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

April 3, 2025

[redacted], ADMINISTRATOR
RENAISSANCE HOME NORTHAMPTON LLC
1001 WASHINGTON AVENUE
NORTHAMPTON, PA, 18067

RE: RENAISSANCE HOME NORTHAMPTON
1001 WASHINGTON AVENUE
NORTHAMPTON, PA, 18067
LICENSE/COC#: 22701

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/12/2024, 01/06/2025 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: *RENAISSANCE HOME NORTHAMPTON* **License #**: *22701* **License Expiration**: *10/31/2025*

Address: *1001 WASHINGTON AVENUE, NORTHAMPTON, PA 18067*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *RENAISSANCE HOME NORTHAMPTON LLC*

Address: *1001 WASHINGTON AVENUE, NORTHAMPTON, PA, 18067*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/01/1995* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/06/2025*

Inspection Dates and Department Representative

12/12/2024 - On-Site:

01/06/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *29*

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**: *28*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *2*

Inspections / Reviews

12/12/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/01/2025*

02/04/2025 - POC Submission

Submitted By: **Date Submitted**: *03/10/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/11/2025*

Inspections / Reviews *(continued)*

02/21/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *03/10/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *03/10/2025*

04/03/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *03/10/2025*
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 Licensing Inspection Summary dated 3/5/24 was not posted in a conspicuous, public area of the home.

Plan of Correction ***Accept (█ - 02/20/2025)***

• The facility LIS dated 3/5/24 was sourced in SansWrite and posted by the Administrator 12/13/24.

• A one-time audit was conducted on 1/24/25 by the Administrator, to ensure all other required postings were in place and current.

• The Regional Director of Operations was informed by the Administrator of this survey finding on 1/22/25 relative to what the requirement is, duly serving as a self-education for the Administrator.

• An audit of required postings will be conducted once a month for three months by the Administrator or delegated person, to determine whether an update or replacement is in order. The results of this audit will be presented to management to determine whether this audit frequency remains necessary.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home had a number of legal violations assigned by the Northampton Borough Code Office related to having unusable stairs that are considered exit routes from the 1st and 2nd floor of the home. The following violations were found by the Northampton Borough Code Office:

2018 IFC – Section 111.1.1 – Unsafe Conditions – Structures of existing equipment that are or hereafter become unsafe of deficient because of inadequate means of egress, that constitute a fire hazard, are otherwise dangerous to human life or the public welfare, or involve illegal of improper occupancy or inadequate maintenance, shall be deemed an unsafe condition. The egress stairs located on your property are completely unsafe and not in compliance with the code.
2018 IFC – Section 1028: Exit Discharge – The exit discharge shall be at grade or shall provide a direct path of egress travel to grade. The steps located from division 1 and division 2 do not provide this. They are in a complete state of disrepair and need to be replaced since this is a primary means of egress for this wing of your facility.
2018 IFC – Section 1027.2 – Use in a means of egress – For occupancies in other than Group I-2, exterior stairways and ramps shall be permitted as an element of a required means of egress for buildings not exceeding six stories above grade plane or that are not high-rise buildings. The exterior stairways are required and need to be maintained in good condition.
2018 IPMC – Section 304.1.1 (12) – Unsafe Conditions – Exterior stairs, decks, porches, balconies and all similar

18 - Compliance With Laws (continued)

appurtenances attached thereto, including guards and handrails, are not structurally sound, not properly anchored or that are anchored with connections not capable of supporting all nominal loads and resisting all load effects. The stairs do not meet this requirement. The balcony area appears to be sagging. A support post appears to be unanchored.
Northampton Borough Code Office provided the following timeline for repairs
Please make all necessary repairs to this means of egress within thirty (30) days of October 7, 2024. A reinspection of this property will occur on November 7, 2024. As per the 2018 IFC – Section 110.2, you as the owner are responsible for the abatement of these violations.
Please be sure to apply for and obtain all necessary building permits as soon as possible. The zoning office will be able to help you obtain your permit(s) and can be contacted at 610-262-1433
Failure to comply with this notice will result in citations being issued against the property owner(s) at the District Court 03-3-01. It also will prompt a review of your allowable occupant load to ensure that your occupant load is within the requirements of the 2018 International Fire Code Section 1004.

