

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

August 28, 2024

[REDACTED], ADMINISTRATOR  
MERAKEY PENNSYLVANIA

RE: MERAKEY PENNSYLVANIA  
515 DELAWARE AVENUE  
BETHLEHEM, PA, 18015  
LICENSE/COC#: 22401

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/25/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *MERAKEY PENNSYLVANIA* License #: *22401* License Expiration: *06/11/2025*  
 Address: *515 DELAWARE AVENUE, BETHLEHEM, PA 18015*  
 County: *LEHIGH* Region: *NORTHEAST*

**Administrator**

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

[REDACTED]

Name: *MERAKEY PENNSYLVANIA*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *R-4* Date: *04/23/2012* Issued By: *Fountain Hill Borough*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *16* Waking Staff: *12*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *07/25/2024*

**Inspection Dates and Department Representative**

07/25/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information

License Capacity: *16* Residents Served: *16*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* Are 60 Years of Age or Older: *8*  
 Diagnosed with Mental Illness: *16* Diagnosed with Intellectual Disability: *2*  
 Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

07/24/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/18/2024*

08/20/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *08/23/2024*  
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/26/2024*

Inspections / Reviews (*continued*)

08/28/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/23/2024

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

Direct care staff person A was hired on [REDACTED] The home did not have documentation that staff person A has a GED or high school diploma.

Plan of Correction

Accept ([REDACTED] - 08/20/2024)

Staff person A GED/High School Diploma is attached.

A new hire checklist has been developed on July 25th, 2024, to ensure that a copy of the GED or High School Diploma is collected at the time of orientation. Beginning August 14, 2024, the Administrator will complete New Hire Checklist by the end of the second day of hire. Once completed, the Administrator will upload a copy of the New Hire Checklist and all corresponding documents to an electronic storage drive and will store a printed in the staff's file. The Adult Director will review all new staff files quarterly to ensure completion.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ([REDACTED] - 08/23/2024)

65a - FS Orientation 1st Day

2. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

- 5. The location and use of fire extinguishers.
- 7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [REDACTED] completed first day orientation on location & use of fire extinguishers and telephone use & notification of emergency services on [REDACTED]

Plan of Correction

Accept ([REDACTED] - 08/20/2024)

Beginning 8/14/2024, the staff training orientation checklist completed by their first scheduled shift, will now identify the first day the staff member is in the home for training. A new hire checklist has been developed on July 25, 2024, to ensure completion and documentation of the staff member's first day in the home and training related to first day orientation on location and use of fire extinguishers and telephone use and notification of emergency services. Beginning August 14, 2024, the Administrator will complete the New Hire Checklist by the end second day of hire. Once completed, the Administrator will upload a copy of the certificate to an electronic storage drive and will store a printed copy in the staff's file. The Adult Director will review all new staff files quarterly to ensure completion.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ([REDACTED] - 08/23/2024)

65d - Initial Direct Care Training

3. Requirements

2600.

65d - Initial Direct Care Training (continued)

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [REDACTED] did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept ([REDACTED]) - 08/20/2024)

Staff person A's certificate for the Department - approved direct care training is attached.

A new hire checklist has been developed on July 25, 2024, to ensure that a certificate of completion for the Department - approved direct care training is collected. Beginning August 14, 2024, the Administrator will complete the New Hire Checklist by the end of the second day of hire. Once completed, the Administrator will upload a copy of the certificate to an electronic storage drive and will store a printed copy in the staff's file. The Adult Director will review all new staff files quarterly to ensure completion.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ([REDACTED]) - 08/23/2024)

65e - 12 Hours Annual Training

4. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff A did not complete 12 hours of annual training during training year 2023.

Repeat Violation 9/26/23

Plan of Correction

Accept ([REDACTED]) - 08/20/2024)

Staff person A's 12 hours of training documentation is attached.

Beginning August 28th, 2024, two tears of training logs for all staff will be stored in the training binder. At the completion of the fiscal year, copies of all staff training logs will be uploaded to an electronic storage drive by the Administrator. The Adult Director will review all staff training logs quarterly for monitoring.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ([REDACTED]) - 08/23/2024)

65f - Training Topics

5. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 5. Personal care service needs of the resident.
- 6. Safe management techniques.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

65f - Training Topics (continued)

**Description of Violation**

Direct care staff person A did not receive training in personal care service needs of the resident, self-management techniques, and care for residents with MH and ID during training year 2023.

Repeat Violation 9/26/23

**Plan of Correction**

Accept ( ) - 08/20/2024

Staff person A's 12 annual training documentation is attached. Beginning August 28th, 2024, two years of training will be stored in the training binder. At the completion of the fiscal year, copies of all staff training logs will be uploaded to an electronic storage drive by the Administrator. The Adult Director will review all staff training logs quarterly for monitoring.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024

65g - Annual Training Content

**6. Requirements**

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
- 3. Resident rights.

