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

March 20, 2025

[REDACTED], ADMINISTRATOR
SOUTH MOUNTAIN MEMORY CARE LLC
201 SOUTH SEVENTH STREET
EMMAUS, PA, 18049

RE: SOUTH MOUNTAIN MEMORY CARE
201 SOUTH SEVENTH STREET
EMMAUS, PA, 18049
LICENSE/COC#: 22721

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/01/2024 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: *SOUTH MOUNTAIN MEMORY CARE* **License #**: *22721* **License Expiration**: *09/17/2025*

Address: *201 SOUTH SEVENTH STREET, EMMAUS, PA 18049*

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

Administrator

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

Legal Entity

Name: *SOUTH MOUNTAIN MEMORY CARE LLC*

Address: *201 SOUTH SEVENTH STREET, EMMAUS, PA, 18049*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/14/2018* **Issued By**: *Emmaus Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/01/2024*

Inspection Dates and Department Representative

10/01/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *24*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *28* **Residents Served**: *24*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

10/01/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/26/2024*

11/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/10/2024*

Inspections / Reviews *(continued)*

03/19/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

03/20/2025 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *03/19/2025*
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 binder containing previous year's License Inspection Summary (LIS) reports, including the most current LIS report dated 12/13/23, was not stored in a public and conspicuous area of the home. The binder was stored on a shelf located next to a piano in the 1st floor common area.
Repeated violation 12/13/23.

Plan of Correction ***Accept (- 12/06/2024)***

Inspection summaries and POCs previously placed in front vestibule were moved by cleaning staff when vestibule was painted and not replaced. Items replaced in vestibule on table for clear display and access. Continued compliance will be monitored by Maintenance Director on a monthly basis. See Attached. This was completed on 10/17/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 10/1/24 a 24 hour report binder that contained confidential resident information with dietary information and care needs was found in an unlocked cabinet in the dining area. A binder with narcotic count sheets containing confidential resident medication information was also stored in the unlocked dining cabinet.

Plan of Correction ***Accept (- 12/06/2024)***

24 hour report binder now kept in locked nursing office.

Narcotic binder placed inside narc drawer in locked med cart. Continued compliance monitored by DOW & 3-11 Supervisor . Completed on 10/4/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

63a - First Aid/CPR Training

3. Requirements

2600.

63a - First Aid/CPR Training *(continued)*

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/14/24 on the third shift hours of 11pm to 7am the home did not have any staff in the building with current First Aid and CPR training certification.

Plan of Correction ***Accept (- 11/05/2024)***

Regularly scheduled 11-7 Med tech tested positive for Covid and found coverage for her shift last minute, but was not aware that person did not have an active CPR/FA cert.

Director of Wellness will monitor staffing coverage for compliance going forward.

CPR/FA certification course scheduled for 12/3/2024 for all SMMC staff, through Safety Training Associates.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented (- 03/20/2025)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

Description of Violation

Staff person A and B did not receive training on the required annual training topic medication self administration for the 2023 training year. Staff person A was hired and staff person B was hired

Plan of Correction ***Accept (- 12/06/2024)***

Topic of Medication Self-administration has been added to the July training topics, powerpoints and quiz for compliance. See Attached.

Staff Member B resigned from SMMC. Last day worked
Staff Member A completed Self-administration training with December 2024 training.
An audit showed all current staff files are missing this training, it was added to December 2024's training to bring everyone to compliance and then will be on July's training in 2025 and going forward. Business Director responsible for compliance with annual training schedule.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

65g - Annual Training Content

5. 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:

65g - Annual Training Content *(continued)*

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.

Description of Violation

Staff person C did not receive training in the required annual training topic fire safety training by a fire safety expert for the 2023 annual training year. Staff person A was hired

Plan of Correction ***Accept (- 12/06/2024)***

Executive Director, is scheduled for Nov. 13, 2024. 12:00pm-3:00pm to take the Fire Safety Train the trainer course. All SMMC staff will then recieve proper fire safety training. See attached confirmation.

