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

March 4, 2026

[redacted], COO
THE BIRCHES OF LEHIGH OPCO LLC
[redacted]

RE: THE BIRCHES OF LEHIGH VALLEY
5030 FREEMSBURG AVE
EASTON, PA, 18045
LICENSE/COC#: 23231

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/25/2025, 12/01/2025 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: *THE BIRCHES OF LEHIGH VALLEY* **License #**: *23231* **License Expiration**: *02/13/2026*

Address: *5030 FREEMSBURG AVE, EASTON, PA 18045*

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

Administrator

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

Legal Entity

Name: *THE BIRCHES OF LEHIGH OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/08/2024* **Issued By**: *TWP of Bethelem*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *158* **Waking Staff**: *119*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *11/25/2025*

Inspection Dates and Department Representative

11/25/2025 - On-Site: [redacted]

12/01/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *106*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *57* **Residents Served**: *47*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *106*

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

Have Mobility Need: *52* **Have Physical Disability**: *0*

Inspections / Reviews

11/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/29/2025*

12/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/05/2026*

Inspections / Reviews *(continued)*

03/04/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/05/2026*

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

51 - Criminal Background Check

1. 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 [redacted] *and The Pennsylvania State Police Criminal Background Check was requested on* [redacted]

Staff person B was hired on [redacted] *and The Pennsylvania State Police Criminal Background Check was requested on* [redacted]

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

1.Violation: 2600.51- Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act.
Immediate Corrective Actions
On 11/25/25, the Executive Director educated the Business Office Director on the DHS requirements for running criminal background checks for new employees. The process for completing and documenting background checks was reviewed as well.
Additional Corrective Actions:
On 12/10/25, the Executive Director and BOD processed criminal background checks for the orientation class starting on 12/15/25, to ensure they were done timely, and the BOD understands the process and expectation that no one is hired without this being completed in advance of hire. In addition, on 11/29/25, the Business Office Director audited all current employees' files to ensure they all have Criminal Background Checks.
Ongoing Quality Assurance Actions:
The BOD will audit 5% sample of staff records each month for timely criminal background checks completion, beginning 11/29/25. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025.
The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 01/16/2026)

124 - Notice to Fire Department

2. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home written notification to the local fire department, dated 5/8/24, doesn't have current location of bedrooms, assistance needed to evacuate in an emergency, and current census of residents with mobility needs.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

2. Violation: 2600.124- The home shall notify the local fire department in writing of the address of the home,

124 - Notice to Fire Department (continued)

location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Immediate Corrective Actions:

On 12/1/2025, the Executive Director updated the letter to include all required elements (address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency) and sent it to the local fire company. The letter includes the address and a copy of the floor plans and clarifies that the current updated list of residents who require assistance will be kept in the emergency binder at the Front Desk with a list of those residents included in the census who are considered immobile. It will be updated every time there are changes and is accessible in emergencies, as of 12/1/2025.

Additional Corrective Actions:

To ensure continuity of record keeping, the Executive Director will provide training by 1/1/26 to the Assistant Executive Director regarding the requirements for documentation of notification to the fire department and the location of the form in the survey binder. A current list of residents requiring assistance to evacuate in an emergency is kept along with a copy of the letter in an emergency binder located at the front desk of the community. The Assistant Executive Director will ensure the list at the front desk is kept current.

Ongoing Quality Assurance Actions:

Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025.

The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 01/16/2026)

171b5 - First Aid Kit

3. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the vehicle used to transport residents does not include a thermometer.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

3.Violation: 2600.171b- The following requirements apply whenever staff persons or volunteers of the home provide transportation for the residents: 5. The vehicle must have a first aid kit with the contents as specified in §2600.96 (relating to first aid kit).

Immediate Corrective Actions:

On 11/25/25, the Executive Director placed the missing thermometer in the first aid kit of the vehicle.

Additional Corrective Actions:

On 11/28/25, the Executive Director completed an audit of all building and vehicle first aid kits to ensure compliance. The Executive Director provided training for the Assistant Executive Director on 12/1/25 regarding the items required to be in all first aid kits. The Assistant Executive Director will complete quarterly audits of the first aid kits.

