



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to EASTERN COMFORT III INC  
LEGAL ENTITY

To operate EASTERN COMFORT III  
NAME OF FACILITY OR AGENCY

Located at 206 DIAMOND STREET, SLATINGTON, PA 18018  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE \_\_\_\_\_ ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE \_\_\_\_\_ ADDRESS OF SATELLITE SITE

To provide Personal Care Homes  
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 20  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: \_\_\_\_\_

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes  
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from November 15, 2019 until November 15, 2020,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **216770**

Robert E. Robinson  
ISSUING OFFICER

[Signature]  
DEPUTY SECRETARY

**NOTE:** This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



November 15, 2019

Mr. Steven J. Miga  
Owner/President  
Eastern Comfort III Inc.  
4136 Nazareth Pike  
Bethlehem, Pennsylvania 18020

RE: Eastern Comfort III  
206 Diamond Street  
Slatington, Pennsylvania 18018  
License #216770

Dear Mr. Miga:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 14, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

A regular license is being issued based on the enclosed violation report. Your license is enclosed.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Inspection](https://www.surveymonkey.com/r/BHSL_Inspection).

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Violation Report

# Violation Report

## Facility Information

Name: EASTERN COMFORT III

License Number: 21677

Address: 206 DIAMOND STREET,, SLATINGTON, PA 18018

County: LEHIGH

Region: NORTHEAST

## Administrator

Name: Diane Deemer

Phone: 6109004074

Email: dbstgc@rcn.co

## Legal Entity

Name: EASTERN COMFORT III INC

Address: 4136 NAZARETH PIKE, BETHLEHEM, PA, 18020

## Certificate(s) of Occupancy

Type: C-2 LP

Date: 01/01/2000

Issued By: L&I

## Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 13

Waking Staff: 10

## Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal, Complaint

## Inspection Dates and Department Representative

08/14/2019 - On-Site: Gerald Dumas, Amy Deluca

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: 20

Residents Served: 13

### Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

### Hospice

Current Residents: 0

### Number of Residents Who:

Receive Supplemental Security Income: 6

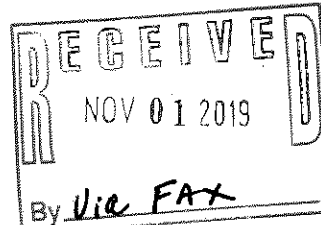
Are 60 Years of Age or Older: 9

Diagnosed with Mental Illness: 5

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 0

Have Physical Disability: 1



3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The License Inspection Summary (LIS) reports dated 1/31/2019 and 3/19/2019 were not posted in a conspicuous place in the home as required.

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 will ensure that facility's current licence with inspection summary is posted in our community area for Public's view. Administrator will post it in a conspicuous place.

Legal Entity Representative

*Diane Deemer*  
Signature

Diane Deemer Admn. 10.30-19  
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 11-4-19  
(Date)

Plan of correction implementation status as of 11-4-19  
(Date)

The above plan of correction was approved by *ag*  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 6/27/19 at 1:00 a.m., the home's fire drill log indicated that the home's fire alarm was activated for unknown reasons. There was no fire. As per a staff interview, residents evacuated to the external fire safe meeting location. The local fire company responded. The home did not report the incident to this Department. Incidents involving a call for emergency services fire, police, paramedics must be reported to the Department.

On 8/7/2019 a case manager from Area Agency on Aging came to the home to investigate suspected verbal abuse of resident # 4. The home did not report the incident to the department's regional office.

Repeat Violation - 12/13/18, 1/9/19.

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 will complete Incident Report within the time per guidelines that are required per specific incidents. The Administrator will then notify DHS per incident following the guidelines from regulation # 2600.

The Administrator will also conduct a training for all staff to ensure that they are familiar with all 19 events that must be reported to the Department and that there is a process to submit reports to the Northeast Regional Office with 24 hours, including nights, weekends and holidays. 11-4-19. *ag*

Legal Entity Representative

*Diane Deemer*  
Signature

Diane Deemer Administrator 10/30/19  
Printed Name and Title Date

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26a - Quality Management Plan

Regulations

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not conduct a quality management meeting in 2018.

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.)

Administrators will conduct a quality management meeting every 6 months per regulation #26.A. Administrator will document and file the date and time that the quality management meeting took place, including all information discussed per the Quality management Plan.

Upon completion of the Annual Quality Plan Meeting that the home will conduct to make up for the 2018 Quality Plan Meeting the home missed, it will submit their notes of the meeting to the Northeast Regional Office for Review. This will ensure compliance for the 2018 Renewal Inspection. The Submission to the the Regional Office should be no later than 15 days after receipt of this Plan of Correction. 11-4-19

ag

Legal Entity Representative

Diane Deemer

Signature

Diane Deemer Administrator 10-30-19

Printed Name and Title

Date

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132b - Safety Inspection/Fire Drill

Regulations

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 home did not complete an annual fire safety inspection due by May, 2019. The last fire safety inspection occurred 5/29/18.

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 will ensure that a fire drill is conducted by a fire safety expert yearly. The Administrator will document the inspection and will FILE the fire safety experts report in the homes fire log binder. The fire log binder will be available for DHS review.

