

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

September 9, 2026

[REDACTED], ADMINISTRATOR
TAYLORS PERSONAL CARE HOME LLC
2113-15 WEST HUNTING PARK AVE
PHILADELPHIA, PA, 19140

RE: TAYLOR'S PERSONAL CARE HOME
2113-15 WEST HUNTING PARK AVE
PHILADELPHIA, PA, 19140
LICENSE/COC#: 13854

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/11/2026 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: TAYLOR'S PERSONAL CARE HOME **License #:** 13854 **License Expiration:** 12/20/2026
Address: 2113 15 WEST HUNTING PARK AVE, PHILADELPHIA, PA 19140
County: PHILADELPHIA **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: TAYLORS PERSONAL CARE HOME LLC
Address: 2113 15 WEST HUNTING PARK AVE, PHILADELPHIA, PA, 19140
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: Other **Date:** 01/14/2009 **Issued By:** Phila. L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 29 **Waking Staff:** 22

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 08/12/2026

Inspection Dates and Department Representative

08/11/2026 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 37 **Residents Served:** 27

Secured Dementia Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 25 **Are 60 Years of Age or Older:** 15
Diagnosed with Mental Illness: 27 **Diagnosed with Intellectual Disability:** 4
Have Mobility Need: 2 **Have Physical Disability:** 0

Inspections / Reviews

08/11/2026 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 08/31/2026

Inspections / Reviews (*continued*)

09/09/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

09/09/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in the following topics during training year 2025:

- *Care for residents with dementia and cognitive impairments.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction

Accept () - 09/09/2026)

1.Regulation: 55 Pa. Code § 2600.65(f) – Training Topics

Description of Violation:

Direct Care Staff Person A did not have documentation showing completion of the following required training topics during the 2025 training year:

Care for residents with dementia and cognitive impairments.

Care for residents with mental illness, intellectual disabilities, or both, as applicable to the population served by the home.

Acknowledgment of Violation:

Administrator acknowledges that the required 2025 training documentation was not available for review during the inspection. The Administrator believes the training was conducted but that the documentation was misplaced.

During the inspection, Licensing Representative reviewed the Administrator's training files and observed documentation showing that training on dementia, cognitive impairments, and mental illness had been conducted during the 2023, 2024, and 2026 training years. However, documentation for the required 2025 training could not be located.

Corrective Action:

All Direct Care Staff received training on "Dementia and Cognitive Impairments" on May 3, 2026. All Direct Care Staff also received training on "Understanding Residents with Mental Illness" on June 3, 2026. Licensing Representative reviewed and witnessed the training documentation during the inspection. The Administrator will provide copies of the attendance records and related training materials as supporting evidence of compliance.

Moving forward, the Administrator will ensure that ALL DCS Trainings including Dementia and Cognitive Impairments and Understanding Residents with Mental Illness is completed and Copies of DCS training record, attendance sheet, training materials, and any certificate of completion will be maintained in the administrator

65f Training Topics (continued)

office onsite at the facility in a Direct Care Staff training binder.

Preventive Measures:

To prevent this violation from recurring, Administrator will ensure that:

All Direct Care Staff receive training on caring for residents with dementia and cognitive impairments.

All Direct Care Staff receive training on caring for residents with mental illness, intellectual disabilities, or both, as applicable to the population served by the home.

Every completed training is recorded on the facility's annual training record.

Training documentation includes the topic, date, start and end times, length of training, instructor's name and qualifications, and required signatures.

Copies of attendance records, certificates, handouts, and supporting documentation are maintained in the Direct Care Staff training binder.

Training records are stored in the Administrator's office and made available for review by the Department of Human Services, Bureau of Human Services Licensing.

The Administrator or designee reviews the training binder after each training to verify that all required documentation is complete and properly filed.

The Administrator or designee conducts a monthly review of the training records to identify and correct any missing documentation.

An annual training checklist is maintained for each Direct Care Staff employee to verify completion of all required training topics.

Taylor's Personal Care Home will ensure that all required Direct Care Staff training is completed, properly documented, securely maintained, and available for Department review.

