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

July 15, 2025

[redacted], OWNER
BETHLEHEM MANOR SENIOR LIVING LLC
815 PENNSYLVANIA AVENUE
BETHLEHEM, PA, 18018

RE: BETHLEHEM MANOR
815 PENNSYLVANIA AVENUE
BETHLEHEM, PA, 18018
LICENSE/COC#: 22684

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/01/2025 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: *BETHLEHEM MANOR* **License #**: *22684* **License Expiration**: *05/24/2026*

Address: *815 PENNSYLVANIA AVENUE, BETHLEHEM, PA 18018*

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

Administrator

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

Legal Entity

Name: *BETHLEHEM MANOR SENIOR LIVING LLC*

Address: *815 PENNSYLVANIA AVENUE, BETHLEHEM, PA, 18018*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/11/2011* **Issued By**: *L&I*

Type: *I-2* **Date**: *04/11/2017* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *05/09/2025*

Inspection Dates and Department Representative

05/01/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *40*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd floor* **Capacity**: *36* **Residents Served**: *11*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *25* **Have Physical Disability**: *1*

Inspections / Reviews

05/01/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/06/2025*

Inspections / Reviews *(continued)*

07/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

07/15/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

The home received a written complaint of an alleged abuse of resident #1 by staff member A on [redacted]. The home failed to complete an Act 13 form and notify the Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

The administrator and admin designee will immediately report any and all suspected abuse to the department of Aging and also to BHSL. Administrator and all admin designees rereviewed abuse reporting regulations. The administrator and all admin designees will ensure continued compliance. The administrator and admin designee on all three shifts will immediately notify Area Agency on Aging, of any and all suspected of alleged abuse on any resident. Please see attached training that was completed.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The home failed to submit an incident report to the Department regarding an allegation of abuse with staff person A and Resident #1 when the home was made aware of it on [redacted]

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

The administrator and admin designee will immediately report any and all suspected abuse to the department of Aging and also to BHSL. Administrator and all admin designees rereviewed abuse reporting regulations. To ensure continued compliance. The administrator and admin designee on all three shifts will immediately notify BHSL, of any and all suspected of alleged abuse on any resident. Please see attached training that was completed.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

44d - Complaint Investigation

3. Requirements

2600.
44.d. The home shall ensure investigation and resolution of complaints. The home shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint.

Description of Violation

On [redacted], Resident #1's family filed a complaint regarding resident abuse with staff person A. The home failed to investigate and resolve the complaint.

44d - Complaint Investigation (continued)

Plan of Correction ***Accept (- 07/15/2025)***

The administrator and admin designee on all three shifts will investigate and resolve complaints and ensure documentation is done .To ensure continued compliance, the administrator and admin designee on all three shifts will conduct an investigation , and come up with resolution as required 2600.44d.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

44e - Complaint Submission

4. Requirements

2600.
44.e. Within 2 business days after the submission of a written complaint, a status report shall be provided by the home to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the home is taking to investigate and address the complaint.

Description of Violation

On , a written complaint regarding an allegation of abuse of resident #1 involving staff person A was sent to the home. The home did not complete an investigation and address the complaint to the complainant within 2 business days.

Plan of Correction ***Accept (- 07/15/2025)***

To clarify there was a phone conversation between President/Owner and admin designee and the two , who wrote the complaint.. Please see text messages that are attached. These text messages were also shown at time of inspection. In addition, all investigative steps and resolution of the compliant, will be documented by the administrator, admin designee, Rasp coordinator and wellness coordinator.
To ensure continued compliance, the administrator and admin designee on all three shifts will update the resident or designated person with all steps Bethlehem Manor is taking to investigate and address the complaint.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's current census of 40 residents includes 11 residents in the secure dementia unit as well as two residents, resident #2 and resident #3, who require an assist of two staff persons for safe transfers and evacuation. The total number of residents with mobility needs in the home is 25. On the following dates the home had only two staff persons scheduled during the 3rd shift hours of 11pm to 7am:
4/13/25, 4/16/25, 4/21/25, 4/23/25, and 4/26/25.
The home did not schedule an adequate number of staff persons on 3rd shift to safely evacuate all residents in the event of an emergency.

