

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

September 23, 2026

[REDACTED], DIRECTOR
LABOR OF LOVE INC
[REDACTED]

RE: LABOR OF LOVE-BUILDING 2
2037 NORTH 62ND STREET
PHILADELPHIA, PA, 19151
LICENSE/COC#: 11637

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/17/2026 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: LABOR OF LOVE-BUILDING 2

License #: 11637

License Expiration: 07/22/2026

Address: 2037 NORTH 62ND STREET, PHILADELPHIA, PA 19151

County: PHILADELPHIA

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: LABOR OF LOVE INC

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-3 SP

Date: 01/29/1985

Issued By: City of Philadelphia

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 9

Waking Staff: 7

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 08/17/2026

Inspection Dates and Department Representative

08/17/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 10

Residents Served: 9

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 8

Are 60 Years of Age or Older: 7

Diagnosed with Mental Illness: 8

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 0

Have Physical Disability: 0

Inspections / Reviews

08/17/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/14/2026

09/11/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/21/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/21/2026

Inspections / Reviews *(continued)*

09/23/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/21/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/17/26 at 9:27 A.M., there was a brown stain present on the toilet seat in the third floor common bathroom.

On 8/17/26 at 9:48 A.M. there was a purple stain inside the refrigerator in the main kitchen on the side of the refrigerator all the way to the bottom.

Plan of Correction

Directed () - 09/11/2026

Direct Care Staff person () cleaned the bathroom at time of inspection. Direct Care Staff person () will check and clean all bathrooms daily after breakfast starting at 8am for future compliance. Direct Care Staff person () cleaned the refrigerator at time of inspection, and () will also check the refrigerator weekly and keep a weekly log for future compliance. () -Director) conducted a Quality Management Meeting along with input from (). We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms and kitchen to ensure cleanliness is maintained, starting immediately for the next four weeks.

By 9/21/26, the administrator will conduct a training to all direct staff on the importance of cleanliness in the home. The administrator will maintain a copy of the training and sign in for the Departments review.

The director will conduct monthly inspections of the home to ensure cleanliness is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/21/2026

Implemented () - 09/23/2026

95 - Furniture and Equipment

2. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

In the 2nd floor back bedroom the towel rack above bed b is not adhered to the wall on the side closest to the window.

Plan of Correction

Directed () - 09/11/2026

New towel racks were purchased and installed by () on August 24, 2026. Direct Care Staff person () keep a weekly log for future compliance. () -Director) conducted a Quality Management Meeting along with input from (). We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed

95 Furniture and Equipment (continued)

our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms, bedrooms and kitchen to ensure cleanliness is maintained and the home is in good repair, starting immediately for the next four weeks.

The director will conduct monthly inspections of the home to ensure cleanliness is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/21/2026

Implemented () - 09/23/2026)

101j5 - Bedside Table/Shelf**3. Requirements**

2600.

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

5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside beds a, b, and c in the 2nd floor back bedroom.

Plan of Correction

Directed () - 09/11/2026)

New tables were purchased and installed by () on August 21, 2026. Direct Care Staff person () keep a weekly log for future compliance. () (Director) conducted a Quality Management Meeting along with input from (). We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms, bedrooms and kitchen to ensure the home is maintaining compliance with this regulation, starting immediately for the next four weeks.

The director will conduct monthly inspections of the home to ensure compliance is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/21/2026

Implemented () - 09/23/2026)

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*Bed A in the 2nd floor back bedroom does not have access to a source of light that can be turned on/off at bedside.***Plan of Correction****Directed ([REDACTED] - 09/11/2026)**

New lights were installed by [REDACTED] on August 21, 2026. Direct Care Staff person [REDACTED] keep a weekly log for future compliance. [REDACTED] (Director) conducted a Quality Management Meeting along with input from [REDACTED]. We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control the meeting took 1 and ½ hours.

*Proposed Overall Completion Date: 09/09/2026***Directed Plan of Correction (slw 9/11/26):**

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms, bedrooms and kitchen to ensure the home is maintaining compliance with this regulation, starting immediately for the next four weeks.

The director will conduct monthly inspections of the home to ensure compliance is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/21/2026**Implemented ([REDACTED] - 09/23/2026)****102a - Toilet - 6 users****5. Requirements**

2600.

102.a. There shall be at least one functioning flush toilet for every six or fewer users, including residents, staff persons and household members.

Description of Violation*On 8/17/26, the home served 9 of residents. On that date, at 9:00 A.M., there were 1 total staff persons in the home for a total of 10 users. The home had only 1 functioning flush toilets at that time for a ratio of one toilet to 10 users.***Plan of Correction****Directed ([REDACTED] - 09/11/2026)**

The 2nd floor bathroom was under construction on the day of inspection. A new bathroom floor was installed by [REDACTED] on August 19, 2026. Direct Care Staff person [REDACTED] keep a weekly log for future compliance. [REDACTED] (Director) conducted a Quality Management Meeting along with input from [REDACTED]. We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

102a - Toilet - 6 users (continued)

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms, bedrooms and kitchen to ensure the home is maintaining compliance with this regulation, starting immediately for the next four weeks.

