Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

October 2, 2023

SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC

RE: SACRED HEART SENIOR LIVING BY SAUCON CREEK II
4801 SAUCON CREEK ROAD
CENTER VALLEY, PA, 18034
LICENSE/COC#: 22080

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/29/2023 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.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SACRED HEART SENIOR LIVING BY SAUCON CREEK II* **License #**: *22080* **License Expiration**: *08/03/2024*

Address: *4801 SAUCON CREEK ROAD, CENTER VALLEY, PA 18034*

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

Administrator

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

Legal Entity

Name: *SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/20/2009* **Issued By**: *Upper Saucon Twp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *36* **Waking Staff**: *27*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/29/2023*

Inspection Dates and Department Representative

08/29/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *18*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The entire unit* **Capacity**: *38* **Residents Served**: *18*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *18*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

08/29/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2023*

09/29/2023 - POC Submission

Submitted By: **Date Submitted**: *10/02/2023*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/03/2023*

Inspections / Reviews *(continued)*

10/02/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *10/02/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

Description of Violation

Direct care staff person "A" did not receive required annual training in infection control for staff training year 2022.

Plan of Correction ***Accept (- 09/29/2023)***

Plan of Correction for 2600.65.f
Training topics for the annual training of direct care staff
Infection control topic missed by Staff Member A

Immediate Correction: Human Resources contacted Staff Member A on 8/29/2023 and assigned two Relias trainings on infection control topics (About Infection Control and Prevention and Understanding Bloodborne Pathogens) with a due date of 9/5/2023. Staff Member A completed both trainings on 9/3/23 and 9/5/2023. Attached Relias Transcript for Staff Member A.

Plan of Correction: Human Resources to review all trainings monthly for all staff to ensure trainings are completed in a timely fashion for annual training. An email will be sent from the Relias training program and Human Resources monthly to all staff to remind staff of any pending trainings.
A monthly update on the trainings will be discussed with Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *09/28/2023*

Implemented (- 10/02/2023)

125a - Combustible Storage

2. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The home's laundry room was found to have a gray cloth or clump of gray lent that was observed behind the Speed Queen Brand dryer creating a potential fire hazard.

Plan of Correction ***Accept (- 09/29/2023)***

Plan of Correction for 2600.125.a
Combustible and flammable materials may not be located near heat sources or hot water heaters

Immediate Correction: Corrected at time of inspection 8/29/2023. The gray cloth/clump of gray lint found in the laundry room was removed and disposed of in a trash receptacle.

Plan of Correction:
1. All Staff that uses the laundry room is instructed to inspect laundry room upon entering and exiting to ensure there are no items located on, near, or on the floor by the washers and dryers.
2. All Staff that uses the laundry room is instructed not to place any items on the top of washing machines/dryers

125a - Combustible Storage (continued)

to prevent items from falling behind the machines.
3. Med Tech Supervisors for each shift will check the laundry room at the end of each shift to ensure no items have fallen behind machines, are on top or between the machines and/or on the floor near the machines,
4. Wedgewood Laundry Room Check sign off sheets are located in the Wedgewood Med Tech Room. Med Techs will initial when the laundry room check is completed.
5. The above Laundry Room Check sign off sheets will be reviewed monthly at the time of the fire drill and will be placed in the Fire Drill Log after being reviewed by one of the following: Administrator, Director of Nursing or Resident Care Director on duty at the time of the fire drill.
6. Any items found behind/on top/near/on the floor by the machines will be removed and disposed of immediately.
7. Evidence of completion will the initials of the Med Tech Supervisors from each shift to show required check of the laundry room prior to leaving their shift. If there is anything left behind, on top, near or on the floor by the washer or dryer, the Med Tech will remove immediately. Documentation of the check three (3) times per day is documented on the SHSL Wedgewood Laundry Room daily check sheet.
8. The Director of Nursing/Resident Care Director will be assigned to monitor, review and sign the laundry room check sheets weekly for compliance.
9. Policy reviewed with staff. See attached sign in sheet.

Licensee's Proposed Overall Completion Date: *09/28/2023*

Implemented - 10/02/2023)

187a - Medication Record

3. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
5. Dosage form.

Description of Violation

Resident #1 MAR was not documented that they received their Mucus relief ER 600 Mg Tab. To be administered two time a day for congestion was not initialed as being administered on 8/27/23 at 8;00 PM and Quetiapine Fumarate 25mg. to be administered two times a day for was not initialed as being administered on 8/24/23 at 2:00PM. Resident #2 received the following PRN medications, and the home did not document the effectiveness of their PRN medication. Resident #2 received Acetaminophen ER 650 MG tabs by mouth Q 6 hours as needed for on 8/11/23, 8/13/23, and 8/14/23. Ibuprofen 200 mg tabs 1 tab every 6 hours PRN for on 8/11/23. Lidocaine Pain relief 4%patch apply daily as needed for on8/10/23.

Plan of Correction ***Accept (- 09/29/2023)***

Plan of Correction for 2600.187.a
Procedure for Med Tech to document dispensing a PRN medication
1. Review blister packs of PRN medications before administering medication.
2. Administer the PRN medication to the resident.
3. Sign the paper MAR (per Med Tech Training) that the PRN medication was administered to the resident.
4. The Med Tech will then document on the paper MAR (per Med Tech Training) the following:
a. If the medication dispensed is for a behavior, the terminology will be:
Effective or Not Effective
b. If the medication dispensed is for a symptom, the terminology will be:

187a - Medication Record (continued)

Relief or No Relief
5. The MAR record will be cued/flagged to ensure the proper word documentation is utilized and the MAR will be reviewed at the end of each shift.
6. The Director of Nursing has reviewed the plan of correction procedure and observed the Med Techs to ensure the plan of correction is being implemented.
a. The above plan of correction has been implemented into the training of all new Med Techs and to be reviewed at the time of the Med Tech MAR review and Med Tech Observation which occurs every six months with the Med Tech Trainer and/or Med Tech Practicum Observer.
7. Policy reviewed with staff. See attached sign in sheet.
See attached.

Licensee's Proposed Overall Completion Date: *09/28/2023*

Implemented (█ - 10/02/2023)

233c - Key-Locking Devices

4. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The home did not have the exit codes posted near the two stairwells emergency exit doors that lead to the home's exterior.

Plan of Correction ***Accept █ - 09/29/2023)***

Plan of Correction for 2600.233.c
If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Immediate Correction: Corrected at time of inspection 8/29/2023. The two (2) exit code signs were replaced in both locations (the two (2) stairwells used as emergency exit doors.) The signage placed listed the location name and address. The code is included as part of the zip code and it is in the color red.

Plan of Correction:
The Director of Maintenance will do weekly service door checks for all doors that are locked/unlocked with a code to ensure the correct signage is in place. If a sign is missing, it will be replaced immediately. The Administrator will conduct monthly walk through of the building to check all door signage. If a sign is missing, it will be replaced immediately.

The Plan of Correction was reviewed with the Director of Maintenance. Please see attached POC with his signature indicating the policy and plan is reviewed.

Licensee's Proposed Overall Completion Date: *09/28/2023*

Implemented (█ - 10/02/2023)