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

March 1, 2023

SAUCON VALLEY MANOR INC.
1050 MAIN STREET
HELLERTOWN,, PA, 18055

RE: SAUCON VALLEY MANOR
1050 MAIN STREET
HELLERTOWN, PA, 18055
LICENSE/COC#: 2058

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/03/2022, 08/04/2022, 08/05/2022, 08/11/2022, 08/12/2022, 08/16/2022 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SAUCON VALLEY MANOR* **Licen e #**: *20581* **Licen e Expiration**: *09/03/2022*

Address: *1050 MAIN STREET, HELLERTOWN, PA 18055*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *SAUCON VALLEY MANOR INC.*

Address: *1050 MAIN STREET, HELLERTOWN,, PA, 18055*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/13/2015* **Issued By**: *Borough Hellertown*

Staffing Hours

Resident Support Staff: *117* **Total Daily Staff**: *410* **Waking Staff**: *308*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/16/2022*

Inspection Dates and Department Representative

08/03/2022 - On-Site: [redacted]
08/04/2022 - On-Site: [redacted]
08/05/2022 - On-Site: [redacted]
08/11/2022 - On-Site: [redacted]
08/12/2022 - Off-Site: [redacted]
08/16/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *213* **Re ident Served**: *176*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *100* **Re ident Served**: *70*

Hospice

Current Re ident : *38*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *174*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *117* **Have Physical Disability**: *1*

Inspections / Reviews

08/03/2022 - Full

Lead In pector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *09/16/2022*

10/17/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted**: *01/27/2023*

Reviewer: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *10/24/2022*

11/21/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted**: *01/27/2023*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *11/28/2022*

03/01/2023 Document Submi ion

Submitted By: [redacted] **Date Submitted**: *01/27/2023*

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

14c - Building Renovations

1. Requirements

2600.
14.c. If a building is structurally renovated or altered after the initial fire safety approval is issued, the home shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 15 days of the completion of the renovation or alteration.

Description of Violation

A new door with a magnetic lock was located near Room [redacted]. The door enters and exits from unit SUB. The door was installed after 8/4/21. A new fire safety approval wasn't obtained or written certification that a new fire safety approval is not required from the appropriate fire safety authority.

POC Submission ***Accept [redacted] - 10/17/2022)***

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the license inspection summary. This plan of correction is prepared and submitted to meet the requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to §55 PA. Code 20 et seq. and 2600.263.

To ensure continued compliance, a Fire Safety expert will be coming on 9/22/2022 to check and make the determination in reference to the new door with magnetic lock. Administration and Maintenance will continue to follow up on this.

Licensee's Plan Completion Date: *09/16/2022*

Implemented ([redacted] - 03/01/2023)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff member A hired [redacted]/22 Pennsylvania State Police Criminal Background check was completed on [redacted]/22. The staff member worked unsupervised prior to the background check being completed.

POC Submission ***Accept ([redacted] - 11/21/2022)***

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Corrected at time of inspection. Background check was given to Licensing. ***Human Resources and Administration*** *will ensure continued compliance with 2600.51 by ensuring that all background checks are run according to the regulations.*

Licensee's Plan Completion Date: *10/24/2022*

Implemented [redacted] - 03/01/2023)

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

The home currently serves 171 residents, 117 of the residents require assistance to evacuate in the event of an emergency. 53 residents require constant cuing to exit the building in the event of an emergency. 23 residents require a one person physical assist to exit the building in the event of an emergency. 13 residents require a two person physical assist to exit the building in the event of an emergency. 5 residents require a two person physical assist with the use of a Hoyer lift to exit the building in the event of an emergency. The home routinely has 10 staff members from 11p-7a working. The home does not have enough staff to meet the needs of the residents from 11p-7a in the event of an emergency according to the residents assessments and support plans.