Responsible Person: Administrator

Correction Date: May 3 and June 3 2026

Please See Attach Documentation for Target Completion:

Licensee's Proposed Overall Completion Date: 08/24/2026

Implemented () - 09/09/2026

66b - Training Plan Content**2. 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:

Description of Violation

The home's staff training plan for 2026 does not include the dates and times of each training.

Plan of Correction

Accept () - 09/09/2026

1. Regulation: 55 Pa. Code § 2600.66(b) Training Plan Content

Description of Violation:

The home's staff training plan for 2026 did not include the scheduled dates and times for each training.

66b - Training Plan Content (continued)**Corrective Action:**

Administrator will revise the 2026 staff training plan to include the specific date and time of each scheduled training. The revised training plan will be maintained in the home's administrative training records and made available for review.

Preventive Measures:

To prevent this violation from recurring, the Administrator will ensure that:

Every annual Direct Care Staff training plan identifies each required training topic, scheduled date, start time, length of training, and instructor.

The annual training plan is reviewed for completeness before it is implemented.

Any change to a scheduled training date or time is promptly documented on the training plan.

Training attendance records and certificates are maintained in each employee's personnel file.

The training plan is reviewed quarterly to ensure that all scheduled training information remains complete and current.

The Administrator will be responsible for monitoring ongoing compliance and ensuring that all future Direct Care Staff training plans include the dates and times of every scheduled training.

Responsible Person: Administrator

Target Completion Date: August 12, 2026

Please See Attach Documentation For Completion.

Licensee's Proposed Overall Completion Date: 08/24/2026

Implemented (████) - 09/09/2026)

85d - Trash Receptacles**3. Requirements**

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/11/2026 at 10:24 am, there was no receptacle for trash in the third-floor men's bathroom.

Repeated violation: 08/18/2025.

Plan of Correction

Accept (████) - 09/09/2026)

1. Regulation: 55 Pa. Code § 2600.85(d) – Trash Receptacles

Violation:

On August 11, 2026, at approximately 10:24 a.m., there was no covered trash receptacle in the third-floor men's bathroom located on the 2115 men's side.

Immediate Corrective Action:

85d Trash Receptacles (continued)

The violation was corrected on site during the inspection. At approximately 10:30 a.m., Administrator placed a brand new trash receptacle with a lid in the third floor men's bathroom. Representative [REDACTED] witnessed the correction.

Preventive Measures:

To prevent this violation from recurring, the Administrator will ensure that:

Direct Care Staff assigned to housekeeping conduct daily environmental rounds.

All resident bathrooms and kitchens are checked daily to ensure that a covered trash receptacle is present and in good condition.

Staff immediately replace any missing, damaged, or uncovered trash receptacle.

Completion of the daily rounds is recorded on an environmental inspection checklist.

The Administrator or designee reviews the checklist weekly to confirm continued compliance.

Taylor's Personal Care Home will ensure that trash in all kitchens and bathrooms is kept in covered trash receptacles that prevent the penetration of insects and rodents.

Date Corrected: August 11, 2026, at approximately 10:30 a.m.

Responsible Person: Administrator

Ongoing Monitoring: Daily, with weekly administrative review

Licensee's Proposed Overall Completion Date: 08/21/2026

Implemented ([REDACTED]) - 09/09/2026)

101j7 - Lighting/Operable Lamp**4. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 8/11/2026, the cord to resident #1's bedside lamp was severed. Resident #2's bedside lamp had no bulb. Resident #3's bedside lamp was unplugged and had no bulb. Resident #4's bedside lamp was inoperable. None of these residents had access to a source of light that could be turned on/off at bedside.

Plan of Correction

Accept ([REDACTED]) - 09/09/2026)

1. Regulation: 55 Pa. Code § 2600.101(j)(7) Lighting/Operable Bedside Lamp

Description of Violation:

On August 11, 2026, the following conditions were observed:

Resident #1's bedside lamp had a severed cord.

Resident #2's bedside lamp did not have a light bulb.