The director will conduct monthly inspections of the home to ensure compliance is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/21/2026

Implemented () - 09/23/2026)

103e - Left Overs

6. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated red sauce that appeared to be tomato sauce in a clear container with a red lid in the main kitchen.

There were multiple sauces with a label but no open date present in the refrigerator of the main kitchen. Examples of the sauces were:

1. Ketchup
2. Steak Sauce
3. Prego Tomato Sauce

Plan of Correction

Directed () - 09/11/2026)

Direct Care Staff person () cleaned the cleaned the refrigerator at time of inspection, and labeled the unlabeled sauces. () will also check the refrigerator weekly and keep a weekly log for future compliance.

Cox-Director) conducted a Quality Management Meeting along with input from ()

We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control, the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all bathrooms and kitchen to ensure cleanliness is maintained, starting immediately for the next four weeks.

By 9/21/26, the administrator will conduct a training to all direct staff on the importance of cleanliness in the home. The administrator will maintain a copy of the training and sign in for the Departments review.

The director will conduct monthly inspections of the home to ensure cleanliness is maintained, starting immediately, for the next four months.

103e - Left Overs (*continued*)

Directed Completion Date: 09/09/2026

Implemented () - 09/23/2026)

121a - Unobstructed Egress

7. 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 8/17/26 at 9:30 A.M., two bags of trash blocked egress from the home's 3rd floor fire escape.

Plan of Correction

Directed () - 09/11/2026)

Direct Care Staff person () cleaned and cleared the Fire Escape at time of inspection. Direct Care Staff person () will check the fire escape weekly for future compliance. () Director) conducted a Quality Management Meeting along with input from ()

() We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day of The Week and Routes for the Fire Drill and Checking the Fire Escapes, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect. Control, the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the steps noted in the submitted plan of correction, the administrator will conduct weekly physical site inspections of all parts of the home to ensure the home is maintaining compliance with this regulation, starting immediately for the next four weeks.

The director will conduct monthly inspections of the home to ensure compliance is maintained, starting immediately, for the next four months.

Directed Completion Date: 09/09/2026

Implemented () - 09/23/2026)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 11/15/24.

Plan of Correction

Directed () - 09/11/2026)

We thought that a fire safety inspection and fire drill conducted by a fire safety expert was completed in 2025. I was told by an Inspector that I could conduct one because I had my Fire Safety Train the Trainer course Certification. We have contacted the Captain of our local fire company by letter to assist us with one and also sent an email to ()

132b Safety Inspection/Fire Drill (continued)

█████ (Fire Prevention) @ for our yearly Observed Fire Drill. The Administrator █████ will check quarterly for Future Compliance.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the noted plan of correction submitted, the administrator or director of the home will schedule a fire safety inspection within the next 15 days, to ensure the fire safety inspection is conducted within the next 45 days. A copy of the fire safety inspection will be submitted to the Department for review.

The Director will schedule an annual fire safety inspection at least 12 months from the date of the inspection conducted in 2026. starting immediately.

Directed Completion Date: 09/09/2026

Implemented (█████ - 09/23/2026)

132g - Fire Drills Days/Times**9. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills on Tuesdays as evidenced by the following drills 1/27/26, 2/24/26, 3/17/26, 4/28/26, and 7/21/26.

Plan of Correction

Accept (█████ - 09/11/2026)

We had a staff quality Management Meeting on August 27, 2026 to discuss all of the current violations including a discussion regarding the repetition of using the same exits. For future compliance, the administrator will check the fire drill log for drill times, drill days, and exits weekly on Fridays from now on. █████ (Director) conducted the Quality Management Meeting along with input from █████ We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day of The Week and Routes for the Fire Drill and Checking the Fire Escapes, The meeting lasted approx. an hour and a half.

Licensee's Proposed Overall Completion Date: 09/09/2026

Implemented (█████ - 09/23/2026)

171b5 - First Aid Kit**10. Requirements**

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

171b5 First Aid Kit (continued)

Description of Violation

The first aid kit in the vehicle used to transport residents does not include scissors, tweezers, and a thermometer.

Plan of Correction**Directed (████ - 09/11/2026)**

New First Aid Kits were purchased for All Autos being used for transportation on August 21, 2026 and installed in each vehicle. This was overseen by █████ Director. Direct Care Staff person █████ keep a weekly log for future compliance. █████ (Director) conducted a Quality Management Meeting along with input from █████ We discussed Reportable Incidents & Reporting Procedures, Complaint Procedures, Reviewed our Staff Training Plan, Reviewed our Violation Reports, Reviewed Assessments and Support Plans, and mostly went over our current Plan of Correction for the current Violation Report. We discussed alternating the Day Of The Week and Routes for the Fire Drill, Proper setup for Resident rooms (tables, chairs, lights), Food Handling & Infect, and First Aid Kits. Control the meeting took 1 and ½ hours.

Proposed Overall Completion Date: 09/09/2026

Directed Plan of Correction (slw 9/11/26):

In addition to the noted submitted plan of correction the administrator or direct care staff will audit the first aid kit in the home's vehicle at least monthly for the next four months, starting immediately.

The director will audit the first aid kit at least bi annually, to ensure all included items are maintained in the vehicle, starting immediately.

Directed Completion Date: 09/21/2026

Implemented (████ - 09/23/2026)