

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

January 7, 2025

[REDACTED]
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

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/07/2024 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: MEADOWS LIVING CENTER AT COUNTRY MEADOWS OF BETHLEHEM License #: 23788 License Expiration: 10/08/2025

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: L & I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 56

Waking Staff: 42

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal, Incident

Exit Conference Date: 11/07/2024

Inspection Dates and Department Representative

11/07/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 64

Residents Served: 28

Secured Dementia Care Unit

In Home: Yes

Area: whole home

Capacity: 64

Residents Served: 28

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 28

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 28

Have Physical Disability: 0

Inspections / Reviews

11/07/2024 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/13/2024

12/26/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/30/2024

Inspections / Reviews *(continued)*

01/07/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The bedside mobility device attached to the bed in resident room [redacted] was not firmly attached to the bed and easily moved from side to side when grabbed posing a possible risk of injury to the resident.

Plan of Correction

Accept [redacted] - 12/26/2024)

- o The bedside mobility device in room [redacted] was immediately removed and inspected for defects by a maintenance coworker on [redacted]
- o After inspection on 11/7/24 the device was securely attached by a maintenance coworker to the bed and tested for stability and safety.
- o All staff responsible for maintaining equipment will be retrained on proper attachment and inspection protocols, as well as the importance of promptly reporting any issues with mobility equipment by the DON or designee on or before December 15, 2024.
- o Effective 12/1/24 the devices will be checked and logged on a monthly basis by the Environmental Supervisor. If a concern is noted, they will notify the Maintenance Director, Executive Director or Director of Nursing and immediately correct the situation to remain in compliance. Log to be provided to DHS.

Licensee's Proposed Overall Completion Date: 12/11/2024

Implemented [redacted] - 01/07/2025)

121a - Unobstructed Egress

2. 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

On [redacted] Licensing Representative observed an outstretched hose lying behind the exit door that leads to the courtyard gazebo area, that prevented the door from fully opening.

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] - 12/26/2024)

- o The obstructing hose was immediately removed from behind the exit door at the time of inspection on 11/7/24 by the maintenance team. The hose was put in the designated storage area to prevent it from being left near egress doors.
- o On 11/7/24 at time of inspection the door was tested to ensure it could fully open and close without further obstruction by the maintenance team.
- o Routine safety inspections of the courtyard will be conducted and logged on a monthly basis beginning the week of 12/15/24 by the Maintenance Director and will include all egress routes in the courtyard to ensure compliance. Documentation to be provided to DHS.

121a - Unobstructed Egress (*continued*)

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented [REDACTED] - 01/07/2025)

132a - Monthly Fire Drill

3. Requirements

2600.

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

Description of Violation*The home did not conduct a fire drill in May 2024 and in August 2024.***Plan of Correction**

Accept [REDACTED] - 12/26/2024)

- o On 11/7/24 the Executive Director reviewed all fire drill logs for the past 12 months to verify compliance and ensure no additional months were missed.*
- o All coworkers responsible for scheduling and conducting fire drills will be retrained on the requirements, including the necessity of unannounced monthly drills and proper record keeping, on or before December 15, 2024 by the Director of Maintenance or designee. Documentation to be provided.*
- o A Fire Drill Schedule Tracker was created on 12/1/24 to ensure that a drill is planned, conducted, and documented each month using the template provided by the corporate fire safety expert.*
- o Effective 12/1/24 the Executive Director will conduct quarterly reviews of the calendar and logs to ensure drills are scheduled and follow the required time frame to be in compliance with the regulation.*

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented [REDACTED] - 01/07/2025)

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*Review of the home's fire drill logs indicated a supervised fire drill was conducted on [REDACTED] by the Fire Safety Inspector. The log does not indicate the time of day the drill was held, the amount of time to evacuate, exit routes used, number of residents in the home, number of residents evacuated, and the number of staff participating.*

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 12/26/2024)

- o The Fire inspector who completed the drill did document the time of the drill, evacuation duration, exit routes, number of residents in the home, number of residents evacuated, and number of staff participating.*
- o The documentation of this drill was not readily available the day of the inspection.*
- o Documentation of the drill conducted by Croker Fire Safety from June 5, 2024 has been obtained from Croker Fire Safety is included with the supporting documentation in this POC.*

132c Fire Drill Records (continued)

- o Croker Fire Safety began servicing this facility in June of 2024. Effective 12/1/24 access to fire drill documentation through Croker Fire Safety has been clarified to avoid similar issues from happening in the future.
- o Effective 12/1/24 fire drill documentation and performance will be reviewed quarterly by the Campus ED or designee during campus safety committee meetings.