Resident #3's bedside lamp was unplugged and did not have a light bulb.

Resident #4's bedside lamp was inoperable.

As a result, these residents did not have access to an operable source of light that could be turned on and off from their bedsides.

101j7 - Lighting/Operable Lamp (continued)**Immediate Corrective Action:**

The violation was corrected on-site during the inspection. Administrator replaced the damaged cord and installed new light bulbs as needed. Each affected bedside lamp was plugged in, tested, and confirmed to be operable. Licensing Representative witnessed the corrective action.

Preventive Measures:

To prevent this violation from recurring, the Administrator will ensure that:

Direct Care Staff assigned to housekeeping conduct daily environmental rounds of all resident bedrooms.

Staff verify that each resident has an operable bedside lamp with a working light bulb and an undamaged electrical cord.

Each lamp is plugged in and accessible so the resident can turn it on and off from the bedside.

Any missing bulb, damaged cord, or inoperable lamp is reported and corrected immediately.

Spare light bulbs and replacement lamps are maintained at the home.

Daily inspections are documented on an environmental-rounds checklist.

The Administrator or designee reviews the checklist weekly to verify continued compliance.

Date Corrected: August 11, 2026

Responsible Person: Administrator

Ongoing Monitoring: Daily environmental rounds with weekly administrative review

Licensee's Proposed Overall Completion Date: 08/21/2026

Implemented () - 09/09/2026

101o - Walls, Floors, Ceilings**5. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 8/11/2026, the wall at the top of resident #4's bed in room [REDACTED] on the third floor, had white scuff marks, or worn, missing patches of paint, approximately 8 inches high and spanning the width of the resident's bed. There were also several small, round holes in three of the walls of room 202 on the second floor.

Plan of Correction

Accept () - 09/09/2026

1. Regulation: 55 Pa. Code § 2600.101(o) – Walls, Floors and Ceilings

Description of Violation:

On August 11, 2026, the wall above Resident #4's bed in Room [REDACTED] on the third floor of the 2113 [REDACTED] had white scuff marks and worn or missing patches of paint. The affected area was approximately eight inches high and extended across the width of the resident's bed. Several small, round holes were also observed in three walls of Room 202 on the second floor. Administrator acknowledged the violation.

101o - Walls, Floors, Ceilings (continued)**Corrective Action:**

Before the inspection, the Administrator had identified Room [REDACTED] as requiring significant repairs and had included the room on the facility's high-priority maintenance punch list for the 2113–2115 buildings. Licensing Representative reviewed the punch list and observed materials and improvements purchased for the planned renovations, including new wood flooring, mirrors, pictures, and a ceiling fan.

The corrective work will include:

Patching and repairing all holes and damaged areas in Rooms 202 and [REDACTED]

Preparing and repainting the affected walls.

Replacing the flooring in Room [REDACTED]

Inspecting the walls, floors, and ceilings for any additional damage.

Installing the planned furnishings and fixtures.

Cleaning and inspecting the rooms after the work is completed.

Work is scheduled to begin on August 24, 2026, and will be completed by September 8, 2026. Residents will be kept away from active work areas and temporarily relocated within the home when necessary to protect their health and safety.

The home's walls, floors, and ceilings are maintained in a clean, safe, sanitary, and good state of repair.

Correction Date: August 31, 2026

Responsible Person: Administrator

Responsible Person: Administrator

Ongoing Monitoring: Daily staff rounds and monthly administrative inspections

Licensee's Proposed Overall Completion Date: 08/21/2026

Implemented ([REDACTED]) - 09/09/2026)

121a - Unobstructed Egress**6. 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 8/11/2026 at approximately 2:05 pm, the rear screen door required excessive force to open, blocking egress from the home's kitchen.

Plan of Correction

Accept ([REDACTED]) - 09/09/2026)

6. Plan of Correction

Regulation: 55 Pa. Code § 2600.121(a) – Unobstructed Egress

Description of Violation:

121a Unobstructed Egress (continued)

On August 11, 2026, at approximately 2:05 p.m., the rear screen door on 2113 side in the Kitchen required excessive force to open, obstructing egress from the home's kitchen. Administrator and Manager immediately inspected the door in the presence of Licensing Representative. Although the door opened, it appeared to be sticking and did not operate freely.

