

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

December 4, 2024

[REDACTED], OWNER
ALEXANDRIA MANOR OF ALLENTOWN, INC.
[REDACTED]

RE: ALEXANDRIA MANOR OF
ALLENTOWN - BETHLEHEM
CAMPUS
3534 LINDEN STREET
BETHLEHEM, PA, 18017
LICENSE/COC#: 21456

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/10/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ALEXANDRIA MANOR OF ALLENTOWN - BETHLEHEM CAMPUS License #: 21456 License Expiration: 09/29/2024

Address: 3534 LINDEN STREET, BETHLEHEM, PA 18017

County: NORTHAMPTON

Region: NORTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: ALEXANDRIA MANOR OF ALLENTOWN, INC.

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 04/04/2006

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 42

Waking Staff: 32

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Complaint

Exit Conference Date: 10/10/2024

Inspection Dates and Department Representative

10/10/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 58

Residents Served: 38

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 38

Diagnosed with Mental Illness: 4

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 4

Have Physical Disability: 2

Inspections / Reviews

10/10/2024 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/02/2024

11/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/02/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/17/2024

Inspections / Reviews (*continued*)

11/25/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 12/02/2024

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 11/30/2024

12/02/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 12/02/2024

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 12/06/2024

12/04/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 12/02/2024

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 License Inspection Summary (LIS) report dated 11/2/23 for the most recent renewal inspection was not posted in the home as required.

On 10/10/24 the home did not have a current license posted in the home. The home had a license with an expiration date of 9/29/24 posted.

Plan of Correction

Accept (█ - 11/25/2024)

LIS was corrected day of inspection.

Unable to correct current license, no new license has been issues by DHS. License that expired 9/29/24 is still posted.

Moving Forward

LIS will be printed and posted by admin or designee. LIS will be audited monthly times 12 months, by admin or designee to ensure proper ongoing compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented (█ - 12/02/2024)

20b3 - Written Receipts

2. Requirements

2600.

- 20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The home provides financial assistance for resident #1. Resident #1 did not sign for cash withdrawals that were documented on the following dates. █.

Plan of Correction

Accept (█ 11/25/2024)

Resident #1 is alert and oriented, █ is aware of the proper signature procedure.

A meeting was held on 10/25/24 with the resident, █ POA, admin and activity director. It was explained that moving forward the resident would need to provide the hairdresser with a check on hairdresser day and Alexandria Manor would no longer be able to assist with financial management. Financial management logs will be audited

20b3 - Written Receipts (continued)

weekly times 12 weeks by admin or designee to ensure proper ongoing compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented () - 12/04/2024)

51 - Criminal Background Check**3. Requirements**

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on (). The home did not obtain a criminal background check for staff person A until ().

Plan of Correction

Accept () - 11/25/2024)

Unable to correct past backgrounds checks not done in timely manner.

Moving Forward:

Finance office is no longer responsible for new hire background checks as of 10/10/24. All background checks will either be done by myself the admin or my designee starting 10/10/24.

Audits of new hires will be completed monthly times 12 months, by administrator or designee.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented () - 12/02/2024)

65d - Initial Direct Care Training**4. Requirements**

2600.

- 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

Staff person A was hired (). The home did not have documentation that staff person A completed the Department's required direct care competency test.

Plan of Correction

Accept () - 11/25/2024)

Staff person A completed comp test as of 11/1/24 and placed in chart.

65d - Initial Direct Care Training (continued)

All DCS charts have been audited as of 11/1/24 and found to be in compliance.

Moving forward:

All DCS will take department-approved direct care training course and competency test immediately upon hire. All DCS charts will be audited upon hire 1 week after hire by administrator or designee to maintain proper on-going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented [REDACTED] - 12/02/2024)

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:

5. Falls and accident prevention.

Description of Violation

The home did not have documentation that staff person B received annual training on falls and accident prevention for the 2023 training year. Repeated violation 11/2/23 and 1/18/24.