Plan of Correction ***Accept (█ - 02/21/2025)***

This finding .18, relating to the staircase, is an existing, open deficiency, written exactly as above, on 10/3/24, by the PA State Surveyor, resulting in having a near 1/2 (28 beds) of our community closed, until a complete, re-correction is made. The Regional Director of Operations was made aware of this cite 1/22/25, and reminded of this requirement respectfully.
The Administrator has been kept informed, and also issues a periodic letter to the residents of recent developments; last letter posted 1/24/25 in a conspicuous, public place.
The Regional Director of Operations met with key persons on 1/31/25, to discuss last detail for a re-do of the last attempted correction, which the residents will also be informed of on 2/24/25.
Details by date are: 2/17/2025 work commenced; 2/24/25 Keycodes is scheduled to inspect prep-work and contractor will pour cement (weather permitting); 72 hours will be allowed from pour-time, for cement to cure; 2/27 or 28/25 work will resume; 3/5 or 6/25 work will be complete.
Residents at absolutely no moment, will occupy or reside on the second floor affected by this exit/egress discrepancy, until work is complete, and considered corrected to applicable safety standards by a respective State surveyor.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

As per interviews with staff of the home, the home does not currently have a voice controlled electronic device policy.

42s - Privacy *(continued)*

Plan of Correction ***Accept (- 02/20/2025)***

• No residents possessed a voice-controlled electronic device that would violate another resident's privacy on day of survey, or as result of a one-time full house audit of residents in shared rooms, conducted by the Administrator 1/23/25, to determine if any resident possessed a voice-controlled electronic device.
• The residents and staff will be made aware in writing by the Administrator of this addition to RSH resident privacy policy on 2/19/25.
• The Regional Director of Operations was made aware of this desired policy on 1/22/25, that expands the definition of any existing privacy policy, in an effort of ensuring resident privacy in these current times.
• New admissions will receive a copy of the new privacy policy as it relates to voice-controlled electronic devices, and an audit will be conducted once a month for three months to further ensure compliance is upheld.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (- 04/03/2025)

65g - Annual Training Content

4. 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:

Description of Violation

Direct Care Staff Member A hired did not complete training in Fire Safety conducted by a fire safety expert or person trained by a fire safety expert in training year 2023.

Plan of Correction ***Accept (- 02/20/2025)***

• Direct Care Staff Member A is no longer an employee of Renaissance; terminated by the Administrator for unrelated reasons.
• A one-time audit of the last fire safety training session will be conducted by the Staff Educator or delegated employee on 2/19/25, to determine if all currently employed staff received this training, and if not, schedule the training accordingly.
• Existing staff members will be subject to a documented reminder (education) on 2/19/25 by the Administrator of the importance of completing Fire Safety as well as other training, when it is offered.
• Results will also be discussed among management, to take additional measures in assuring future compliance if necessary.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (- 04/03/2025)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

The trash cans in the common bathrooms near the kitchen do not have lids.

Resident room #132 is shared by 2 residents, the trash can in the bathroom does not have a lid.

Plan of Correction ***Accept (█ - 02/20/2025)***

- *The trash can discrepancy was corrected immediately on 12/12/24 by a staff team member. A one-time audit of occupied shared rooms and public trash receptacles was conducted by the Administrator on 1/23/25, to identify further non-compliance and correct this finding.*
- *An audit of shared resident rooms plus common areas, will be conducted by the Housekeeper, once a week for four weeks to ensure compliance and/or identifying instances of lids for example - that go missing.*
- *An all-staff education will be issued by the Administrator on 2/19/25 relating to standards of trash receptacles.*
- *Results will be presented to management for review and safely determine if compliance can be maintained.*

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

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

Resident room # 132 does not have a bedside lamp or any other source of lighting within reach of the bed.

Plan of Correction ***Accept (█ - 02/20/2025)***

- *The resident's lamp was immediately sourced for room 132 by a staff team member and placed within reach of the bed on 12/12/24.*
- *A one-time full-house audit of occupied resident rooms will be conducted on 2/19/25 by the Administrator to ensure compliance is maintained throughout the community.*
- *All direct care and med tech staff will be educated by the Director of Wellness on 2/19/25 as to when conducting their rounds, to ensure each resident has a light source within reach from their bed.*
- *An audit of five random occupied rooms will be conducted by a Personal Care Aide once a week for four weeks to determine compliance is being continued, and results presented to the Administrator for further corrective action if necessary.*

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

102i - Soap Dispenser

7. Requirements

102i - Soap Dispenser *(continued)*

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

Resident room #132 is shared by 2 residents. Two bars of soap were noted on the sink in the shared bathroom without the residents name on them.