**Description of Violation**

Staff person A did not receive training in fire safety by a fire safety expert or staff trained by a FSE and resident rights during training year 2023.

**Plan of Correction**

Accept ( ) - 08/20/2024

Staff person A's training documentation is attached.

Beginning August 28, 2024, two years of training logs for all staff will be stored in the training binder. At the completion of the fiscal year, copies of all training logs will be uploaded to an electronic storage drive by the Administrator. The Adult Director will review all staff trainings quarterly for monitoring.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024

66a - Staff Training Plan

**7. Requirements**

2600.

66.a. A staff training plan shall be developed annually.

**Description of Violation**

Staff training plan for 2024 did not contain the name, date, source, content, or source of training.

66a - Staff Training Plan (continued)

Plan of Correction

Accept ( [redacted] - 08/20/2024)

The staff training plan has been updated to include all required parts. The Adult director will review the training plan once developed to ensure completion prior to implementation.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( [redacted] - 08/23/2024)

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

During physical site inspection, there was a puddle of urine on the floor in the 2nd floor bathroom. There was a very strong smell of urine in the bathroom and in the hallway outside of the bathroom.

Plan of Correction

Accept ( [redacted] - 08/20/2024)

The bathrooms are cleaned twice a day by staff. The rounds sheet will be updated to include Bathrooms by the Administrator by August 12, 2024. Beginning August 12, 2024, staff will complete a walkthrough of the bathrooms to ensure sanitary conditions and will document on the Rounds Sheet. If unsanitary conditions are found, the staff member will address the issues immediately. The Administrator will review the Rounds sheet completed from the day prior to ensure completion. Beginning August 12, 2024, a weekly walkthrough will be completed by the Administrator or designee to ensure bathrooms are sanitary at the of the walkthrough. This will be documented on the Weekly House Walkthrough. At the Residents Council, the Administrator will remind residents to notify staff if there is unsanitary conditions in the bathroom.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( [redacted] - 08/23/2024)

96a - First Aid Kit

9. 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

First aid kit did not contain tape or scissors as required.

Plan of Correction

Accept ( [redacted] - 08/20/2024)

Tape and scissors have been replaced in the First Aid Kit. By August 27th, 2024, a reminder will be provided to all staff on the importance of returning all First Aid Kit items once used into the kit and that if any item is missing to report to the Administrator. A list of all items that are required to be in the First Aid Kit will be developed and placed in the First Aid Kits by August 16, 2024. Beginning 8/12/2024 a weekly walkthrough will be completed by the Administrator or designee to ensure all required items are included in the First Aid Kit. This will be documented on the Weekly House Walkthrough. The First Aid Kit is checked monthly by the Administrator or nurse and documented on the Residential Safety Walkthrough Checklist Smartsheet. The Residential Safety Walkthrough Checklist monitored by Merakey ABH support team, and any issues identified are reported.

96a - First Aid Kit (continued)

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024

101j7 - Lighting/Operable Lamp

10. Requirements

2600.

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

Description of Violation

Resident #1 who resides in room [redacted] doesn't have an operable lamp or other source of lighting that can be turned on at bedside. The push lamp bedside was inoperable at time of inspection.

Repeat Violation: 9/26/2023

Plan of Correction

Accept ( ) - 08/20/2024

The batteries were replaced in the push lamp by the staff at the time of the inspection.

A Resident Council meeting was held to review with the residents the importance of keeping the bedside lamp at the bedside and not to remove batteries from the push lamp for personal use on August 14, 2024. By August 27, 2024, a reminder will be provided to all staff that if a bedside lamp is out of order to report to the Administrator or address the issue immediately. Beginning August 12, 2024, staff will complete a walkthrough of the bedrooms to ensure that all push lamps are operable and will document on the Rounds Sheet. The Administrator will review the Round Sheets completed from the day prior to ensure completion. Beginning August 12, 2024, a weekly walkthrough will be completed by the Administrator or designee to ensure that all push lamps work as well as all other lamps in the room. This will be documented on the Weekly House Walkthrough. Bedside lighting is also checked monthly by the Administrator or nurse and documented on the Residential Safety Walkthrough Checklist Smartsheet. The Residential Safety Walkthrough Checklist is monitored by Merakey ABH support team, and any issues identified are reported.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024

103f - Refrigerator/Freezer Temps

11. 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 refrigerator in the dining room did not have a thermometer that was working.

Plan of Correction

Accept ( ) - 08/20/2024

A new thermometer was placed in the refrigerator in the dining room at time of inspection by staff. By August 25, 2024, a reminder will be provided to all staff that if a refrigerator thermometer is not present or inoperable to report this to the Administrator or designee to ensure that the thermometers in all refrigerators are in working condition. This will be documented on the Weekly House Walkthrough.