Plan of Correction

Accept [REDACTED] - 11/25/2024)

Staff person B completed training as of 11/1/24

All DCS charts have been audited as of 11/1/24 and found to be in compliance.

Moving forward:

All DCS will attend in-services/training/educations as required, admin or designee will audit in-service signature sheets day of in-services/training/educations to follow proper on-going compliance.

In addition, all in-services/training/educations signature sheets will be audited monthly times 12 months by admin or designee to follow proper compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

65g Annual Training Content (continued)

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented () - 12/02/2024)

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Upon entering the 2nd floor of the home from the stairwell a strong odor of urine was detected during the initial walk through.

Plan of Correction

Accept () - 11/25/2024)

Corrected day of inspection.

Housekeeping staff was educated 10/16/24 on the importance of keeping floors clean and free of odors

Moving Forward:

Carpets were shampooed in hallways and common areas as of 10/16/24. Carpets will be shampooed as needed or on a monthly schedule.

Admin or designee will audit facility floors weekly times 4 weeks starting 11/4/24 and then monthly times 6 months to follow proper on going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented () - 12/04/2024)

132c - Fire Drill Records

7. 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 recorded fire drill evacuation times in minutes only on the following dates:

12/14/23 at 7:30am 6 minutes

3/4/24 at 1:20pm 4 minutes

4/17/24 at 4:15pm 6 minutes

8/11/24 at 1:38pm 7 minutes

132c - Fire Drill Records (continued)

Plan of Correction

Accept (J) - 11/25/2024)

Admin was educated by owner on the importance of following 132c - Fire Drill Records.

Moving Forward:

The admin or designee will be using a stopwatch to properly time fire drills. Owner, Admin or designee will monitor fire drill logs monthly times 12 months to follow proper on-going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented (J) - 12/04/2024)

144c1 - Smoking Area Guidelines

8. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

Cigarette butts were observed in the rocks on the ground in the staff smoking area. Also, cigarette butts were found in a planter located in the resident smoking area. The cigarette butts were mixed in with pine needles in the planter.

Plan of Correction

Accept (J) - 11/25/2024)

All smoking areas were cleaned at time of inspection.

All smoking sections have been audited as of 10/11/24 to ensure proper smoking vessels are available, functional and surrounding area is clean and free of cigarette butts.

Moving Forward:

Residents and Staff have been educated on the dangers of not using proper extinguishing vessels.

All smoking sections will be audited weekly times 4 weeks starting 11/4/24 and then monthly times 6 months.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

144c1 - Smoking Area Guidelines (continued)

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented (█ - 12/02/2024)

181c - Self-administration Assessment

9. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 is assessed to self-administer supplements █. The resident's room was inspected and it was observed that the resident also had a bottle of █ at bedside which the resident is not assessed to self-administer.

Plan of Correction

Accept (█ - 11/25/2024)

Order for medications found in resident 2's room have been obtained as of █.

Meeting with resident and POA to explain the importance of not purchasing medication not on medication list. Instructed resident if he would like a new medication, that request must go thru █ family doctor.

Moving Forward:

The admin or designee will monitor and have check in's with resident #2 weekly times 12 weeks starting 11/4/24 to follow proper on-going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/24/2024

Implemented (█ - 12/02/2024)

183b - Meds and Syringes Locked

10. Requirements

2600.

183b Meds and Syringes Locked (continued)

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/10/24 at approximately 9:10am, the medication cart was found in the living room of the home and was unlocked and unattended. Repeated violation 6/4/24 et al.

Plan of Correction

Accept (█ - 11/25/2024)

Medication cart corrected at time of inspection.

Admin has been educated on 10/10/24 by owner of facility of the importance of medication cart being locked.

All Medtech's have been education on 10/16/24 on the importance of medication cart being locked.

Moving Forward:

The admin or designee will monitor med carts weekly times 4 weeks starting 11/4/24 and then monthly times 12 months to follow proper on going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/24/2024

Implemented (█ - 12/02/2024)

185a - Implement Storage Procedures**11. 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 #3 has a PRN order for █ every 4 hours as needed. The home did not have the medication on hand to administer if needed.