Business Director will be responsible for continued compliance with annual training schedule.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

82a - Poisonous Materials

6. Requirements

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

Description of Violation

On 10/1/2024, Laundry detergent pods were observed stored in a clear container without the original label in a laundry room cabinet.

Plan of Correction ***Accept (- 12/06/2024)***

Original containers returned to laundry room and signage posted not to remove detergent pods from original container. Maintenance Supervisor will monitor continued compliance on monthly basis. See attached photo. Completed 10/4/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/1/2024, In room 109 a bed rail was not securely fastened to the bed and very loose. Licensing representative was able to move the bed rail 3-4 inches towards and away from the bed.

Plan of Correction ***Accept (- 12/06/2024)***

Bed rail has been removed from Room 109 with family's permission. This bed rail was not functional and resident did not need bed rail for support or assistance with ADLs. See attached photo.

This was completed 10/4/2024. All rooms were audited. No bed rails exist. DOW is responsible for compliance.

95 - Furniture and Equipment (continued)

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

103e - Left Overs

8. Requirements

2600.
103.e. Food served and returned from an individual’s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 10/1/2024, a container of ice cream was found in the freezer uncovered and with no label or date.

Plan of Correction ***Accept (- 12/06/2024)***

A signage reminder was placed on all staff accessible refrigerators/Freezers with instructions to label and date all food items. Dining Manager will check fridge/freezers weekly to maintain compliance. See attached photo. Completed 10/4/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

131a - Fire Extinguisher

9. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

The home did not have a fire extinguisher stored in the basement of the home.

Plan of Correction ***Accept (- 12/06/2024)***

A fire extinguisher was added to the basement in order to be compliant. This extinguisher has been added to the list of extinguishers serviced by the home. See photo attached.

This was completed on 10/4/2024. Maintenance Director is responsible for compliance.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

131f - Fire Extinguisher Inspection

10. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home’s laundry area had a tag on it with an expiration date of 8/2024 and hand written across the tag was the word “FAIL”.

131f - Fire Extinguisher Inspection *(continued)*

Plan of Correction ***Accept (- 12/06/2024)***

The extinguisher failed as it was due for it's 6 year hydro recharge. The service was completed but a new tag was not placed. The corrected tag has been placed and the extinguisher is compliant. SMMC has authorized VFP to complete all maintenance/services at the time of inspection to maintain compliance. See photo attached.
This was completed on 10/4/2024. Maintenance Director is responsible for compliance. An audit was completed and all extinguishers are in compliance.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

132a - Monthly Fire Drill

11. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home was unable to document that any fire drills were conducted from December 2023 through August 2024. The home was unable to locate their fire drill logs. The only documentation of a fire drill being conducted during this time period was a fire safety inspection letter dated 7/22/24 in which the fire safety expert supervised a fire drill.

Plan of Correction ***Accept (- 11/05/2024)***

Drills have not been found. SMMC DOES conduct monthly fire drills, but only kept hard paper copies previously. The 7/22/24 drill was sent to the Fire Department for their records so they provided this copy for us. See attached.

Also attached is Sept 2024 (which was provided to DHS at the time of the inspection on 10/1) and the since completed 10/10 drill.

SMMC will maintain hard, paper copies of all drills, but will also maintain drill records electronically, in a secure file system to prevent being unable to locate drills in the future. Both ED and Maintenance Director will keep hard copies in addition to the electronic copy. A proposed 2024-2025 fire drill calendar is included.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented (- 03/20/2025)

132b - Safety Inspection/Fire Drill

12. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most current required fire safety inspection and supervised fire drill conducted by a fire safety expert was completed on 7/22/24. The previous fire safety inspection and supervised fire drill was conducted on 5/18/23, more than 12 months prior.

Plan of Correction ***Accept (- 12/06/2024)***

Fire safety inspection from 2023, conducted by , was completed 7/7/2024. (see attached documentation). However, listed May 2023 on the letter in error. After repeated attempts to obtain the letter the incorrect date

132b - Safety Inspection/Fire Drill (continued)

was overlooked. However, the 2023 inspection took place July 7, 2023 and 2024 inspection took place July 22, 2024.