Type text here

Legal Entity Representative

*Diane Deemer*

Signature

Diane Deemer Administrator 10-30-19

Printed Name and Title

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EASTERN COMFORT III

132d - Evacuation

Regulations

2600. 132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 5/29/18, the local home's fire chief designated the maximum time to evacuate as 1 minute 45 seconds based on the construction of the building. The home documented drills exceeded the time given on the following dates: 6/12/18 3:00p.m. 2 minutes, 7/16/18 9:30 a.m. 2 minutes, 8/31/18 2:45 a.m. 2 minutes, 9/2/18 10 a.m. 2 minutes, 10/24/18 7 a.m. 2 minutes 20 seconds, 11/12/18 1 p.m. 2 minutes, 12/2/18 10 p.m. 2 minutes 19 seconds, 1/8/19 5:50 a.m. 2 minutes, 2/12/19 2 p.m. 2 minutes 22 seconds, 3/20/19 12 p.m. 2 minutes 15 seconds, 4/28/19 6 p.m. 2 minutes 20 seconds, 5/16/19 10 a.m. 2 minutes 30 seconds, 6/20/19 12 Noon 2 minutes 10 seconds, 6/27/19 1 a.m. 2 minutes 25 seconds, and 7/8/19 2 p.m. 2 minutes 10 seconds.

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.)

Administrator talked with Fire Safety Expert (Fire Chief) The 1min 45sec. was error. Administrator had Fire Chief fill out Fire Evacuation Time/Fire Safe Area Designation Form on 8-14-19 with the proper information. Please see attached completed form. In the future Administrator will double check form to ensure it is correctly filled in before filling the form in Log.

Legal Entity Representative

Diane Deemer  
Signature

Diane Deemer Administrator 10-30-19  
Printed Name and Title Date

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132f - Alternate Exit Routes

Regulations

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home's fire drill log indicated that the home did not alternate routes used during a fire drill on the following dates: 1/8/19 at 5:50 a.m. using exits 1&3, 2/12/19 at 2:00 p.m. using exits 1 & 3, 3/20/19 at 12 p.m. using exit 1&3, 4/28/19 at 6:00 p.m. using exits 1 &3, 5/16/19 at 10:00 a.m. using exits 1 & 3, 6/20/10 at 12 noon using exits 1 & 3 and 6/27/19 at 1:00 a.m.using exits 1 & 3. The home should alternate routes to ensure staff and residents are prepared and able to respond to different fire scenarios.

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.)

Administrative spoke with staff regarding using different exits when doing fire drills. Administrator explained the importance of alternating routes. To ensure residents can vacate responding to different fire scenarios. Administrator will check fire log to ensure different routes are being used for drills.

The Administrator will review the home's fire drill logs monthly in order to ensure ongoing compliance. 11-4-19

ag

Legal Entity Representative

*Diane Deemer*

Signature

Diane Deemer Administrator 10.30-19

Printed Name and Title

Date

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141a.1-10 Medical Evaluation Information

Regulations

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.

Description of Violation

The Documentation of Medical Evaluation (DME) form for resident # 1 dated 4/2/2019 was missing the following information: Height, weight, and current medications

The DME form for resident # 2 dated 1/31/2019 was missing the following information: health status and cognitive functioning.

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.)

Prior to filing residents DME's in their personal chart Administrator will review the completed DME to ensure all required areas are properly filled in. In the event there are blocks not completed the form will then be given back to physician to complete properly. The completed DME will then be filled in the residents personal chart.

Legal Entity Representative

*Diane Deemer*  
Signature

Diane Deemer Administrator  
Printed Name and Title

10-30-19  
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182b - Prescription Medication

Regulations

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

Staff person "A" did not receive their annual medication training by their annual due date of 4/2019. Staff person "A's" last annual medication training occurred 4/18/18.

Repeat Violation 12/13/18

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.)

Administrator will be mindful and double check all employees medication Trainings and update all trainings within The dates required. Training will be documented in employees files.

Legal Entity Representative

*Diane Deemer*

Signature

Diane Deemer Administrator

Printed Name and Title

10.30.19

Date

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185a - Implement Storage Procedures

Regulations

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 #3 's glucometer was not calibrated to the correct date and time.

Resident # 3 receives regular blood glucose monitoring with insulin administered on a sliding scale. On 8/9/2019 the 4pm reading in the glucometer was 275. The reading was documented as 229 on the blood glucose monitoring sheet.

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.)

Administrator RE-educated Staff to procedures regarding glucometer readings, calibration of machine and administration of insulin. Glucometer was immediately calibrated to correct date and time. Staff will check each reading to ensure that they properly administer correct unit of insulin to resident.

Legal Entity Representative

Diane Deemer  
Signature

Diane Deemer Administrator 10-30-19  
Printed Name and Title Date

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187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #3 receives regular blood glucose monitoring with insulin administered on a sliding scale. On 8/9/2019 the 4pm reading in the glucometer was 275, requiring 12 units of insulin. According to the Medication Administration records, only 10 units of insulin were administered.

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.)

Administrator reviewed with staff the importance of double checking all glucometer readings prior to administering insulin to ensure proper dose of units are given.

Legal Entity Representative

*Diane Deemer*

Signature

*Diane Deemer Administrator*

Printed Name and Title

*10.30-19*

Date

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