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

September 9, 2025

SALISBURY BEHAVIORAL HEALTH LLC, LEGAL ENTITY
SALISBURY BEHAVIORAL HEALTH LLC

RE: SALISBURY BEHAVIORAL HEALTH
1482 CHERRY LANE
EAST STROUDSBURG, PA, 18301
LICENSE/COC#: 21213

Dear SALISBURY BEHAVIORAL HEALTH LLC,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/23/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SALISBURY BEHAVIORAL HEALTH* **License #**: *21213* **License Expiration**: *08/19/2025*

Address: *1482 CHERRY LANE, EAST STROUDSBURG, PA 18301*

County: *MONROE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *SALISBURY BEHAVIORAL HEALTH LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/26/2008* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *20* **Total Daily Staff**: *42* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/23/2025*

Inspection Dates and Department Representative

07/23/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *22*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

07/23/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/23/2025*

08/27/2025 - POC Submission

Submitted By: **Date Submitted**: *09/08/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/03/2025*

Inspections / Reviews *(continued)*

09/03/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/08/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *09/10/2025*

09/09/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/08/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. 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

On 7/16/25, the home lost power, and disabling the fire system. The home did not report the incident to the department until 7/23/25.

Plan of Correction ***Accept (- 09/03/2025)***

On 7/16/2025 at 10:58PM Administrator was notified of a lightning storm that triggered the alarm and affected the Internet & Wi-FI. Immediately after maintenance was notified of the situation. Maintenance then notified the Alarm company. All emergency preparedness was put into place including fire watch and staff doing hourly checks. Lights, sprinklers and water were working with no problems. The fire panel was down and needed repair. A part was ordered and scheduled for deliver and repair on 8/11/25. In the interim New smoke detectors have been put into each resident bedroom. (under Regulations 130a-h; 131e-f; 132a all extinguishers are in working orders, monthly fire drills are up to date with no complications) Fire watch was kept in place until alarm panel was fixed on 8-11-25. Please see attached incident report. On 7/28/25 the PCH director reviewed reg. 16c with administrator and the importance of reporting within the 24hour period. (please see attached) The administrator is the person responsible for complying with all PCH regulations. On 7-16-26 the administrator failed to send an incident report that happened on 7-16-25. failed to comply with the required mandatory reporter guidelines and time frame. Immediately after the inspection the administrator sent the incident report on 7/23/25. (please see attached). On 7/28/25 the PCH director had a meeting with the administrator and reviewed reg.16c and emphasized the importance of reporting within the 24-hour period. (please see attached) Moving forward the administrator will report once daily and as needed to the PCH director any incidents, updates, or concerns of the facility. If an incident report is determined required by the PCH director the administrator must send the incident report within the 24-hour time frame. The administrator must also send proof to the PCH director that it was sent. That way the PCH director can monitor if the incident reports were sent within the mandatory reporter time frame. This will eliminate the chances of the violation happening again.

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented (- 09/09/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At 9:05 a.m., observed a dirty cereal bowl and spoon stored under resident 5's bed. Also, at approximately 2:40 p.m. resident 4's bathroom, observed dried feces on the toilet.

Plan of Correction ***Accept (- 09/03/2025)***

Immediately on 7/23/25 the dirty cereal bowl and spoon under resident 5's bed was removed and the bathroom toilet in resident's 4 room was cleaned. Staff clean the residents bathroom daily. The day after the inspection on 7-24-25 the administrator meet with the residents and encouraged them to let staff know if their bathroom needs any additional cleaning because things happen and staff is there to help. The administrator also had a staff meeting on

85a - Sanitary Conditions (continued)

7-30-25 were ■ reviewed 85.a. (Sanitary conditions shall be maintained) with all staff. (please see attached) Staff were also informed to conduct room checks during there shifts to ensure sanitary conditions are maintained. The administrator will monitor these checks.

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented (■ - 09/09/2025)

85b - Infestation

3. Requirements

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

Description of Violation

At 1:30 p.m. a mouse ran across the floor and tried to climb the table leg where the licensing representative was sitting.

Plan of Correction ***Accept (■ - 08/27/2025)***

Immediately the administrator notified maintenance who were already there the day of inspection so they put down the glue traps in that room. The administrator also notified Enrich our pest control vender. They came out on 7-25-25 and treated the facility. (please see attached) We have a contract with Enrich so they come out regularly monthly and as needed when we call like in this situation. On 7-30-25 the administrator had a staff meeting were (reg 85b Infestation) was reviewed with staff. The administrator also informed staff to report any sighting of infestations to ■ immediately.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (■ - 09/09/2025)

85d - Trash Receptacles

4. Requirements

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

Description of Violation

At 2:33 p.m., there was an uncovered trash can in the kitchen that was not being actively used by staff.

Plan of Correction ***Accept (■ - 08/27/2025)***

The lid on that receptacle was broken and replaced by maintenance the following day. On 7-30-25 the administrator had a staff meeting were (reg 85d Trash Recptacles) was reviewed with staff. (please see attached) The administrator also informed staff to report any trash receptacles that do not have a lid or not in good repair to ■ immediately.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (■ - 09/09/2025)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j7 - Lighting/Operable Lamp *(continued)*

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At approximately 2:45 p.m., resident 5 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction ***Accept (█ - 08/27/2025)***

Immediately A new lamp was placed next to resident 5's bedside. On 7/28/25 the PCH director reviewed (reg. 101j Lighting/Operable Lamp) with the administrator and how it is a safety issue if the resident doesn't have an operable lamp or other source of lighting that can be turned on at bedside. (please see attached) Moving forward the administrator will conduct bi-weekly checks of the resident rooms to ensure they have operable lighting.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (█ - 09/09/2025)

130g - Smoke Detector Repair

6. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 7/23/25 at 9:00 a.m., the home's fire panel was found to be inoperative. The home has been on a fire watch since 7/16/25.