POC Submission ***Directed (- 10/17/2022)***

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We respectfully disagree with this violation. We safely evacuated all of our residents to a fire safe area as indicated in our fire safety plan by the fire safety expert in September of 2021 with 11 staff members. Please see the attached Saucon Valley Manor Fire Drill Log, incident report, statement, and notes. Dewey Fire Company was onsite for this evacuation. In addition, we safely evacuated our residents on August 29, 2022 following the same protocol. Please see the attached Saucon Valley Manor Fire Drill Log, proof from Brinks that the drill was done, and the Fire Drill Record Log. To ensure continued compliance, we will be meeting with our fire safety expert on 9/22/2022. Administration and Maintenance will continue to follow up. If at any point we feel we cannot evacuate with 11 staff members, we will ensure more staff is scheduled to 11-7. To ensure continued compliance with this, Nursing, Maintenance, and Administration will continue to follow up.

Directed Plan of Correction:
As discussed in the preparation of this submission, the home will continue to do an "after action report" following each fire drill or actual emergency implementation of the fire alarm system when residents are evacuated from the building to critique resident mobility status and staff readiness to respond, react and follow up to residents' mobility, cognitive and supervisory needs in the event of fire drills and actual emergencies.

This will in turn dictate, on a month to month basis what the home's staffing patterns will needs to be going forward, keeping in mind admissions and discharges, as well as any improvements or declines of individual residents over that same time period.

All of this was discussed at length with the Management Team via phone during the preparation of this POC.
, 10-17-22

The violation stands.

Directed Completion Date: *09/16/2022*

60a - Staff/Support Plan *(continued)*

Implemented - 03/01/2023)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

A grey rectangular rug was located outside the shower and kitchen sink in Room #. The rugs did not have a slip resistant backing, posing a possible fall hazard.

POC Submission ***Accept - 10/17/2022)***

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Corrected at time of inspection. The resident in room was reeducated that the rugs need to have a slip resistant backing to prevent any fall hazards. To ensure continued compliance with this regulation, at the time of admission, the Admission Director/Administration will continue to review the lease and house rules with the families and resident. In addition, Administration and Nursing will continue to check rooms on our weekly state days.

Licensee's Plan Completion Date: *09/16/2022*

Implemented 03/01/2023)

121a - Unobstructed Egress

5. 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

The exit door near Room was locked with a magnetic lock, preventing immediate egress in the event of an emergency.

POC Submission ***Accept 11/21/2022)***

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Corrected and unlocked at time of inspection. As per the Director of Maintenance, Architect, and Fire Safety expert, the magnetic part was disengaged to ensure the door does not lock. Administration and Maintenance will continue to check to make sure door is unlocked.

Licensee's Plan Completion Date: *10/24/2022*

Implemented - 03/01/2023)

132a - Monthly Fire Drill

6. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

It was determined through staff and resident interviews, as well as a review of the reports from the 24-hour alarm monitoring company that home did not complete fire drills on [redacted]/22 at [redacted] am, [redacted]/22 at [redacted] am and [redacted]/22 at [redacted] pm as indicated on the fire drill logs.

POC Submission ***Accept (AG - 10/17/2022)***

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We respectfully disagree to the above violation. To ensure continued compliance, we will request the log from the security company as we did on 8/29/22 (see attached) and will continue to hold the drills as required. We respectfully disagree with the use of the alarm company logs as they admitted that there were times when even their recording system was down during their transition period. Please note that when Select Sercurity was sold to Brinks Home Security, several items occured - we were not billed for months after the transition, the Service Techs admitted that the system went down several times, and we were also not aware of the change nor were given the new passcode and account number until July 2022. Administration and Maintenance will ensure all drills are being completed on a monthly basis and logged appropriatly on the Fire Drill Record.

Licensee's Plan Completion Date: *09/16/2022*

Implemented ([redacted] - 03/01/2023)

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill conducted on [redacted]22 at [redacted] pm notes 12 staff members participated in the fire drill. The number of staff members participating in the fire drill is incorrectly documented on the fire drill logs. Ancillary staff member B reported that the staff member will write down the fire drill information and then give it to Ancillary staff member C to document on the fire drill logs. Staff member B and C do not keep the original fire drill information to look back on.

POC Submission ***Accept ([redacted] - 10/17/2022)***

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the license inspection summary. This plan of correction is prepared and submitted to meet the requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to §55 PA. Code 20 et seq. and 2600.263.

Due to a clerical error, the number was input wrong. As you known, it was shown that a higher number of staff

132c - Fire Drill Records (continued)

was present during that time period. To ensure continued compliance that this does not happen, Administration and Maintenance will ensure that the information on the fire drill log is correct to the best of our knowledge. Also, we will make sure that an original log is kept so we can look back.

