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

June 13, 2023

[redacted], ADMINSTRATOR
1680 SPRING CREEK ROAD OPERATIONS LLC
1680 SPRING CREEK ROAD
[redacted]

RE: LEHIGH COMMONS
1680 SPRING CREEK ROAD
MACUNGIE, PA, 18062
LICENSE/COC#: 22205

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/04/2023, 04/05/2023 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.

[redacted]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEHIGH COMMONS* **License #**: *22205* **License Expiration**: *03/16/2024*

Address: *1680 SPRING CREEK ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *1680 SPRING CREEK ROAD OPERATIONS LLC*

Address: *1680 SPRING CREEK ROAD, MACUNGIE, PA, 18062*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/19/1998* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *90* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *04/05/2023*

Inspection Dates and Department Representative

04/04/2023 - On-Site:

04/05/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *first floor secured* **Capacity**: *15* **Residents Served**: *14*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

04/04/2023 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/06/2023*

05/10/2023 - POC Submission

Submitted By: **Date Submitted**: *06/08/2023*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/15/2023*

Inspections / Reviews *(continued)*

05/16/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/22/2023*

06/13/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2023*

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff person "A" DOH [redacted], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 05/16/2023)***

1) All current staff records have been audited for compliance by the Staffing Coordinator; [redacted] and the Human Resources Director Jacqueline Zurl. This audit was completed on 5/1/23.
2) Staff Person A has been reassigned to laundry/housekeeping and assigned to the night shift. They have also currently enrolled in a CNA course in hopes of returning to patient care at some point.
3) All future employment candidates will have their qualifications for employment reviewed and verified by 2 directors. Staffing coordinator; [redacted] and Human resources director Jacqueline Zurl. In the absense of one of the above the Executive Director; [redacted] will verify the accuracy of potential employee candidates.
4) As a facility we have implimented the use of the two attached audit forms which will be completed and stapled to the inside of each personal file. These audit forms will be signed by both the staffing coordinator and the H/R representative to ensure verification.
5) On a monthly basis the Executive Director; [redacted] will audit 25% of the new hires from the previous month to verify ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Implemented ([redacted] - 06/13/2023)

132g - Fire Drills Days/Times

2. 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 during the last week of the month as evidenced by the following drills - 4/29/22; 5/29/22; 6/27/22; 7/28/22 and 8/30/22.

Plan of Correction ***Accept [redacted] - 05/10/2023)***

The contract with Croker Fire Safety has been terminated due to their insistance on having fire drills on only the last week of each month. Lehigh Commons has entered into an agreement with Fire Life Safety Solutions to conduct all firedrills, inspections, or anything related to fire safety at lehigh commons. The Executive Director will monitor and track all drill dates and times to ensure proper compliance with regulations occur and no pattern for drills develope. Croker requires a 30 day notice to terminate contract is why completion date is 6/1/2023

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] - 06/13/2023)

182b - Prescription Medication

3. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

The home did not have documentation that Staff Person B had received training for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies as required.

Plan of Correction ***Accept (- 05/10/2023)***

The attached documentation will be added to the bi-annual med-tech recertification paperwork and signed off completed and passed by the instructor. These will be verified upon completion of re-certification by the Executive Director or his designee. All med-techs employed by Lehigh Commons will have recieved the additional route training (oral; topical; eye; nose; and ear drop presription medications; insulin injections and epinephrine injections training certifications by 6/1/2023

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented (- 06/13/2023)

185a - Implement Storage Procedures

4. Requirements

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 #1 's glucometer had a blood glucose test reading on at of and the home's MAR had a blood glucose test recorded for at of

Plan of Correction ***Accept - 05/16/2023)***

1) Residents with an order for accu-checks has a shoebox size plastic container marked with their name and room number. Each container is kept in the med-room. Each container contains that residents Glucometer, alcohol swabs,test strips and lancets. The Director of nursing Lori Simons is responsible for auditing each box on a monthly basis to ensure it contains appropriate equipment.

2) At the time of the equipment audit the DON will also audit the glucometers for accuracy of reading to match the blood sugar reading in the MAR for each resident.

3) The night shift Med-tech's/LPN weekly will also audit the glucometer of every resident to determine documentation accuracy and verify it was in fact done.

4) This policy with audits begins 5/5/2023

Licensee's Proposed Overall Completion Date: *05/15/2023*

Implemented - 06/13/2023)

185a - Implement Storage Procedures *(continued)*

236 - Staff Training

5. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff working on the secured dementia care unit, didn't't' receive the required 6 hours of annual training related to dementia care and service for training year 2022.

Plan of Correction ***Accept (- 05/16/2023)***

1) The executive Dir.; the Dementia Dir; and the Staffing Coordinator; . Conducted an audit of all employee's who were employed in 2022 to determine completion of dementia training from 2022. Audit was complete by 5/10/23.
2) Employee's without sufficient training time are required to finish 2022 training before working in the Dementia unit. All training for 2022 will be complete by 5/19/23.
3) The Executive Director; and the Staffing Coordinator; will monitor ongoing compliance using the attached checklist sheet to monitor training of each individual staff member.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Implemented - 06/13/2023)

252 - Record Content

6. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident's #2 and #3's record didn't include any identifiable marks. The response was left blank.

Plan of Correction ***Accept (- 05/16/2023)***

1) The admission director , conducted an audit of all resident admission records looking for not only the identifiable mark question but also for completness of all questions on the application form. The Executive Director Kevin Page then also audited all applications for admission for completness and a second check. That audit is complete as of 5/5/2023
2) All admission application information must be audited before admission by the admission director. It will then be audited by either the Executive Director; or designee for completness of all questions.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Implemented - 06/13/2023)