



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

JUL 19 2016

Mr. Michael A. Barton, Executive Vice President  
NHS Pennsylvania  
4391 Sturbridge Drive  
Harrisburg, Pennsylvania 17110

RE: NHS Lehigh Valley Center  
515 Delaware Avenue  
Bethlehem, Pennsylvania 18015  
License #: 224010

Dear Mr. Barton

As a result of the Department of Human Services' annual licensing inspection on April 5, 2016 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Jay Bausch".

Jay Bausch  
Deputy Secretary

Enclosure  
License Inspection Summary

**VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: NHS LEHIGH VALLEY CENTER		License Number: 22401
Address: 515 DELEWARE AVENUE, BETHLEHEM, PA 18015		County: Lehigh
Administrator: SUZANNE DAUGHTREY		Region: NORTHEAST
Legal Entity Name: NHS PENNSYLVANIA		
Legal Entity Address: 4391 STURBRIDGE DRIVE, HARRISBURG, PA 17110		
Certificate(s) of Occupancy R-4 04/23/2012 FOUNTAIN HILL BOROUGH		
<b>Staffing Hours</b>		
Resident Support: 0	Total Daily Staff: 18	Waking Staff: 14
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Renewal, Incident		
On-Site Inspections Dates and Department Representatives On-Site 04/05/2016: Dumas, Gerald; Valence, Duane		
Off-Site Inspection Dates and Inspectors, if Applicable		
Other Details		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 16 Number of Residents Served: 16 Secured Dementia Care Unit in Home: No Area: Secured Dementia Unit Capacity, if Applicable: Number of Residents Served in Secured Dementia Care Unit, if applicable: Number of Current Hospice Residents: 0 Number of Hospice Residents in past year: 0		Number of Residents who: Receive Supplemental Security Income: 10 Are 60 Years of Age or Older: 6 Have Mental Illness: 16 Have an Intellectual Disability: 0 Have a Mobility Need: 2 Have a Physical Disability: 1

Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 56 Pa.Code §2600**  
 2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

**2a. DESCRIPTION OF VIOLATION**  
 The home's resident Abuse and Neglect policy does not include information regarding the reporting requirements under ACT 70 for the protection of abused, neglected, exploited or abandoned adults between the ages 18 and 59 who have a physical or mental impairment.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

On 4/10/16, this policy was changed and updated with the correct information included as well as a reference to the NHS policy that includes the correct ACT 70 information. The correct information was put into the PCH binder of policies as well as communicated to all staff on 4/21/16, during staff meeting. Please see the attached policy and training agenda/sign in. Moving forward the administrator will monitor for changes in the OAPSA and Adult Protective services policies and update PCH policies and procedures accordingly. Staff will be informed of any new changes in staff meeting and in training at the start of employment.

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page) *Michael A. Barton*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Michael A Barton, Exec. VP of BN*      Date *05-10-2016*

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The above plan of correction is approved as of <u>6-11-16</u> (Date)	Plan of correction implementation status as of <u>6-11-16</u> (Date)
The above plan of correction was approved by <i>[Signature]</i> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 66 Pa.Code §2600**  
 2600.25(c)(10) - The contract shall include a statement that the resident is entitled to at least 30 days' advance notice, in writing, of the home's request to change the contract.

**2a. DESCRIPTION OF VIOLATION**  
 The home failed to provide a 30 day advance notice in writing that resident #1's room and board charge would change effective January, 2016. The contract change was post-dated and signed on 2/8/2016 by resident #1's Guardian.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Moving forward all residents will be given written 30 day notice of contract changes. This will be completed and tracked by the administrator, who is responsible for all contracts signed in the home.

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page) *[Handwritten Signature]*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Michael A. Boston, Exec. V.P. of BH*      Date *03-10-2016*

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Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCN Name: NHS LEHIGH VALLEY CENTER

1. REGULATION 55 Pa.Code §2600  
 2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION

During a monthly audit of the home's glucometers, it was discovered that on 3/20/16 at 4:00 p.m. resident # 6 had a documented reading of 148 which was not recorded in [redacted] glucometer but appeared in resident #4's glucometer. Resident # 5 had [redacted] blood sugar tested using resident # 4's glucometer. Sharing glucometers is prohibited as it may result in transmitting a disease.

3. PLAN OF CORRECTION (POC) [Attach pages as necessary. Remember that you must sign and date any attached pages.]


Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

This violation was found by the home's Assistant Administrator on 3/30/16 and self reported, the following corrective action has already been taken to address the problem:

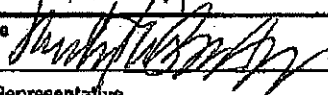
1. Retraining was held for all staff on the following dates: 3/31/16 and 4/1/16. This course outlined proper blood glucose monitoring and prevention of the spread of disease. (agenda attached)
2. Staff involved in the incident were disciplined
3. The residents were both informed; both resident's doctors and designated persons were also informed of the incident.
4. Both residents were sent for blood work to rule out any disease transmission. All results have been negative to this time. The home will continue to follow up according to doctors instructions.

The following steps will be taken to prevent this violation from happening again:

1. All resident glucometers were placed in plastic containers with bright colored tape on the outside, displaying the residents name. The glucometer is placed inside with the same tape and name.
2. Each resident has a different color tape and has been taught their "tape color". They have also be informed that they should refuse if they do not have the right kit/color
3. Monthly glucometer checks will continue to be done by the home's assistant administrator.
4. Proper use of diabetic supplies will be part of the home's infection control training that is held yearly. This will also be part of new hire diabetic training.