Resident #4 has a PRN order for █ once daily as needed. The home did not have the medication on hand to administer if needed.

Resident #5 has the following PRN order for insulin █ If blood sugar is over █ and patient is not due for an █ dose with a meal, administer 8 units 2 times daily as needed. The home did not have the medication on hand to administer if needed.

Plan of Correction

Accept (█ - 11/25/2024)

All Medtech's have been educated as of 11/4/24 on the importance of develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

All medications for resident 3, resident 4 and resident 5 have been obtained or discontinued.

185a - Implement Storage Procedures (continued)

Moving Forward:

All medication carts have been audited as 11/22/24 by admin or designee.

The admin or designee will monitor med carts weekly times 4 weeks starting 11/22/24 and then monthly times 12 months to follow proper on-going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/24/2024

Implemented [REDACTED] - 12/04/2024)

187b - Date/Time of Medication Admin.**12. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 has an order for [REDACTED] insulin 3 times daily per sliding scale. On [REDACTED] the blood glucose reading in the glucometer was [REDACTED]. The sliding scale order indicates to call the physician if the blood glucose reading is over [REDACTED]. Staff did not record the number of sliding scale insulin units administered at this time on the resident's MAR and did not note if the physician was called. Staff interview indicated [REDACTED] had been administered on [REDACTED] at [REDACTED] but were not recorded on the MAR.

On [REDACTED] resident #5's [REDACTED] medications were administered but staff did not initial the resident's Medication Administration Record (MAR) at the time of administration.

Resident #5's [REDACTED] medications are: [REDACTED] one tablet at bedtime; [REDACTED], 2 puffs twice daily at [REDACTED]; [REDACTED], 1 tablet 3 times daily at [REDACTED]; [REDACTED] tablet twice daily at 9am and 9pm.

Repeated violation 6/4/24 et al.

Plan of Correction

Accept [REDACTED] - 11/25/2024)

All Medtech's have been educated as of 10/16/24 on the importance of following Date/Time of Medication Administration (signing MAR's and properly following sliding scale directions.

Moving Forward:

The admin or designee will monitor the MARs weekly times 4 weeks starting 11/4/24 and then monthly times 12 months to follow proper on-going compliance.

187b - Date/Time of Medication Admin. (continued)

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/24/2024

Implemented [REDACTED] - 12/04/2024)

187d - Follow Prescriber's Orders

13. Requirements

2600.

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

Description of Violation

Resident #3 has an order for [REDACTED], 8 units daily at [REDACTED], hold if the blood glucose is less than [REDACTED]. On [REDACTED] blood glucose reading was [REDACTED]. The MAR indicates the [REDACTED] was not held as required by the prescriber's order.

Plan of Correction

Accept [REDACTED] - 11/25/2024)

All Medtech's have been educated as of 10/16/24 on the importance of following prescriber's orders.

Moving Forward:

The admin or designee will monitor the MARs weekly times 4 weeks starting 11/4/24 and then monthly times 12 months to follow proper on-going compliance.

AS THE ADMINISTRATOR I AM RESPONSIBLE FOR PROPER ON-GOING COMPLIANCE

Licensee's Proposed Overall Completion Date: 11/24/2024

Implemented [REDACTED] - 12/04/2024)

224a - Preadmission Screen Form

14. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #6 was admitted to the home on [REDACTED]. Resident #6's preadmission screening was not dated and it could not be determined when it was completed by the home.

224a - Preadmission Screen Form (*continued*)**Plan of Correction****Accept** [REDACTED] - 11/25/2024)

Pre-screen was corrected day of inspection.

Moving Forward:

All prescreens have been audited on 11/20/24 and found to be in compliance. Admin will work in conjunction with the marketing manager to ensure all prescreens are completed within proper time frame. Audits will be completed for all new residents times 12 weeks, by admin or designee.

As the administrator I am responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 11/20/2024

Implemented [REDACTED] - 12/02/2024)