60a - Staff/Support Plan *(continued)*

Plan of Correction ***Accept (- 07/15/2025)***

The administrator, admin designee and scheduler will be responsible for ensuring all shifts are appropriately staffed. We will also be reminding staff of the importance of calling off at least two hours before the start of their scheduled shift. This will allow the administration, admin designee, and the scheduler adequate time to arrange necessary coverage.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

64c - Annual Training

6. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The home's administrator, completed only 20 of the required 24 hours of administrator training during the 2024 training year.

Plan of Correction ***Accept (- 07/15/2025)***

The administrator will make sure that has at least 24 annual training hours. The administrator will make up the 4 hours in additional to maintaining the 24 hours needed during the 2025 training year. To ensure continued compliance, administrator will audit her hours on a monthly basis.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

Approximately at 9:46a.m., on the 2nd floor, inside the freezer in the dining room, 4fl oz spillage of chocolate ice cream was noted on the bottom of the freezer.

Plan of Correction ***Accept (- 07/15/2025)***

This was corrected at time of inspection by the housekeeping who cleaned the freezer in the dining room. Pictures were emailed to inspectors, the day of inspection and are also attached. Housekeepers were given a checklist to make sure these areas are being cleaned. To ensure continued compliance , administrator and admin designee will walk the building on a weekly basis.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

85b - Infestation

8. Requirements

85b - Infestation *(continued)*

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

At approximately 9:30 a.m. there was a collection of dead bugs and spiders observed on the window sills of the dining area windows on the 1st floor.

Plan of Correction ***Accept (- 07/15/2025)***

This was corrected at time of inspection by the Housekeeper who cleaned the dead bugs and spiders observed on the windowsills. Pictures were emailed to inspectors, the day of inspection and are also attached. Housekeepers were given a checklist to make sure these areas are being cleaned. To ensure continued compliance, administrator and admin designee will walk the building on a weekly basis. Please see attached chart to keep track on audits

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

92 - Windows

9. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 9:40 a.m. three of the windows located in the 2nd floor common room were observed to be open 2 to 3 inches and had tears in the window screens. One window had a large tear across the bottom of the screen, another window had a large tear to the right of the screen and another window screen had a bent frame that created a gap between the windowsill and the screen.

Plan of Correction ***Accept (- 07/15/2025)***

The administrator and admin designee on all three shifts along with housekeeping will check weekly to ensure all windows and screens are in good repair and securely screened when windows are open. To ensure continued compliance, Housekeeping will conduct checks when cleaning daily and administrator and admin designee on all 3 shifts will walk the building on a weekly basis. Please see attached chart to keep track on audits.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

95 - Furniture and Equipment

10. Requirements

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

Description of Violation

The handicap elevator used to transport residents from the first floor to the lower level physical therapy area was not functioning on 5/1/25. Staff indicated that the elevator had been out of service for approximately 2 weeks.
At approximately 9:00 a.m., the handicap door accessibility button at the entrance had wires and a 9v battery exposed and it wasn't operating to open the doors.
At approximately 10:03 a.m., on the 1st floor at the end of the hallway, an electric box for an exit sign had exposed wires that were not capped.

95 - Furniture and Equipment (continued)

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

The handicap elevator used for transporting residents between the first floor and the lower-level physical therapy is now in working order.
During inspection, the handicap door accessibility button at the entrance and an electric box were found open as they were undergoing repairs that same day. We sent emails confirming that these issues have been resolved by maintenance .
To further ensure safety and compliance moving forward, please be aware that whenever maintenance is being performed in these areas, "work in progress" signs will be displayed. The attached signs will be used for this purpose.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

102k - No Common Towel

11. Requirements

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

Description of Violation

At approximately 9:25 a.m. a hand towel was found on the towel bar of the left side bathroom shared by rooms 114 A,B, and C. The towel was not labeled with the name of the resident to whom it belonged.
Also, there were no paper towels or any other hand drying options found in the bathroom that is shared by rooms 205 A,B, and C.
Repeat violation 5/9/24, et al.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

Housekeeping immediately removed the towel. The administrator and admin designee on all three shifts along with nursing staff will make sure that all towel racks are labeled at the time of admission. Housekeeping will make sure daily all shared rooms have paper towels to dry their hands. To ensure continued compliance, Housekeeping will keep track of this using or audit chart attached