*Not as needed based on events or issues*   
 6-11-16

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Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Michael A. Barton, Exec. V.P. of BH*      Date *05/10/2016*

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Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**  
 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.

**2a. DESCRIPTION OF VIOLATION**  
 The home's fire drill record indicates that fire drills were all conducted on the last week of each month:  
 3/30/16, 1/29/16, 12/30/15, 11/30/15, 10/30/15, and 9/29/15. Staggering the monthly drills throughout the month prevents residents and staff from anticipating drills routinely occurring on the last week of each month.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.


The administrator has planned/scheduled out the fire drills for future months and staggered the weeks, days and times according to regulations. The administrator will review every 3 months to ensure that there are not trends to the fire drills in an effort to keep staff and residents from anticipating the drills and increasing the likelihood of safe evacuations in the event of an actual emergency. This will enhance the home's efforts towards ongoing compliance.   
 6-11-16

Repeat Violation: No      Date(s) of Previous Violation(s):

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Michael A. Barton, Exec. VP of BH*      Date *05-10-2016*

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Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

1. REGULATION 55 Pa.Code §2600  
 2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION  
 Resident #2's Medical Evaluation dated 1/29/2016 was not completed in its entirety by the resident's physician. Item #8, Cognitive Functioning was left blank.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

This medical evaluation was sent back to the doctor to have item #9 completed. The doctor was not willing to complete this item in the evaluation because of the length of time that had passed. This resident was sent for a new evaluation on 4/7/16 and this was completed in its entirety. That new evaluation is attached. Moving forward all Medical evaluations will be checked to make sure they are completed in their entirety by both the Administrator and Assistant Administrator when they come back from the doctor. Staff was also educated in staff meeting on 4/21/16 about how to look for mistakes on Medical evaluations when at the doctor with residents, so that these mistakes can be corrected immediately.

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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Michael A. Barton*

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Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2606**  
 2800.143(a) - The home shall have a written emergency medical plan that includes the following:  
 (1) The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.  
 (2) Emergency transportation to be used.  
 (3) An emergency-staffing plan.

**2a. DESCRIPTION OF VIOLATION**  
 The home's written emergency medical plan procedures do not address a list of hospitals or sources of health care that would be utilized in an emergency situation.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

The home amended the face sheet in each chart to indicate the resident's preference in hospitals to be used in emergency. A copy of a blank face sheet is attached. All existing residents face sheets were updated to the new form. This was completed on 5/3/16. Moving forward all new residents will use the new face sheet, completed by the administrator on intake, to include their preference for hospitals or emergency health care. The preference will be reviewed during yearly RASP reviews and the sheet will also be updated by the administrator if a resident expresses a change in preference. *To ensure ongoing compliance. 6-11-16*

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Printed Name and Title of Legal Entity Representative  
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 (Date)

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- Not Implemented

Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**  
 144(c)(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

**2a. DESCRIPTION OF VIOLATION**  
 The outside side porch smoking area is in close proximity to the entrance door that opens to the home's dining room and is not a safe distance away from the entrance. This common dining room exit is used by residents to exit and enter the building.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

On 4/5/16 all furniture and smoking chimneys/receptacles were moved at least 20 feet from the dining room door. Residents were also told as a group that smoking must occur away from all entry doors. Moving forward all staff will remind residents to move away from entry doors when smoking. Staff will also encourage residents to keep the furniture and receptacles away from the entry doors. To insure ongoing compliance. *Q. 6-11-16*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Michael A. Barton*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michael A. Barton, Exec. V.P. of BH</i>	Date <i>05-10-2016</i>
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Violation Report: 22401 - 04/05/2016 - Dumas, Gerald  
 PCH Name: NHS LEHIGH VALLEY CENTER

- 1. REGULATION 65 Pa.Code §2600**  
 2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:
- (1) Resident's name.
  - (2) Drug allergies.
  - (3) Name of medication.
  - (4) Strength.
  - (5) Dosage form.
  - (6) Dose.
  - (7) Route of administration.
  - (8) Frequency of administration.
  - (9) Administration times.
  - (10) Duration of therapy, if applicable.
  - (11) Special precautions, if applicable.
  - (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
  - (13) Date and time of medication administration.
  - (14) Name and initials of the staff person administering the medication.

**2a. DESCRIPTION OF VIOLATION**  
 The Medication Administration Record (M.A.R.) for resident # 3 was not initiated on 3/31/16 at 12 noon or on 3/31/16 at 12:00 a.m. Resident # 3 is prescribed ointment to both eyes every 6 hours for 10 days. It could not be determined if resident # 3 received the ointment as prescribed.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
*Includes steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

While the home cannot determine if resident 3 was given this ointment or not, we believe after talking to the resident that it was a documentation error. All staff were educated on 4/21/16 about the importance of documentation in the MAR as well as not omitting medications. Moving forward the MAR will be audited weekly by nursing staff for omissions in documentation or omissions of medication. The Administrator will follow up on any problems with individual staff and continue education about the importance of correct documentation.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/02/2015	
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

*Michael A. Barton*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michael A. Barton, Exec. VP of RH</i>	Date <i>05/10/2016</i>
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