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

January 11, 2024

[redacted], VICE PRESIDENT OF OPERATIONS AND REGULATORY COMPLIANCE
COUNTRY MEADOWS OF NORTHAMPTON ASSOCIATES LP
[redacted]

RE: MEADOWS LIVING CENTER AT
COUNTRY MEADOWS OF
BETHLEHEM
4005 GREEN POND ROAD
BETHLEHEM, PA, 18020
LICENSE/COC#: 23788

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/05/2023, 12/06/2023, 12/12/2023 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,
[redacted]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MEADOWS LIVING CENTER AT COUNTRY MEADOWS OF BETHLEHEM* **License #**: *23788* **License Expiration**: *10/08/2024*

Address: *4005 GREEN POND ROAD, BETHLEHEM, PA 18020*

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

Administrator

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

Legal Entity

Name: *COUNTRY MEADOWS OF NORTHAMPTON ASSOCIATES LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/25/2013* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *2* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/12/2023*

Inspection Dates and Department Representative

12/05/2023 - On-Site: [redacted]
12/06/2023 - On-Site:
12/12/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *29*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections 1st flr* **Capacity**: *64* **Residents Served**: *29*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *29*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

12/05/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/28/2023*

Inspections / Reviews *(continued)*

12/28/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/03/2024*

01/08/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/10/2024*

01/11/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The batteries in the Carbon monoxide detector on the wall across from the Co-Worker Lounge expired in October 2022.

Plan of Correction ***Accept [redacted] - 12/28/2023)***

• Replaced detector batteries on the day of inspection with a corresponding date of installation on 12/08/23.

• Scheduled battery replacements will be completed every six months by maintenance associates under the oversight of the Director of Maintenance and Neighborhood Manager.

• Random audits of the detectors will be conducted monthly by the Director of Maintenance over the next three months beginning in January of 2024. Documentation will be provided and retained for the inspector.

• The Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented [redacted] - 01/08/2024)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A 24 oz. spray bottle containing Peroxide Multi Surface Disinfectant was noted in an unlocked cabinet under the sink in the kitchenette area. The instructions stated, "Causes irreversible eye damage and skin burns. Call 911 if inhaled". None of the residents can safely avoid poisonous materials.

Plan of Correction ***Accept [redacted] - 12/28/2023)***

• The spray bottle was removed immediately on the day of inspection on 12/08/23.

• The week of 12/12/23 safety locks were placed on cabinets to secure items inside those cabinets.

• Connections coworkers will be re-trained on the proper storage of poisonous materials by 1/4/2024. Documentation will be provided.

• The Executive Director and Connections Manager will monitor ongoing adherence to the proper storage of poisonous materials.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented ([redacted] - 01/08/2024)

121a - Unobstructed Egress

3. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress *(continued)*

Description of Violation

The Exit door located in the stairwell near Resident Room 14 was sticking and required force to open it. The door leads outside to the locked Courtyard.

Plan of Correction ***Accept [redacted] - 12/28/2023)***

• The Director of Maintenance assessed the door on the day of inspection 12/8/23.

• The door was adjusted, and lubrication was added to allow it to open without requiring additional force on 12/8/23.

• Beginning 12/8/23 the Director of Maintenance and the manager will monitor this door daily for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented ([redacted] - 01/08/2024)

132c - Fire Drill Records

4. 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 home conducted a sleeping hour drill on 10/12/23 at 1:18 am. Staff person A confirmed 5 staff participated in the drill, however 10 is documented on the log.

Plan of Correction ***Accept ([redacted] - 12/28/2023)***

• The fire drill log was corrected at time of inspection on 12/08/23.

• Training was provided to the coworker who made the documentation error on the fired rill log on 12/22/23.

• A double-check procedure of documentation between the maintenance associate completing the drill and the Executive Director has been put in place on 12/22/23 and will continue ongoing.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented [redacted] - 01/11/2024)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 DME for Resident #1 dated [redacted], does not indicate whether the resident has the ability to self-administer medications.

The DME for Resident #2 dated [redacted] does not indicate the need for body positioning if any.

Plan of Correction ***Accept [redacted] - 12/28/2023)***

• Review and correction of information were verified on the day of inspection, to ensure proper care parameters were being followed for resident #1 and resident #2.

Documentation to be provided.

• Training will be completed by 1/4/24 for managers, wellness secretary, and ADON on regulatory requirements for completing a DME. Documentation to be provided.

• Effective the week of 1/1/24 a DME review procedure will be followed to help prevent errors or omissions on the DME in the future. The review procedure includes a review of the DME by the Wellness Secretary, DON/ADON, and Executive Director or designee.

• The DON or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented [redacted] - 01/11/2024)

184a - Resident's Meds Labeled

6. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
4. The prescribed dosage and instructions for administration.

Description of Violation

The MAR for Resident #5 indicates they are prescribed [redacted].1 tab daily, with instructions to hold if systolic blood pressure is less than 120. The pharmacy blister pack does not indicate these instructions.

Plan of Correction ***Accept ([redacted] - 12/28/2023)***

• The label was corrected by the pharmacy on the day of inspection on 12/08/23.

• Training regarding proper medication prescription labeling related to dosage and instructions will be completed with nursing coworkers by 1/4/24. Documentation to be provided.

184a - Resident's Meds Labeled (continued)

• Beginning on 12/12/23 weekly medication cart audits will be conducted ongoing for 4 weeks by the DON and ADON. Documentation to be provided.

• The DON or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented (- 01/11/2024)

231c - Preadmission Screening

8. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

The Preadmission Screening for Resident #2 dated [redacted] does not indicate that the resident can safely avoid poisonous materials or that the home can meet the resident's needs.

The Preadmission Screening for Resident #3 dated [redacted] does not indicate the title of the person completing the screening or the name of the admitting personal care home.

Plan of Correction ***Accept (- 12/28/2023)***

• The documents were corrected on 12/8/23.

• Training on required documentation on the preadmission screen will be completed by 1/4/24 for the Manager, Wellness Secretary, and ADON. Documentation to be provided.

• The DON will conduct random audits of preadmission screens beginning the week of 1/2/24 for new residents once a month for the next three months to ensure an understanding of the preadmission screening requirements. Documentation to be provided.

•The DON or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented - 01/11/2024)