



Pennsylvania Department of Human Services

Sent via email to [REDACTED]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 27, 2026

[REDACTED]
Administrator/Legal Entity
Saucon Valley Manor Inc.

RE: Saucon Valley Manor
License # 205811

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on December 3, 2025, December 4, 2025, and February 4, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (LICENSE NO 205810) dated September 3, 2025 to September 3, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from MARCH 27, 2026 to SEPTEMBER 27, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: SAUCON VALLEY MANOR License #: 20581 License Expiration: 09/03/2026
Address: 1050 MAIN STREET, HELLERTOWN, PA 18055
County: NORTHAMPTON Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: SAUCON VALLEY MANOR INC.
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: 1 2 Date: 11/13/2005 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 300 Waking Staff: 225

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Interim Exit Conference Date: 02/04/2026

Inspection Dates and Department Representative

02/04/2026 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 201 Residents Served: 189

Secured Dementia Care Unit

In Home: Yes Area: A,B,C,D Capacity: 100 Residents Served: 66

Hospice

Current Residents: 34

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 188
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 111 Have Physical Disability: 2

Inspections / Reviews

02/04/2026 - Partial

Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 03/08/2026

03/23/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/23/2026

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document Submission*

03/24/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/23/2026

Reviewer: [REDACTED]

Follow Up Type: *Enforcement*

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

Resident [redacted] has enabler bars attached to their bed on both sides. At 9:27 a.m. the enabler bars were not securely attached to the bed frame and could be moved easily from side to side creating gaps between the bars and the bed frame.

Plan of Correction

Accept [redacted] - 03/18/2026)

Resident 1 and 2 bed canes were immediately secured at time of inspection by maintenance . To ensue continue compliance these will be check by nursing daily, by administration and maintenance during out weekly walk arounds to ensure that they are secure safely.. Please see attached photos residents 1 and 2 enable bars are secured to ensure that they are secured. Please note after these photos were taken, they were coved by maintenance.

Proposed Overall Completion Date: 03/06/2026

Licensee's Proposed Overall Completion Date: 03/06/2026

Not Implemented [redacted] - 03/23/2026)

82c Locking Poisonous Materials

2. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 10:15 a.m. there was an unlocked, unattended, and accessible bottle of Drug Buster found in the lower cabinet located in Secure Dementia Unit D. The Drug Buster had a label indicating to "Consult a physician or Poison Control Center immediately if swallowed".

At 10:20 a.m. there was an unlocked, unattended, and accessible bottle of REMEDY Essentials Spray Cleanser found in the bathroom of room [redacted] in the secure dementia unit D. The bottle had a label indicating " In case of eye contact, flush eyes with water. If irritation persists, contact your physician". All residents of the secure dementia unit D have been assessed as not capable of recognizing and using poisons safely.

Plan of Correction

Directed [redacted] 03/12/2026)

The drug buster was immediately removed and locked up by med aid.

The residents on d floor who are immobile did not have access to this, but to ensure continued compliance , all poisonous materials will be locked and not assessable to residents in the secure unit. This will be checked daily by nursing, and administration will check weekly during walk around.

Proposed Overall Completion Date: 03/06/2026

82c - Locking Poisonous Materials (continued)

(Directed Plan of Correction)

Staff will be instructed to check all areas of the home for poisonous materials at least once per shift. Any poisonous materials not in use will be made locked and inaccessible to residents immediately. The home will create an audit sheet and document the daily audits of poisonous materials.

Directed Completion Date: 04/01/2026

95 - Furniture and Equipment

3. Requirements

2600.

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

Description of Violation

At 9:29 a.m. there was a Wi-Fi router installed on the wall in the A floor dining room that was missing the cover and had the motherboard exposed with a battery pack hanging from the unit.

Plan of Correction

Directed [REDACTED] - 03/12/2026)

It was corrected immediately at time of inspection by maintenance. Please see attached photo to show cover on the WIFI router. Administration will check weekly during walk arounds.

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

Staff will be instructed to check all areas of the home for furniture and equipment that must be in good repair, clean and free of hazards at least once per month. Any issues with furniture and equipment the home will immediately fix. The home will create an audit sheet and document the monthly audits.

Directed Completion Date: 04/01/2026

100b - Removal Snow/Obstructions

4. Requirements

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

At 10:03 a.m. there was an accumulation of snow covering the egress path leading from the secure dementia unit C activity room side exit and also an accumulation of snow covering the egress path leading to the secure dementia courtyard exit.

At 10:10 a.m. there was an approximate accumulation of 4 inches of snow covering the back exit of the secure dementia unit D leading to the courtyard.

At 10:15 a.m. the stairs leading from the exit located near room [REDACTED] were covered with approximately 3 inches of snow all the way to the sidewalk.

100b Removal Snow/Obstructions (continued)

Plan of Correction

Accept (JH - 03/18/2026)

These areas were all cleaned of ice and snow at time of inspection by maintenance, it was immediately cleaned. Please see attached photos to ensure continued compliance.

Any snow or ice event , administration & maintenance will do a walk through to ensure that these areas are cleaned from snow, ice or obstruction. These photos were emailed to State on 2/4/26 to ensure compliance. Please see the attached photos.

Proposed Overall Completion Date: 03/06/2026

Licensee's Proposed Overall Completion Date: 03/06/2026

Implemented [redacted] - 03/23/2026

103e - Left Overs

5. 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

At 9:40 a.m. there was an unlabeled, undated block of sliced cheese found in the secure dementia unit A kitchen refrigerator.

At 10:36 a.m. there were 4 unlabeled, undated containers of diced tomatoes found in the main kitchen walk in refrigerator.

At 10:40 a.m. there were unlabeled, undated bags of frozen chicken drumsticks and funnel cakes found in the main kitchen's standing freezer.