Licensee's Plan Completion Date: *09/16/2022*

Implemented (- 03/01/2023)

132e - Fire Drill Sleeping Hours

8. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

It has been determined through staff and resident interviews, as well as a review of the reports from the 24-hour alarm monitoring company that the home did not complete an overnight sleeping hours fire drill on /22 at am as indicated on the fire drill logs.

POC Submission ***Accept (AG - 10/17/2022)***

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the license inspection summary. This plan of correction is prepared and submitted to meet the requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to §55 PA. Code 20 et seq. and 2600.263.

We respectfully disagree with this violation. The time card for the employee (Staff member B) present to conduct the drill was given to show that he was here to conduct drills. Unfortunately, the log does not show the documentation ike it is shown for the other two buildings. To ensure continued compliance, Maintenance and Administration will request the information for the log from the security company immediately following the drill as we did on 8/29/22. Please see attached. In addition, Administration will be present to observe that the fire drill is completed in each building.

Licensee's Plan Completion Date: *09/16/2022*

Implemented (- 03/01/2023)

132h - Designated Meeting Place

9. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

It has been determined through an interview with the fire safety expert that the supervised fire drill conducted on /21 at AM was only timed for the evacuation of the fire affected area. Residents in the affected area, which was the simulated location of the fire for the drill, were evacuated in 3 minutes and 41 seconds. During the supervised fire drill, residents who were in the unaffected fire areas were not evacuated out of their rooms to an internal fire safe area, and be at the ready for a full evacuation, as required by this regulation.

POC Submission ***Accept (- 11/21/2022)***

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the

132h - Designated Meeting Place (continued)

personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the license nspection summary. This plan of correction is prepared and submitted to meet the requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to §55 PA. Code 20 et seq. and 2600.263.

We respectually disagree that the resident or staff wouldn't be ready for a full evacuation. To ensure continued compliance, our fire safety expert will be conducting a supervised fire drill on 9/22/2022. Maintenanace and Administration will be working with him to ensure that all residents are evacuated as per our fire safety letter and plan.

Sent 132d letter to [redacted] Also, it is attached to this submission.

Licensee's Plan Completion Date: *10/24/2022*

Implemented ([redacted] - 03/01/2023)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 has an order for [redacted] twice daily, the bottle to the medication notes once daily. The label to the medication is incorrect.

Resident #1 has an order for [redacted], hold for systolic blood pressure less than 100 or heart rate less than 55. The label to the medication does not include the blood pressure parameter.

POC Submission ***Accept [redacted] - 10/17/2022)***

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Corrected at time of inspection. Administration and Nursing will continue to train staff to ensure that the order on the MAR matches the label on the bottle. This will be completed on a daily basis.

Licensee's Plan Completion Date: *09/16/2022*

Implemented [redacted] 03/01/2023)

227d - Support Plan Medical/Dental

11. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2's assessment and support plan dated /21 and /22 does not address the resident's care and wound vac care .

POC Submission ***Accept (11/21/2022)***

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We respectfully disagree. We spoke with on 9/15/2022 that the /2021 care plan does not apply to this violation as did not have either of these items at this time. On the /2022 RASP, the wound vac is on there - please see the attached RASP which was copied and given to the inspectors at the time of inspection. The is not on there because did not have one. To ensure continued compliance, we will continue to use the old RASP format to ensure all medical items are listed correctly.

Licensee's Plan Completion Date: *10/24/2022*

Implemented - 03/01/2023)

251c - Standardized Forms

12. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

The resident assessment and support plans (RASP) for residents #1-5 were not completed on the department's form. The home's version of the RASP does not meet all the requirements on the departments form.

POC Submission ***Accept (11/21/2022)***

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the license inspection summary. This plan of correction is prepared and submitted to meet the requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to §55 PA. Code 20 et seq. and 2600.263.

We respectfully disagree, however, to ensure continued compliance, we will continue to use the RASP format until we know if one of our new formats is approved by the Department.

Licensee's Plan Completion Date: *10/24/2022*

Implemented (- 03/01/2023)