Licensee's Proposed Overall Completion Date: 08/18/2024

103f - Refrigerator/Freezer Temps (continued)

Implemented ( ) - 08/23/2024)

103i - Outdated Food

12. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Located in the can storage area off of the main kitchen, there was a can of old-fashioned baked beans and can of sliced green olives. Both cans had large dents in the sides of the cans.

Plan of Correction

Accept ( ) - 08/20/2024)

The dented cans were removed by staff at time of inspection.

By August 27th, a reminder will be provided to all staff that all dented cans should be removed immediately. At the time of food delivery, all cans are inspected to ensure no dents are present by the staff accepting the order. If a dent is found, the staff member will immediately remove the can and either notify the Administrator or Cook so that contact with the store can be completed for replacement. Any issues found are documented on the invoice. Beginning 8/12/2024, a weekly walkthrough will be completed by the Administrator or designee to ensure all cans present are not dented. This will be documented on the Weekly House Walkthrough.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024)

121a - Unobstructed Egress

13. 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 fire exit on the second floor would not open without an excessive amount of force, preventing immediate egress in the event of an emergency.

Plan of Correction

Accept ( ) - 08/20/2024)

Merakey Facilities was notified of the issue by the Administrator the day of the inspection. Prior to the inspection, the facility was painted recently resulting in the door being more difficult to open. Merakey Facilities came out on August 14, 2024, and sanded the door and made adjustments to ensure it open easily.

By August 27, 2024, a reminder will be provided to all staff that all doors for the fire escape should open without excessive force. If excessive force is needed to open the doors, the staff member will immediately notify the Administrator. Beginning August 12, 2024, a weekly walkthrough will be completed by the Administrator or designee to ensure that all doors to the fire escape can open without excessive force. This will be documented on the Weekly House Walkthrough.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024)

125a - Combustible Storage

14. Requirements

2600.

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

Description of Violation

On 7/25/2024, department Representative observed a floor cleaning pad on the floor behind the dryer, posing a potential fire hazard.

Plan of Correction

Accept ( ) - 08/20/2024)

The cleaning pad was removed during the time of the inspection by staff.

On July 26, 2024, the mops were moved to a different location in the room to ensure that nothing should be behind the dryer. If something is found behind the dryer, the staff member will remove the item immediately. Beginning 8/12/2024, a weekly walkthrough will be completed by the Administrator or designee to ensure nothing is behind the dryer. This will be documented on the Weekly House Walkthrough.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024)

185a - Implement Storage Procedures

15. 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

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results from the individual glucometer. Resident #2 – At 4:30pm on 7/16/24 had a reading on the glucometer of 74 but was incorrectly transcribed as 72 and at 4:30pm on 7/19/24 the reading on the glucometer was 118 but was incorrectly transcribed as 162.

Plan of Correction

Accept ( ) - 08/20/2024)

On July 26, 2024, the Medication Administration Record system was adjusted so that each individual has their own record sheet to reduce transcription errors. This was reviewed and implemented with the staff by the Administrator on August 1, 2024. A weekly Medication Administration Record review will be completed by the Nurse to verify that the information found on the glucometer matches the information on the Medication Administration Record. If an error is found, the Nurse or administrator will complete an incident report and will review the error with the staff who completed the entry.

Licensee's Proposed Overall Completion Date: 08/18/2024

Implemented ( ) - 08/23/2024)

187d - Follow Prescriber's Orders

16. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 7/19/24 Resident #2 is on a sliding scale. For readings between 161-200 = 1u, 201-240 = 2u, 241-280 = 3u, 281-321 = 4u, over 321 = 5u. Resident #2's MAR was documented with a blood glucose reading of 162 instead of the actual reading on the glucometer of 118, resulting in 1u being administered instead of 0u.

**187d - Follow Prescriber's Orders (continued)**

Repeat Violation 9/26/23

**Plan of Correction****Accept ( [REDACTED] - 08/20/2024)**

*In the review of the incident, it was determined to be a transcription error only and no medication was administered incorrectly. On July 26, 2024, the Medication Administration Record system was adjusted so that each individual has their own record sheet to reduce transcription errors. This was reviewed and implemented with the staff by the Administrator on August 1, 2024. A weekly Medication Administration Record review will be completed by the Nurse to verify that the information on the glucometer matches the information on the Medication Administration Record. If an error is found, the nurse or Administrator will complete an incident report and will review the error with the staff who completed the entry.*

**Licensee's Proposed Overall Completion Date: 08/18/2024**

**Implemented ( [REDACTED] - 08/23/2024)**