

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

March 20, 2024

[REDACTED], ADMINISTRATOR
WG BETHLEHEM SH LLC

RE: ATRIA BETHLEHEM
1745 WEST MACADA ROAD
BETHLEHEM, PA, 18017
LICENSE/COC#: 22281

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/07/2023, 12/12/2023, 12/20/2023 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: ATRIA BETHLEHEM License #: 22281 License Expiration: 10/16/2024
 Address: 1745 WEST MACADA ROAD, BETHLEHEM, PA 18017
 County: NORTHAMPTON Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: WG BETHLEHEM SH LLC
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 09/28/1998 Issued By: DLI

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 126 Waking Staff: 95

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 12/12/2023

Inspection Dates and Department Representative

12/07/2023 - On-Site [REDACTED]
 12/12/2023 - On-Site [REDACTED]
 12/20/2023 - Off-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 150 Residents Served: 113
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 112
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 13 Have Physical Disability: 2

Inspections / Reviews

12/07/2023 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/20/2024

Inspections / Reviews *(continued)*

02/06/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/16/2024

03/20/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

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 home did not have the License Inspection Summary dated 10/22/22 posted in the home in a conspicuous manner as required.

Repeat Violation 10/22/22

Plan of Correction

Accept [redacted] - 02/06/2024)

On 12/7/2023 Executive Director posted inspection summary dated 10/22/22 and removed old inspections while inspector was still in the community

? Executive Director reeducated Administrative Assistant and Community Business Director on 1/1/2023 about the requirement to post current license and license inspection summary.

? To ensure ongoing compliance, Executive director created a calendar reminder for Administrative Assistant or Community Business Director to review posted material monthly starting 1/1/2024.

Licensee's Proposed Overall Completion Date: 01/26/2024

Implemented [redacted] - 03/04/2024)

57c - 2 Hours/Day

2. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 11/18/23 the home had a census of 119 residents with 13 of those residents identified as immobile. The home was required to provide 132 hours of direct care based on the needs of the immobile residents. The home was only able to verify that 107 hours of direct care was provided on that date.

On 11/19/23 the home had a census of 119 residents with 13 of those residents identified as immobile. The home was required to provide 132 hours of direct care based on the needs of the immobile residents. The home was only able to verify that 127.5 hours of direct care was provided on that date.

Repeat violation from 8/26/2022 and 10/18/22.

Plan of Correction

Accept [redacted] - 02/06/2024)

Executive Director has recently hired 2 direct care staff, one who starts [redacted] and the other who starts [redacted].

? Executive Director created an Excel Spreadsheet on 1/15/24 to calculate the direct care hours needed based on resident's current mobility needs. Executive Director will update the mobility needs in the spreadsheet if mobility

57c - 2 Hours/Day (continued)

changes on an assessment, and recalculate hours.

? Beginning 1/22/24 and for the next 90 days, Executive Director/Care Director will review the spreadsheet in comparison to the care schedule weekly to ensure that the amount of hours of direct care staff shown on the staffing schedule match the required number

of hours for all residents with mobility needs. Executive Director will address any issues immediately.

Licensee's Proposed Overall Completion Date: 01/29/2024

Implemented (████) - 03/04/2024)

57d - Waking Hours

3. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 11/18/23 the home had a census of 119 residents with 13 of those residents identified as immobile. Of the required 132 direct care hours, 99 hours were required during waking hours. The home was only able to verify that 88 hours of direct care was provided during waking hours on that date.

On 11/19/23 the home had a census of 119 residents with 13 of those residents identified as immobile. Of the required 132 direct care hours, 99 hours were required during waking hours. The home was only able to verify that 92.5 hours of direct care was provided on that date.

Repeat violation from 8/26/2022 and 10/18/22.

Plan of Correction

Accept (████) - 02/06/2024)

Executive Director has recently hired 2 direct care staff, one who starts (████) and the other who starts (████).

? Executive Director created an Excel Spreadsheet on 1/15/24 to calculate the direct care hours needed based on resident's current mobility needs. Executive Director will update the mobility needs in the spreadsheet if mobility changes on an assessment, and recalculate hours.

? Beginning 1/22/24 and for the next 90 days, Executive Director/Care Director will review the spreadsheet in comparison to the care schedule weekly to ensure that the amount of hours of direct care staff shown on the staffing schedule match the required number of hours for all residents with mobility needs. Executive Director will address any issues immediately.

Licensee's Proposed Overall Completion Date: 01/30/2024

Implemented (████) - 03/04/2024)

88a - Surfaces

4. Requirements

88a Surfaces (continued)

2600.

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

Description of Violation

Room 220 had a rug in the bathroom that was not anti-slip, posing a fall hazard.

Plan of Correction

Accept [redacted] - 02/06/2024)

? Executive Director worked with the resident in Room 220 to remove the rug from the room on 12/12/23.

? Executive Director will reeducate all care, housekeeping and maintenance staff about this regulation starting by 1/24/24.

? Executive Director will communicate to residents and families by 1/24/2024 regarding the use of only anti-slip rugs.