Plan of Correction ***Accept (█ - 08/27/2025)***

On 7/16/2025 at 10:58PM Administrator was notified of a lightning storm that triggered the alarm and affected the Internet & Wi-FI. Immediately after maintenance was notified of the situation. Maintenance then notified the Alarm company. All emergency preparedness was put into place including fire watch and staff doing hourly checks. Lights, sprinklers and water were working with no problems. The fire panel was down and needed repair. A part was ordered and scheduled for deliver and repair on 8/11/25. In the interim New smoke detectors have been put into each resident bedroom. (under Regulations 130a-h; 131e-f; 132a all extinguishers are in working orders, monthly fire drills are up to date with no complications) Fire watch was kept in place until alarm panel was fixed on 8-11-25. (Please see attached incident report) On 7/28/25 the PCH director reviewed (reg. 130g) and the importance of if the fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative. (please see attached)

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (█ - 09/09/2025)

144c1 - Smoking Area Guidelines

7. 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:

144c1 - Smoking Area Guidelines *(continued)*

Description of Violation

Approximately 10:30 a.m., approximately 10 to 15 discarded cigarette butts observed in the gravel area located below the back porch.

Repeat Violation: 6/18/25, 5/21/25, 9/17/24.

Plan of Correction ***Accept (- 08/27/2025)***

Immediately that back porch area was shut down and no longer a designated smoking area. That area is now a smoke free area were residents can enjoy the fresh air. On 7/24/25 maintenance went out side and power washed that area and placed no smoking signs. There is now only one designated smoke area in the front of the home in the two gazebos. This allows staff to better monitor and keep that one designated smoking area clean. On 7-30-25 the administrator had a staff meeting were (reg 144c- Smoking area guidelines) were reviewed with staff. (please see attached) The administrator also informed staff that this is a repeat violation and looks bad on our facility. The administrator will conduct random smoke area checks three times a week to ensure staff are cleaning the smoke area. (please see attached)

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (- 09/09/2025)

144d - Smoking Outside

8. Requirements

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 7/23/25 at 9:00 a.m., the inspector sensed a strong odor of cigarette smoke upon entering the facility. The inspector entered resident 5's bedroom and determined that the resident was smoking in their room from the strong odor of cigarette smoke. Also, observed were 8 cigarette butts and ashes on resident 5's bedroom floor.

Plan of Correction ***Accept (- 08/27/2025)***

Immediately staff went in resident 5's room and removed the cigarettes and let know that this is a non smoking area and that can not smoke in room or inside the Lakewood facility. On 7-24-25 the administrator and resident 5's team meet with and issued a 30 day notice. (please see attached) On 8-1-25 a plan was also but in place to monitor resident 5. (please see attached) Resident 5 went to the hospital on and was diagnosed passed away (please see attached incident report)

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (- 09/09/2025)

162d - Past Menus

9. Requirements

2600.
162.d. Past menus of meals that were served, including changes, shall be kept for at least 1 month.

162d - Past Menus *(continued)*

Description of Violation

At 9:30 a.m., the current weeks menu was not posted in the home.

Repeat Violation: 5/21/25, 10/28/24, 9/17/24.

Plan of Correction ***Accept (- 09/03/2025)***

Immediately on 7/23/25 the menu was re-posted and the issue was fixed. The cook re-posted the current menu back in the designated area after updating the change on the menu before serving lunch at 12'oclock. The cook had taken it down temporarily that morning to make changes to the menu. The cook understands the (reg 162d) Past menu and just wanted to ensure the menu accurately reflects what is being served. One of the items on the menu was no longer available and the cook wanted to update the substitution on the menu. The administrator will conduct weekly checks to ensure the approiate menus are posted for the residents to see our in compliance with 162d, (please see attached)

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented (- 09/09/2025)

185a - Implement Storage Procedures

10. 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 7/23/25, resident 1's Medication Administration Record (MAR) had a documented blood glucose level of 103 but there was no corresponding glucometer reading on 7/23/25.
On 7/22/25 Resident 1's glucometer had a blood glucose reading of 103 but was transcribed as 98 on the MAR.
On 7/19/25, Resident 2's glucometer had a reading of 242 but was documented as 158 on the MAR.

Plan of Correction ***Accept (- 08/27/2025)***

Administrator meet with staff on 7-25-25 who was the person that made all 3 documentation errors. During the meeting the administrator found that while the resident was self administering their blood sugar reading they verbally told staff what there reading was then staff documented what the resident said on their MAR. Affective immediately staff will no longer ask the resident what there glucometer reading is for documentation. Moving forward staff will have to view the reading in a residents glucometer meter before documenting it on the MAR. The lead Staff will complete a weekly glucometer/MAR audit. The administrator will monitor the weekly glucometer/Mar audit and initial and date after review. (please see attached)

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (- 09/09/2025)

251b - Record Entries Legible

11. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

251b - Record Entries Legible *(continued)*

Description of Violation

Resident 3's Resident Assessment signature page dated [redacted] had correction fluid used on the refused to sign check box.

Plan of Correction ***Accept ([redacted] - 09/03/2025)***

On 7/28/25 the PCH director reviewed (reg. 251b-Record Entries Legible) with administrator and the importance of not using white out on any residents documents, RHA document or documents in general (please see attached) The administrator signed/Initial and updated/dated [redacted] error on the RASP on 7-24-25

Licensee's Proposed Overall Completion Date: *09/02/2025*

Implemented ([redacted] - 09/09/2025)