Maintenance Director responsible for continued compliance

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (█ - 03/20/2025)

132e - Fire Drill Sleeping Hours

13. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home did not have documentation of fire drills conducted from December 2023 to August 2024, and therefore could not verify that a sleeping hour drill was conducted every six months as required over the previous 12 months.

Plan of Correction ***Accept (█ - 11/05/2024)***

Drills are completed MONTHLY at SMMC. Original record of drills Dec. 2023-August 2024 cannot be physically located and scanned copies were not previously maintained. Drills will continue to be completed in compliance with regulation. In addition to hard copy drill logs, electronic copies will also be kept in a secure file system. Maintenance Director and ED will keep hard paper copies in addition to electronic copy. 11-7 sleeping hours drill are scheduled for November 2024 and May 2025. See attached drill calendar

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented (█ - 03/20/2025)

185a - Implement Storage Procedures

14. 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 has an order for blood glucose readings twice daily before breakfast and dinner. On 9/26/24 at 4pm the blood glucose reading was 307, but was documented as 309 on the resident's Medication Administration Record. (MAR).

Plan of Correction ***Accept (█ - 12/06/2024)***

All SMMC Med Techs have been provided an education by DOW about the importance of correctly documenting glucometer readings. This was a human error in recording the wrong number. DOW and 3-11 supervisor will maintain compliance by auditing glucometers and MAR every biweekly. This was completed on between 10/4/2024 and 10/9/2024 to account for all MT's.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (█ - 03/20/2025)

187a - Medication Record

15. Requirements

187a - Medication Record *(continued)*

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
11. Special precautions, if applicable.

Description of Violation

Resident #2 has an order for Lisinopril 10mg tablets once daily, hold for systolic blood pressure (SBP) less than 110. On 9/1/24, 9/6/24, 9/11/24, 9/18/24, and 9/29/24 the home did not document the SBP used to determine if the medication needed to be held on the resident's Medication Administration Record (MAR). On all dates the medication was held according to the coding used on the MAR.
Resident #3 has an order for Amlodipine 2.5mg and an order for Edarbi 40 mg, both to be held if the SBP is less than 110 or heart rate is less than 55. Both medications are administered at 8:30am The home is not recording the SBP or the heart rate on the resident's MAR. From 9/1/24 to 9/30/24 both medications were administered on all dates with no documentation of the resident's SBP or heart rate.

Plan of Correction ***Accept (- 12/06/2024)***

The home has adjusted Point Click Care's settings to prompt Med Techs and provide a place to document these necessary vitals to be reflected on the MAR.

An audit was completed for all residents with perameter medications. All are in compliance. DOW is responsible for continued compliance. This was completed on 10/9/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

233c - Key-Locking Devices

16. 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

During the initial walk through it was found that there was no code posted on or near the keypad used to open the exit gate for the outdoor garden area.

Plan of Correction ***Accept (- 12/06/2024)***

Code was impacted by weather and fell off. Code has been reposted and secured with waterproof tape. Maintenance Director will monitor and audit quarterly for compliance. This was completed on 10/2/2024.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented (- 03/20/2025)

234b - Support Plan Needs Elements

17. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

234b - Support Plan Needs Elements *(continued)*

Description of Violation

Resident #4's Resident Assessment Support Plan (RASP) dated [redacted] does not reflect that the resident is unable to safely use and avoid poisonous materials and does not include a plan to ensure the resident does not encounter poisonous materials. Resident #4 has a diagnosis of dementia and resides in a secure dementia unit.
Resident #5 uses a bedside mobility device. The Resident's Assessment Support Plan dated 3/18/2024 does not reflect the specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 12/06/2024)***

RASP for resident #4 has been corrected to reflect the error made and establish that resident #4 cannot safely avoid poisionous materials.

Resident #5's bedside mobility device has been removed with the family's permission. A note has been made on the RASP addendum to reflect this change.

This was completed on 10/9/2024. DOW will maintain compliance. An audit was completed and all residents are in compliance.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Implemented ([redacted] - 03/20/2025)