Plan of Correction ***Accept (- 02/20/2025)***

• The mentioned bars of soap were discarded, replaced and properly labeled by a staff team member on 12/12/24.
• A one-time audit of occupied shared rooms was conducted by the Administrator on 1/23/25, to identify if any other residents do not possess personally labeled soap.
• Personal Care Aides and Med Techs will be educated by the Director of Wellness on 2/19/25 regarding the requirement of personally labeled soap in a shared room environment.
• An audit of five random shared occupied rooms will be conducted by Personal Care Aides once a week for four weeks to determine compliance is being continued, and results presented to the Administrator for further corrective action if necessary.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (- 04/03/2025)

102k - No Common Towel

8. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

Resident room #132 is shared by 2 residents. The towel bars in the bathroom, one of which had a washcloth hanging on the bar are not labeled with the residents' names.

Plan of Correction ***Accept (- 02/20/2025)***

• The towel bars in the mentioned room were labeled by a staff team member 12/12/24.
• A one-time audit of occupied shared rooms was conducted by the Administrator 12/13/24, to identify if any other residents do not possess personally labeled towel bars.
• Personal Care Aides and Med Techs will be educated by the Director of Wellness 2/19/25 regarding the requirement of personally labeled towel bars in a shared room environment.
• An audit of five random shared occupied rooms will be conducted by Personal Care Aides once a week for four weeks to determine compliance is being continued, and results presented to the Administrator for further corrective action if necessary.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (- 04/03/2025)

107b - Emergency Procedures

9. Requirements

107b - Emergency Procedures *(continued)*

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
4. Means of transportation in the event that relocation is required.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home does not have the following procedures developed as part of their Emergency Preparedness Plan:

• Contact information for each resident's designated person.
• The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
• Means of transportation in the event that relocation is required.
• Alternate means of meeting resident needs in the event of a utility outage

Plan of Correction ***Accept (█ - 02/20/2025)***

• The Regional Director of Operations was informed by the Administrator on 1/22/25 of this survey finding relative to what the requirement is, duly serving as a self-education for the Administrator.
• The Emergency Preparedness Manual is being updated by the Administrator by the in-compliance date of 2/28/25, with
- Contact Information for each resident's designated person,
- Our established means of transportation in the event of a need to relocate, and
- Information relating to alternate means of meeting resident needs in the event of a utility outage.
A properly labeled enclosure will be acquired by the Administrator to secure emergency medical information for each resident prior to the 2/28/25 in-compliance date.
• A periodic review of the Emergency Preparedness Plan will be conducted by the Administrator once a quarter for two quarters to guarantee accuracy.
• The Regional Director of Operations will be made aware of these review results and if update or correction is necessary.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

123b - Emergency Procedures Posted

10. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

A copy of the home's Emergency Preparedness Plan was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (█ - 02/20/2025)***

• The Emergency Preparedness Plan was returned to a conspicuous and public place in the home by the Administrator 12/13/24.

123b - Emergency Procedures Posted (continued)

• The Regional Director of Operations was informed by the Administrator of this survey finding on 1/22/25, relative to what the requirement is; duly serving as a self-education for the Administrator. All staff members will be made aware of its location on 2/19/25.
• An EMP placement check will be conducted by the Administrator once a quarter for two quarters to guarantee its presence in a conspicuous and public area.
• Results of this check will include corrections if necessary, and communicated to the Regional Director of Operations.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

132b - Safety Inspection/Fire Drill

11. 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 home's annual fire safety inspection was held on 5-14-24. The previous annual fire safety inspection was held on 1-27-23 greater than 1 year and 15 days from the most recent inspection

Plan of Correction ***Accept (█ - 02/21/2025)***

• The Regional Director of Operations was made aware of this finding by the Administrator on 1/22/25, duly serving as a self-education.
• The Administrator will assure with the service provider that the next fire safety inspection occurs prior to 5/29/25. An email was placed to the fire safety training expert to reach out to us and determine a date, within compliance, to offer the training.
• The respective fire safety inspection intended to take place in 2026, will be scheduled if possible with the service provider within 1 year and 15 days, of the 2025 inspection taking place.
The Administrator will take the following measures to ensure all required personnel are in attendance. 1) The education which was provided 2/19/25 - indicating the requirement. 2) Once the date is known, posting a reminder and the importance at the employee timeclock, to include the probable consequence of not attending. 3) Informing staff via the human resource messaging system. 4) Obtaining a list prior to the training date, to determine who should be present and record attendance.
• Any developments or changes to this plan will be communicated to the Regional Director of Operations.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