Licensee's Proposed Overall Completion Date: 12/11/2024

Implemented [redacted] - 01/07/2025)

132e - Fire Drill Sleeping Hours

5. Requirements

2600.

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

Description of Violation

The home conducted a sleeping hour drill [redacted] at 4:04 am; the next sleeping hour drill was held on [redacted] at 5:30am; one month past the 6 month required time frame.

Plan of Correction

Accepted [redacted] - 12/26/2024)

- o Coworkers responsible for scheduling and conducting fire drills will be retrained on or before 12/15/24 by a fire safety expert on the specific requirement to hold sleeping hour drills at least every six months. Emphasizing the importance of timely scheduling and compliance with regulatory time frames. Documentation to be provided.
- o A Fire Drill Schedule Tracker was created on 12/1/24 to ensure that a drill is planned, conducted, and documented each month using the template provided by the corporate fire safety expert.
- o Effective 12/1/24 the Executive Director or designee will conduct quarterly reviews of the calendar and logs to ensure sleeping hour drills follow the required time frame to be in compliance with the regulation.

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented [redacted] - 01/07/2025)

233c - Key-Locking Devices

6. 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

The courtyard gate located near the gazebo in the homes fenced in yard did not open when the posted code was entered.

The code posted on the gate located in between the memory care courtyard and the skilled nursing building did not open when the posted code was entered.

233c Key Locking Devices (continued)

Plan of Correction

Accept [redacted] - 12/26/2024)

- o The gate was inspected on 11/8/24 by a maintenance associate, and the locking/unlocking mechanisms were tested to ensure proper functioning. Any issues found were corrected at this time.*
- o Updated signage was posted near the gate indicating the correct operational procedure by the maintenance associate on 11/08/24.*
- o The Maintenance Director will conduct a monthly gate inspection that will begin the week of December 15th to ensure all locking devices, posted codes, and egress routes are functional and compliant.*
- o Maintenance logs will be reviewed monthly by the Executive Director to ensure locking devices and codes are functional and compliant effective 12/15/24.*
- o Effective 12/15/24 findings from inspections will be reviewed in monthly safety committee meetings to ensure ongoing compliance.*
- o Documentation to be provided, a photo of the gate and copy of the first monthly log.*

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented [redacted] - 01/07/2025)

234d - Support Plan Revision

7. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [redacted] Resident Assessment and Support Plan (RASP) dated [redacted] does not indicate the following behavioral and cognitive needs: aggression, communication of needs and short term memory. The residents RASP does not indicate the resident had an unwitnessed fall in their bathroom on [redacted]. Resident [redacted] was sent to [redacted] [redacted] for evaluation and was admitted with a maxillary fracture and laceration of the head.

Resident [redacted] requires a bed cane. The resident's RASP dated [redacted] does not reflect the following information: • 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 • If a cover is required to meet FDA guidelines.

Plan of Correction

Accept [redacted] - 12/26/2024)

- o The RASP was updated on [redacted] by the DON for resident [redacted] to reflect the unwitnessed fall on [redacted], including: description of the incident, evaluation of potential contributing factors, and interventions.*
- o Coworkers responsible for completing and revising RASPs will be retrained on regulatory requirements on or before December 15th, 2024 focusing on: the importance of updating support plans promptly when a resident's condition changes. Recognizing and addressing the need for adaptive devices. Documentation to be provided.*
- o The Executive Director or designee will conduct quarterly audits of a random sample of RASPs to ensure compliance with regulatory requirements beginning on 12/1/24.*

234d - Support Plan Revision (continued)

o On [REDACTED] Resident [REDACTED] RASP was reviewed and it was realized that resident [REDACTED] was indicated to need a bed cane on the list given to the inspector. Resident [REDACTED] did not require the assistance of a bed cane at the time of inspection or prior to the date of inspection. This information was reviewed with [REDACTED], [REDACTED] on [REDACTED] [REDACTED] instructed to detail this information in the POC to confirm the mistake made listing Resident [REDACTED] utilized a bed cane.

Licensee's Proposed Overall Completion Date: 12/11/2024

Implemented ([REDACTED] - 01/07/2025)