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

103e - Left Overs

12. 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

A jar of Tostitos salsa was found in the refrigerator of the 1st floor dining area at approximately 9:21 a.m. The jar had not been labeled with the date it was opened for use.
Repeat violation 5/9/24, et al.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

Jar was immediately discarded at the time of inspection. To ensure continued compliance, housekeeping, and Ancillary staff will use log daily and sign off when done daily along with temps. In addition, admin designee will

103e - Left Overs (continued)

check this weekly during building walk thru. Please see attached audit check list.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

107c - Food/Water 3 Day Supply

13. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

The home had a current census of 40 residents on 5/1/25. On 5/1/25 the home only had a total of 18 gallons of emergency water on hand. The home's plan for emergency water delivery dated 1/6/25 indicates that emergency water delivery will be provided within a 24 hour time frame.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

This was corrected at the time of inspection. We currently have 45 gallons available.
To maintain compliance, the maintenance and ancillary staff will ensure that the supply remains readily available and is restocked on a weekly basis.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

144c1 - Smoking Area Guidelines

14. 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

At approximately 9:00 a.m. cigarette butts were observed in the mulch of the area next to the sidewalk leading to the entrance as well as in a pile of dried leaves that were piled up against the front of the building. Also there was a cigarette butt on the ground approximately two feet front the entrance door. Cigarette butts were also observed in the cylinder of the base of an umbrella stand that was placed near the entry door.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

All cigarette butts were immediately removed by our Maintenance team. To ensure ongoing compliance, both Maintenance and Administration will conduct daily checks as part of their walk-throughs. Additionally, all house rules and handbook will be consistently followed, and staff and residents have been reminded of the designated smoking area.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)

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

On 4/23/25 resident #4's blood glucose reading was 108 at 7:00 a.m.; the home documented a reading of 147 on the Medication Administration Record for this time slot. On 4/28/25 resident #4's blood glucose reading was 224 at 7:00 a.m; the home documented a reading of 109 on the Medication Administration Record for this time slot.

Plan of Correction ***Accept (- 07/15/2025)***

The medication administration trainer recently reviewed the documentation procedure with the medical aide. To maintain compliance, please ensure that documentation occurs immediately after each blood glucose reading and that the correct readings are accurately recorded. This will be checked by daily by the med aids, the practicum person will check it weekly.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 4/13/25 resident #4 was not administered the following prescribed medications at 4:00 p.m. as per prescriber's orders:
Pantoprazole 40mg and Atorvastatin 10mg.
In addition, resident #4 has an order for Insulin Aspart to be administered before meals on a sliding scale basis. On 4/13/25 at 4:00 p.m. resident #4's blood sugar was not tested to determine if sliding scale units of insulin were required. The home was not able to explain the reason for the missed blood glucose reading.
On 4/28/25 at 7:00 a.m. resident #4's blood glucose reading was 224 and required 4 units of sliding scale insulin; the blood glucose reading was documented as 109 on the Medication Administration Record for the 7:00 a.m. time slot on 4/28/25 indicating 0 units of insulin were administered.
Resident #5 has an order for Insulin Lispro to be administered 3 times daily on a sliding scale basis. On 4/13/25 at 5:00 p.m. and 4/28/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m. the resident's blood sugar was not tested to determine if sliding scale units of insulin were required.
Resident #5 also has an order for Lantus insulin, 21 units at bedtime. On 4/13/25 the resident was not administered 21 units of Lantus insulin at bedtime. The home was not able to explain the reasons for the missed blood glucose readings and missed insulin administration.

Plan of Correction ***Accept (- 07/15/2025)***

The medication administration trainer reviewed lesson 8 with the med aide. To ensure continued compliance, practicum observer will audit and review weekly to ensure all providers orders are being followed.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 07/15/2025)

224a - Preadmission Screen Form

17. 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

The preadmission screening dated [redacted] is incomplete as there is nothing noted if resident #3 can safely use and avoid poisonous materials.
Repeat violation 5/9/24, et al.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

To maintain ongoing compliance, monthly audits of resident records will be conducted by the administrator and/or the administrative designee. This will help us ensure that all new records are complete and that our documentation remains up to date.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 07/15/2025)