Ongoing Quality Assurance Actions:

Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of

171b5 - First Aid Kit (continued)

Q4 (October, November, and December) 2025.
The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 01/16/2026)

181f - Record of Medication

4. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

Resident #1's record did not include a current list of medications. The list in the resident's record did not include new prescriptions of Trospium Chloride 20mg tab and Lisinopril 10mg tab. The resident's current list of medications included 5 discontinued medications.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

4.Violation: 2600.181.F- The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.
Immediate Corrective Actions:
On 11/25/25, the Executive Director reached out to the MD for an updated medication list for Resident 1, whose medication did not match [redacted] current medication regimen at the time of inspection. The updated list was received on 11/25/25 and uploaded into the resident file. The resident was reminded by the Executive Director on 11/25/2025 to alert the Assistant Executive Director if there is a medication change made by [redacted] MD.
Additional Corrective Actions:
The Executive Director provided training for the Assistant Executive Director and Resident Care Coordinator on 11/25/25 on the need to maintain updated medications lists for residents who self-administer their medications. On 11/26/25, the Resident Care Coordinator completed an audit of medication lists for all current residents who self-administer medications to ensure the lists match the medications on hand and the orders.
Ongoing Quality Assurance Actions:
Beginning 12/5/25, the Assistant Executive Director will audit the medication lists of residents who self-administer medications quarterly, to ensure the list matches the medications on hand and the current orders. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025.
The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 01/16/2026)

183e - Storing Medications

5. Requirements

2600.

183e - Storing Medications *(continued)*

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #2's prescribed Clearlax polyethylene glycol 3350 had expired on 11/20/25 and was stored in the medication cart.

Repeat Violation: 8/6/24

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

5.Violation: 2600.183.E- Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's
instructions.
Immediate Corrective Actions:
On 11/25/25, the Resident Care Coordinator immediately removed the expired medication and replaced it with the new bottle of MiraLAX in the medication cart.
Additional Corrective Actions:
On 11/26/25, an audit was completed by the overnight shift med tech on all the medication carts to ensure all expired medications were identified, removed immediately and replaced. On 12/10/25, the Executive Director provided training to Med Tech's regarding storage regulations and the medication cart audit process including checking for expired medications.
Ongoing Quality Assurance Actions:
The Assistant Executive Director will complete monthly cart audits in both Memory and Personal Care beginning 12/1/25 and review the completed weekly cart audit documents to verify they are done. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025.
The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 01/16/2026)

185a - Implement Storage Procedures

6. 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 an order for blood glucose readings twice daily. On 11/20/25 at 10:20 a.m. Resident #3's blood glucose reading was noted on the medication administration record as 276. The glucometer did not have a reading in it for this time.

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

6.Violation: 2600.185.A-The home shall develop and implement procedures for safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.
Immediate Corrective Actions:

185a - Implement Storage Procedures (continued)

On 11/25/25, the Executive Director provided training for Medication Technicians regarding use of individual resident glucometers per physician orders and accurate documentation of blood sugar readings as well as the shift change responsibilities for outgoing and incoming medication technicians to review the glucometers and the readings.
Additional Corrective Actions:
On 11/26/25, an audit was completed by the Executive Director and the Resident Care Coordinator to ensure blood sugar checks are completed per physician orders and that all readings in the glucometers are documented in Tabula Pro and that all resident glucometers are labeled and stored appropriately.
Ongoing Quality Assurance Actions:
Beginning 12/1/25, Medication technicians will review glucometers and the related documentation of blood sugar readings to ensure accuracy as a part of the shift change responsibilities. Beginning 12/1/2025 the Assistant Executive Director completed monthly glucometer audits in addition to reviewing the shift change responsibilities weekly to ensure completion. The AED will investigate all medication errors and concerns with blood sugar readings. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025.
The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 03/04/2026)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #4 had an order for cephalexin 500 mg at 6:00 a.m., 2:00 p.m., and 10:00 p.m., on 11/15/25 the medication was given at 10:30 a.m. in addition to the normal dose.

Resident #3 has an order for blood glucose readings twice daily. On 11/20/25 Resident #3's blood glucose reading was not completed in the morning.

Repeat Violation: 8/6/24

Plan of Correction ***Accept ([redacted] - 12/30/2025)***

7.Violation: 2600.187. D- The home shall follow the directions of the prescriber.
Immediate Corrective Actions:
On 11/16/25, the Executive Director investigated and immediately started educating Med Techs on administering medications as ordered by the Physician following the 5 rights of medication training, comparing MAR's and physician orders with medications, and shift change responsibilities for outgoing and incoming mediation technicians to review the smart dashboard to ensure all medications have been administered as ordered.
Additional Corrective Actions:
On 11/17/25, the Executive Director concluded her investigation and educated the Business Office Director on

187d - Follow Prescriber's Orders (continued)

decision making as the manager on call and assigned the Medication Technician who was involved in the error additional RELIAS education (Avoiding Common Med Errors and Basic Medication Management). The Executive Director also educated all the Med Tech's in the building on following the 5 rights of medication administration prior to administering medications.
Ongoing action:
The Assistant Executive Director will complete daily reviews of the SMART Dashboard to monitor medication administration. The AED or EC will investigate all medication errors. Ongoing compliance will be reviewed at the quarterly QA meetings, beginning on 1/14/2026, with the review of Q4 (October, November, and December) 2025. The Executive Director will provide ongoing oversight to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented ([redacted] - 03/04/2026)