? Executive Director / designee will complete an audit by 1/29/24 of all rooms to check for anti-slip rugs and address any found immediately.

? The Executive Director/designee will create a task in the Preventative Maintenance system for the Maintenance Director to randomly check for anti-slip rugs weekly, beginning 1/18/2024.

Licensee's Proposed Overall Completion Date: 01/30/2024

Implemented [redacted] - 03/04/2024)

96a First Aid Kit

5. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit at the reception desk, which is the one accessible to all staff, did not contain protective eye wear.

The first aid kit in the kitchen, which is available to all staff, did not contain a thermometer or protective eye wear.

Plan of Correction

Accept [redacted] - 02/06/2024)

On 12/7/23, the Executive Director added any missing items to the first aid kits in the kitchen and the reception desk

• On 1/8/2024, Executive Director reeducated directors about the regulatory required contents the first aid kit.

• By 1/28/24, the Executive Director / designee will audit all first aid kits for all required items and correct any issues found immediately.

On 1/15/24, the Executive Director created a calendar reminder for each director to check first aid kits for their

96a - First Aid Kit (continued)

departments every other week to ensure all required contents remain in the kits.

Licensee's Proposed Overall Completion Date: 01/26/2024

Implemented (█) - 03/04/2024)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Room 201 did not have an accessible light source that can be reached from the bedside.

Plan of Correction

Accept (█) - 02/06/2024)

On 12/19/23, the Executive Director reorganized resident's room to move the accessible light next to the bed.

? Executive Director will reeducate all care, housekeeping and maintenance staff regarding the requirements of this regulation starting by xx/xx/24 and will reeducate residents and families by 1/24/24 regarding the requirement to have an accessible light reachable from the bed.

****By 1/29/24, the Executive Director/designee will complete an audit of all rooms to verify there is an accessible light source next to the bed

? The Executive Director/designee will create a task in the Preventative Maintenance system for the Maintenance Director to randomly check for accessible lighting by residents' bedsides, beginning 1/18/2024.

Licensee's Proposed Overall Completion Date: 01/29/2024

Implemented (█) - 03/04/2024)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The ice cream chest freezer located in the home's kitchen did not have a thermometer.

Plan of Correction

Accept (█) - 02/06/2024)

- On 12/7/2023, Culinary Director placed a Thermometer in the ice cream chest.
- On 12/22/2023, Culinary Director educated culinary staff about the importance of refrigeration thermometers.
- On 12/29/2023, Culinary director conducted an audit of all refrigeration to ensure all equipment had proper visible thermometers.
- Starting 1/18/2024, the Restaurant coordinator, DCS and Cooks Checklist was updated to include a check for

103f - Refrigerator/Freezer Temps (continued)

thermometers in refrigerators and freezers to ensure no future violations occur.

Licensee's Proposed Overall Completion Date: 01/25/2024

Implemented (████) - 03/20/2024)

141a 1-10 Medical Evaluation Information

8. Requirements

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 dated █████ for resident # 1, did not include an assessment of the resident's cognitive functioning.

The annual DME for resident # 4 is missing the resident's temperature and immunization history.

The annual DME for resident # 5 dated █████ does not indicate the resident's immunization history.

Repeat 10/22/2022, 2/7/2023

Plan of Correction

Accept (████) - 02/06/2024)

· The Resident Services Director (RSD) will work with each resident's physician to obtain updated information for the DME for Resident # 1, Resident #4, and Resident #5 by █████

· The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by █████ to ensure DMEs are completed in full. Any issues found during the audit will be addressed immediately.

· Regional Care Director will provide additional education by 1/31/24 to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 2600 141a to make sure DMEs are completely filled out upon admission. Regional Care Director will provide additional training to Executive Director and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining DME and DME

141a 1 10 Medical Evaluation Information (continued)

completeness prior to move in by 1/31/2024.

· Executive Director/designee will be meeting with the Resident Services Director/designee weekly starting 1/22/2024 for 90 days to review move in checklist for all new resident DMEs to ensure compliance with regulation 2600 141a.

Resident Services Director will be responsible to ensure continue compliance with regulation

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented (█ - 03/04/2024)

141b1 - Annual Medical Evaluation

9. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The most current DME form for resident # 1 was completed █ and the previous annual DME form was completed on █. The home did have documentation that a medical assessment was completed for resident # 1 in 2022.

An annual DME was completed for resident # 6 on █. The previous DME on record was completed on █.

Resident # 7 was admitted on █. An annual DME was completed on █ however there are no previous DMEs on record.

Repeat violation 2/7/2023

Plan of Correction

Accept █ - 02/06/2024)

· The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by █, to ensure compliance with regulation 2600 141b. Any issues found during the audit will be addressed immediately.

· Regional Care Director will provide additional education by 1/31/2024 to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 141b to ensure DMEs are completed within the required timeframe (annually).