Immediate Corrective Action:

The Administrator and Manager immediately inspected the rear screen door and determined that the lock needed to be replaced. The violation was corrected on site during the inspection. At approximately 2:30 p.m., DCS Manager installed a brand new lock. The door was tested after the lock was replaced and opened freely without requiring excessive force.

Preventive Measures:

To prevent this violation from recurring, Administrator and PCH DCS Manager will ensure that:

Direct Care Staff inspect all exit doors and egress routes at the beginning of every shift.

Staff confirm that each exit door opens freely and without excessive force.

All hallways, stairways, doorways, and exit routes remain free from obstructions.

Any sticking, damaged, locked, or inoperable exit door is reported immediately to the Administrator or Manager.

Any condition affecting emergency egress is treated as a high priority maintenance issue and corrected immediately.

Exit inspections and corrective actions are documented on the facility's environmental safety checklist.

Taylor's Personal Care Home will ensure that all exits and egress routes remain unobstructed, operable, and readily accessible at all times.

Responsible Persons:, Administrator, and DCS Manager

Correction Date: August 31, 2026, at approximately 2:30 p.m.

Ongoing Monitoring: Each shift, with weekly administrative review

Licensee's Proposed Overall Completion Date: 08/21/2026

Implemented () - 09/09/2026)

141a 1-10 Medical Evaluation Information**7. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1 10 Medical Evaluation Information (continued)

Description of Violation

Resident #5's medical evaluation, dated [REDACTED] did not include a health status or mobility assessment.

Plan of Correction**Accept ([REDACTED] - 09/09/2026)***Plan of Correction*

Regulation: 55 Pa. Code § 2600.141(a)(1) (10) Medical Evaluation Information

Description of Violation:

Resident #5's medical evaluation, dated [REDACTED], did not include the resident's health status or mobility assessment.

Immediate Corrective Action:

The violation was corrected on site during the inspection. At approximately 11:15 a.m., Administrator completed the missing health status and mobility information on Resident #5's medical evaluation form. Licensing Representative witnessed the correction.

The Administrator reviewed the completed form to confirm that all information required under § 2600.141(a)(1) (10) was included.

Preventive Measures:

To prevent this violation from recurring, Administrator will ensure that:

Every resident's medical evaluation is reviewed upon admission and annually thereafter.

Each medical evaluation contains all information required under § 2600.141(a)(1) (10), including the resident's health status and mobility needs.

A medical evaluation checklist is used to verify that every required section is complete.

Any incomplete medical evaluation is returned to the appropriate medical professional for completion.

Completed medical evaluations are reviewed before being placed in the resident's record.

The Administrator or designee conducts a upon admission and annually audit of resident records to identify missing, incomplete, or outdated medical information.

Any deficiency identified during an audit is corrected promptly and documented.

Taylor's Personal Care Home will ensure that every resident's medical evaluation is completed in its entirety and maintained in the resident's record for Department review.

Responsible Person: Administrator

Correction Date: August 11, 2026, at approximately 11:15 a.m.

Ongoing Monitoring: Upon admission, and annually, record audits

Please See Documentation For Targeted Completion Date:

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented ([REDACTED] - 09/09/2026)

187a - Medication Record

8. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #5 is prescribed a monthly 1-ml injection of Haloperidol Decanoate. However, resident #5's August 2026 medication administration record does not indicate the diagnosis or purpose for this medication.

Resident #6 is prescribed one 1-mg Benztropine Mesylate tablet every evening and one 10-mg Jardiance tablet daily. However, resident #6's August 2026 medication administration record does not indicate the diagnoses or purposes for these medications.

Plan of Correction

Accept () - 09/09/2026)

Plan of Correction

Regulation: 55 Pa. Code § 2600.187(a) – Medication Record

Description of Violation:

Resident #5 is prescribed a monthly 1-mL injection of Haloperidol Decanoate. However, Resident #5's August 2026 Medication Administration Record (MAR) did not identify the diagnosis or purpose for the medication.