The current and upcoming weekly menus were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (█ - 02/20/2025)***

- *The respective menus for the current and following week were posted by the kitchen staff on 12/12/24.*
- *The kitchen staff will be re-in-serviced by the CDM on 2/19/25 as to the requirement of consistently posting both the current and following week of menus for the residents.*
- *An audit of whether the proper menus are posted will be conducted by the CDM once a week for four weeks to monitor compliance.*
- *Results will be reported to the Administrator to determine if further corrective measures are necessary to ensure keeping within regulation.*

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #1 had a Pro Re Nata (PRN) prescription for Acetaminophen 325 mg tablets and Meclizine 25 mg tablets that was discontinued on 9-28-24. Both medications were found in the medication cart at the time of inspection. The resident also had a PRN order for Melatonin 3mg tablets that was discontinued on 7-26-24. The Melatonin 3mg tablets were still in the medication cart at the time of inspection.

Plan of Correction ***Accept (█ - 02/21/2025)***

- *The Director of Wellness corrected these findings on 12/12/24 and reviewed the medication cart and med room for discontinued medication.*
- *The med techs were in-serviced by the Director of Wellness on 1/31/25 of the risks involved and importance of ensuring discontinued medications are removed from the medication cart and med room, discarded, or returned to pharmacy where applicable.*
- *A weekly audit of ten residents starting 1/31/25 will be conducted for four weeks to determine if this practice is remaining within guidelines.*
- *Results of these audits will be presented to the Administrator to determine of further measure is necessary to achieve regular compliance.*

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

185a - Implement Storage Procedures

14. Requirements

185a - Implement Storage Procedures *(continued)*

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 # 2's glucometer is not calibrated to the correct date and time.

Resident #3 uses a Dexcom blood glucose monitor and has an order for blood glucose readings to be 3 times daily at 7:30am, 11:30am and 5:30pm. The resident's blood glucose reading on 12-12-24 at 7:30am was noted as 135 in the monitor but was recorded on the Medication Administration Record (MAR) as 132. The blood glucose reading on 12-11-24 at 5:30pm was noted as 185 in the monitor but was recorded as 184 on the resident's MAR.

Resident #4 has a PRN order for An Albuterol HFA inhaler and Benzonatate 100mg capsules. Both medications were not available at the time of inspection.

Resident #5 has a PRN order for Robitussin 5ml Liquid and Senekot 8.6mg tablets. Neither medication was available at the time of inspection.

Repeat Violation 12-27-23

Plan of Correction ***Accept (█ - 02/21/2025)***

• The Director of Wellness took necessary steps to correct these findings on 12/12/24, and reviewed the medication cart to 1) determine if proper glucometer calibration was being conducted, and 2) that true blood glucose levels were being documented and treated for, and 3) determine if other PRN medications were not readily available.
• The med techs were in-serviced by the Director of Wellness on 1/31/25 of the importance and requirement of calibrating glucometers, documenting actual blood glucose levels, and having prescribed PRN medication available at all times and potential effects these can have on residents.
• A weekly audit of ten residents starting 1/31/25 will be conducted for four weeks to determine if these practices are remaining within guidelines.
• Results of these audits will be presented to the Administrator to determine if further measure is necessary to achieve regular compliance.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)

187c - Refusal of Medication

15. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #4 has an order for Antacid 500mg chewable tablets to administered daily at 8am. The resident refused the

187c - Refusal of Medication (continued)

medication on 12-4-24 and 12-10-24. As per interviews with staff, the resident's physician was not contacted regarding the refusals of the medication.

Plan of Correction ***Accept (█ - 02/21/2025)***

• The Director of Wellness reviewed medication administration records best possible on 12/12/24 to determine if other recent medication refusals needed to be further processed, documented, or communicated.
• The med techs were in-serviced by the Director of Wellness on 1/31/25 of the importance and requirement of documenting and communicating medication refusals timely.
• A weekly audit of ten residents starting 1/31/25 will be conducted for four weeks to determine if these practices are remaining within guidelines.
• Results of these audits will be presented to the Administrator to determine if further measure is necessary to achieve regular compliance.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Implemented (█ - 04/03/2025)