Executive Director will be meeting with the Resident Services Director/designee weekly starting 1/22/2024 and for the next 90 days to review new DMEs to ensure compliance with regulation 2600 141b. Resident Services Director will be responsible to ensure continue compliance with regulation

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented █ - 03/04/2024)

183d - Prescription Current

10. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current (continued)

Description of Violation

Resident # 2 had a bottle of [REDACTED] with an expiration date of [REDACTED].

Plan of Correction

Accept ([REDACTED] - 02/06/2024)

• Resident Service Director destroyed Resident #2 Expired [REDACTED]. Resident Service Director will ensure new [REDACTED] is ordered and received for Resident #2.

• Resident Service Director/designee will check all carts for any expired medications by [REDACTED]. Any issues found will be corrected immediately.

• The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 1/31/2024. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 2/15/2024.

• The Resident Services Director/designee will audit medication carts weekly starting 1/22/2024 for any expired medication for the next 90 days.

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented ([REDACTED] - 03/04/2024)

184a - Resident's Meds Labeled

11. Requirements

2600.

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

Description of Violation

Resident # 3 's [REDACTED] that is being currently used did not contain the initials of the staff person who opened it.

Resident # 3 's [REDACTED] that is being currently used did not contain the initials of the staff person who opened it.

Repeat 10/22/22

Plan of Correction

Accept ([REDACTED] - 02/06/2024)

• Resident Service Director/Designee ensured that Resident #3 has new insulin pens with the staff initials written on the pen that opened the insulin pen as of 12/7/23.

• Resident Service Director/ designee will audit all medication carts to ensure all opened insulin pens have the initials of the staff that opened the pen by 1/31/2024. Any issues found will be corrected immediately.

• The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling and Medication Cart Audit Process by 1/31/2024. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 2/15/2024.

• The Resident Services Director/designee will audit all carts weekly starting 1/22/2024 for the next 90 or any

184a - Resident's Meds Labeled (continued)

discrepancies with medication labels to ensure proper labeling days.

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented (█) - 03/20/2024)

187a - Medication Record

12. Requirements

2600.

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

- 3. Name of medication.
- 6. Dose.

Description of Violation

Resident # 3 has an order for █, 1 a day. The Medication Administration Record (MAR) lists the order for █, 1 per day by mouth every morning. The MAR indicates the incorrect medication.

Repeat 10/22/22

Plan of Correction

Accept (█) - 02/06/2024)

- Resident Service Director/ designee will obtain clarification order for Resident #3 vitamin by █.
 - Resident Service Director/designee will complete audit of all medication records match the orders by 2/15/2024. Any issues found will be corrected immediately.
 - The Regional Care Director will provide training by 1/31/24 to the Executive Director and Resident Services Director/designee on the med cart audit process, order verification process to ensure understanding of policies and processes
- medications orders matching MAR. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 2/15/2024.
- The Resident Services Director/designee will review order verification forms and med cart audits weekly starting 1/22/24 to ensure proper documentation in medication record of diagnoses/ purposes for all medication for the next 90 days.

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented (█) - 03/04/2024)

227d - Support Plan Medical/Dental

13. Requirements

2600.

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.

227d Support Plan Medical/Dental (continued)

Description of Violation

The RASP for Resident # 5, dated [REDACTED] does not identify a reason why the resident requires the use of a bed enabler.

Repeat 10/22/2022

Plan of Correction

Accept [REDACTED] - 02/06/2024)

Executive Director/Resident Services Director will complete new service plan/support plan for Resident #5 by 1/31/2024 to ensure the service plan/support plan documents or address the use of the bed enablers.

- Resident Service Director/designee will complete an audit of the current residents' service plans/support plans by 2/15/2024, to ensure the service plan/support plan document/address the use of all bed enablers. Any issues found during the audit will be addressed immediately.

- Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 1/31/2024 to ensure service plans/support plans document/address the use of all bed enablers.

- Executive Director will meet with Resident Services Director/designee weekly starting 1/22/2024 for the next 90 days to review all new support plans to ensure service plans/support plans have documentation or address the use of the bed enablers

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented [REDACTED] - 03/04/2024)

252 - Record Content

14. Requirements

2600.

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

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The records for resident # 8; # 10 and # 11 did not contain a photo of the resident.

Repeat 10/22/2022

Plan of Correction

Accept [REDACTED] - 02/06/2024)

- Executive Director/Resident Services Director will ensure residents #8, Resident #10, and Resident #11 has current photograph in the chart by 1/31/2024.

- Resident Service Director/designee will complete an audit of the current residents' charts to ensure we have current photograph within 2 years for every resident by 2/15/2024, to ensure compliance with Regulation 2600.252. Any issues found during the audit will be addressed immediately.

- Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 1/31/2024 on the need for current photograph within 2 years for every resident per regulation 2600.252.

- Executive Director will meet with Resident Services Director/designee weekly starting 1/22/2024 for the next 90

252 Record Content (continued)

days to review all new resident charts for current photograph to ensure compliance with regulation 2600.252.

Licensee's Proposed Overall Completion Date: 02/15/2024

Implemented [REDACTED] - 03/04/2024)