Resident #6 is prescribed one 1-mg Benztropine Mesylate tablet every evening and one 10-mg Jardiance tablet daily. However, Resident #6's August 2026 MAR did not identify the diagnoses or purposes for these medications.

Immediate Corrective Action:

The violation was corrected on-site during the inspection. At approximately 2:15 p.m., Administrator and Med Tech reviewed the residents' medication orders and added the prescribed diagnosis or purpose for each medication to Residents #5 and #6's August 11, 2026 MARs. Licensing Representative witnessed the correction.

The Administrator and Medication Technician reviewed the corrected MARs to confirm that the required medication information was complete and consistent with the residents' current medication orders.

Preventive Measures:

To prevent this violation from recurring, Administrator and Medication Technician will ensure that:

Every resident's MAR identifies each prescribed medication, dosage, route, frequency, diagnosis, or purpose.

All information entered on a resident's MAR is consistent with the current medication order issued by the prescribing practitioner.

New and revised MARs are reviewed for completeness before medications are administered.

Staff do not independently determine a medication's diagnosis or purpose. Missing information will be verified with the prescribing practitioner or pharmacy.

Any missing or incorrect MAR information is reported and corrected promptly.

187a - Medication Record (continued)

The home's administrator and The Medication Technician reviews all MARs at the beginning of each month and whenever a medication is started, discontinued, or changed.

The Administrator and Med TC will audit all residents' MARs monthly and documents the results.

Medication Administration Records are maintained in each resident's record and made available for Department review.

Taylor's Personal Care Home will ensure that each resident's MAR includes the diagnosis or purpose for every prescribed medication.

Responsible Persons: Administrator, and Medication Technician

Correction Date: August 11, 2026, at approximately 2:15 p.m.

Ongoing Monitoring: Monthly and whenever a medication order is initiated or changed

Please See Attach documentation For Targeted Completion:

Licensee's Proposed Overall Completion Date: 08/27/2026

Implemented ([REDACTED] - 09/09/2026)

227i - Support Plan Accessible**9. Requirements**

2600.

227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 8/11/2026 at 9:00 am, all resident support plans were locked in the administrator's office and were inaccessible to direct care staff, including staff person A.

Plan of Correction

Accept ([REDACTED] - 09/09/2026)

Plan of Correction

Corrective Action:

Administrator has made current copies of all residents' Resident Assessment-Support Plans (RASPs) and has them in a binder labeled Residents RASP in the Personal Care Home's emergency file. The emergency file will be maintained on the 2113 side of the building, next to the Administrator's office, near the employee time clock.

This location will remain accessible to authorized DCS during all shifts while protecting the residents' confidential information from unauthorized access. DCS will be informed of the location of the RASPs and instructed to review and follow each resident's plan when providing care and services.

Preventive Measures:

To prevent this violation from recurring, Administrator will ensure that:

Current copies of all residents' RASPs are maintained in the designated emergency file.

The emergency file remains accessible to authorized DCS during every shift.

All Direct Care Staff are informed of the location of the RASPs.

New Direct Care Staff are shown the location of the RASPs during orientation.

227i Support Plan Accessible (continued)

*DCS has been trained to review and follow each resident's RASP when providing care and services.
Updated RASPs are placed in the emergency file immediately after completion or revision.*

The Administrator and the PCH designee will check the emergency file monthly to ensure that every resident's current RASP is present, complete, and accessible.

Residents RASP are stored in a manner that protects resident confidentiality while allowing authorized staff immediate access.

Taylor's Personal Care Home will ensure that every resident's current RASP is accessible to Direct Care Staff at all times.

Responsible Person: Administrator

Correction Date: August 13, 2026

Ongoing Monitoring: annually and whenever a RASP is completed or updated

Please See Attach Document for Targeted Completion Date:

Licensee's Proposed Overall Completion Date: 08/24/2026

Implemented ([REDACTED] - 09/09/2026)