the Assistant Director of Engineering & Maintenance, who completed the inspection with the fire safety expert, notified the Administrator Siemens was contracted to install additional smoke detectors in front of apartments 318, 367, 372 and 377. Annual inspections are already completed by a fire safety expert and the

130a Smoke Detector 15 ft Bedroom (continued)

Assistant Director of Engineering & Maintenance; going forward Administrator will be present during inspection to ensure if there are noted issues they are addressed in a timely manner. This will begin to occur with the next annual inspection to occur in 2027.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Implemented ([redacted] - 08/05/2026)

133.2 - Exit Signs Direction

3. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

From 6/6 to 7/6/2026, there was no visible exit sign indicating the path of travel to an exit upon leaving rooms 329, 340, and 371. The rooms do not have a direct visual line to the nearest exit.

Plan of Correction ***Accept ([redacted] - 07/28/2026)***

On 7/8/26 the Assistant Director of Engineering & Maintenance, who completed the inspection with the fire safety expert, notified the Administrator new exit signs were purchased for installation in view of apartments 329, 340 and 371. These signs have been installed. Annual inspections are already completed by a fire safety expert and the Assistant Director of Engineering & Maintenance; going forward Administrator will be present during inspection to ensure if there are noted issues they are addressed in a timely manner. This will begin to occur with the next annual inspection to occur in 2027.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Implemented ([redacted] - 08/05/2026)

181f - Record of Medication

4. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 7/8/2026 at 11:04 am, resident #1 record did not include a current list of medications. The list in the resident's record did not include Cetirizine HCL 10mg, which the resident has been self administering for allergies.

Plan of Correction ***Accept ([redacted] - 07/28/2026)***

Resident was admitted on [redacted], at that time Nurse Manager reviewed with the resident the medication listed on [redacted] DME and reconciled with medication resident had in apartment. At that time Cetirizine was not listed on the initial DME and the resident did not have that medication in [redacted] apartment. Residents are instructed to notify the Team Leader of any medically related changes so that we are able to update records accordingly. Normally to rectify this issue, we would immediately contact the resident's PCP for an order to add this medication to the resident's medication list so it is current and accurate. However, we were not notified of this violation until 7/15/2026 and this resident discharged from Personal Care and transferred to Independent Living on the morning of [redacted] Residents who self administer medications are already assessed annually or after a significant change in status to ensure that they are able to continue self administering medications. As an ongoing measure, the Nurse Manager

181f Record of Medication (continued)

will meet with any residents self administering medications quarterly to reconcile their current medication list with the medications in their apartment. This quarterly audit will begin in July 2026.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Implemented (- 08/05/2026)

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 7/8/26, the following medications had punctures in the back of their blister packs, exposing doses:
Resident #2's 325 mg Acetaminophen tablets
Resident #3's 325 mg Acetaminophen tablets

Plan of Correction ***Accept (- 07/28/2026)***

On 7/8/26, the medications in the effected blister packs were disposed of. On 7/8/26, an audit was completed by the Nurse Manager of all blister packed medication to check for any additional punctures; none were found. The Team Leader LPN currently completes an audit of PRN medications weekly; as an ongoing measure this audit has been updated to include checking blister packs for punctures/other issues with storage. This additional weekly audit will begin in July 2026.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Implemented (- 08/05/2026)

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

Resident #4 is prescribed one 10 mg Prochlorperazine tablet every six hours as needed. On 7/8/2026, this medication was not available in the home.

Plan of Correction ***Accept (- 07/28/2026)***

On 7/8/26, Nurse Manager, contacted hospice who ordered missing medication which was received that date. On 7/8/2026, an audit was completed by the Nurse Manager of all PRN medications to make sure all were present in the home; no additional PRN medications were missing. PRN medication audits are already being completed by the Team Leader weekly; as an ongoing measure, the Nurse Manager will also audit the PRN medications quarterly. This additional quarterly audit by the Nurse Manager will begin July 2026.

Licensee's Proposed Overall Completion Date: *07/28/2026*

Implemented (- 08/05/2026)