Plan of Correction

Accept [redacted] - 03/18/2026

This was corrected at time of inspection. The above three items were immediately thrown by dietary aid. In addition to checking these on a daily basis, dietary is sending administration photos on a weekly basis showing that all food items are dated and labeled. To ensure continue compliance, dietary is sending photos to administration on a weekly basis of the fridge and freezer. Please see attached photo to show compliance of 103.

Proposed Overall Completion Date: 03/06/2026

Licensee's Proposed Overall Completion Date: 03/06/2026

Not Implemented [redacted] - 03/23/2026

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps (*continued*)**Description of Violation**

At 10:35 a.m. the exterior door thermometer of the main kitchen walk-in refrigerator was inoperable, and no internal thermometer was present inside the unit.

At 10:40 a.m. the temperature in the standing freezer in the main kitchen area was 28°F.

Plan of Correction

Directed [REDACTED] **03/18/2026)**

This was corrected on 2/5/2026 by maintenance and dietary. Please see attached 2 photos to ensure continued compliance. This will be checked daily by dietary and maintenance and administration weekly.

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

Thermometers will be added to the identified areas. The administrator will ensure that food is stored as required by this regulation. The home will complete weekly audits for thermometer and maintain documentation.

Directed Completion Date: 04/01/2026

121a - Unobstructed Egress

8. 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

At 10:03 a.m. there was an accumulation of snow covering the egress path leading from the secure dementia unit C activity room side exit and also an accumulation of snow covering the egress path leading to the secure dementia courtyard exit. Both exit doors could not be opened fully due to the snow blocking the doors.

At 10:10 a.m. there was an approximate accumulation of 4 inches of snow covering the back exit of the secure dementia unit D leading to the courtyard that prevented the door from being opened fully.

Plan of Correction

Directed [REDACTED] **- 03/12/2026)**

This was immediately corrected at time of inspection by maintenance. Please see attached pictures that showed all area were cleared. You can see in the attached photos that all egress routes were unobstructed. This will be checked on every snow event to ensure continued compliance.

These areas were all cleaned of ice and snow at time of inspection, these were immediately cleaned.

Any snow or ice event, administration will do a walk through to ensure that these areas are cleaned from snow, ice or obstruction. These photos were emailed to State on 2/4/26.

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

121a - Unobstructed Egress (continued)

The administrator or designee will then inspect all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed twice daily for one week and then weekly thereafter.

Documentation of these checks shall be kept and provided to the Department upon request.

Directed Completion Date: 04/01/2026

131f - Fire Extinguisher Inspection

9. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

At 9:30 a.m. the fire extinguisher located in the secure dementia unit A dining room was missing the tag.

Plan of Correction

Directed [redacted] - 03/12/2026)

The tag was located on the secured unit by maintenance and immediately put back on the fire extinguisher . Please see attached photos. To ensure continued compliance this will checked as required by out fire safely expert yearly. This will be checked monthly by our maintenance department to ensure continued compliance .

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

The administrator will ensure that all fire extinguishers in the home are inspected as required by this regulation by setting an annual reminder 60 days prior to the annual inspection expiration date.

Directed Completion Date: 04/01/2026

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141a 1-10 Medical Evaluation Information (*continued*)

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation form dated [REDACTED] for resident [REDACTED] was missing the following information: height, weight, pulse, blood pressure, and temperature.

The medical evaluation form dated [REDACTED] for resident [REDACTED] was missing the following information: height, weight, pulse, blood pressure, and temperature.

Plan of Correction

Directed [REDACTED] - 03/12/2026)

Please see attached DMES showing the correction was done by the PCPs for resident #3 and #4. To ensure continued compliance wellness, rasp coordinator and administration will follow our spreadsheet to ensure that all DMES are given on time and complete.

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on DME form. Attachments will be added to DME form as needed to ensure that all actions are documented. The home will audit all resident's DME and document the audits.

Directed Completion Date: 04/01/2026

184a - Resident's Meds Labeled

11. Requirements

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident [REDACTED] has an order for Artificial Tears, one drop in each eye 4 times a day. The pharmacy label on the medication incorrectly indicates the order is for one drop in each eye 4 times a day as needed.

184a - Resident's Meds Labeled (continued)

Plan of Correction

Directed [redacted] - 03/12/2026)

Please see attached order. This was corrected by the pharmacy on the day of inspection 2/4/2026. Please see the attached order. The pharmacy label and order match. To ensure continued compliance med aids will continue to check the emar vs the label.

Proposed Overall Completion Date: 03/06/2026

(Directed Plan of Correction)

The home will conduct monthly audits of resident's medication labels to ensure the labels have correct instructions. The home will correct any medication instructions and document the monthly audits.

Directed Completion Date: 04/01/2026

225c - Additional Assessment

12. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 1. Annually.

Description of Violation

Resident [redacted] most current support plan was completed [redacted]

Plan of Correction

Directed [redacted] 03/12/2026)

Please see the attached Rasp which was completed by our Rasp Coordinator . To ensure continued compliance wellness, rasp coordinator and administration will make sure all rasp are completed in a timely manor.

Proposed Overall Completion Date: 03/06/2026

(Direct Plan of Correction)

The identified resident(s) will have a detailed, comprehensive assessment that identifies all of the resident(s)'s personal care needs. The assessment(s) will be documented on the Department's required form. Forms will be filled out in their entirety, including signatures and dates. The administrator will audit all residents RASPs and develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter

Directed Completion Date: 04/01/2026

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

Facility Information

Name: SAUCON VALLEY MANOR License #: 20581 License Expiration: 09/03/2026
Address: 1050 MAIN STREET, HELLERTOWN, PA 18055
County: NORTHAMPTON Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: SAUCON VALLEY MANOR INC.
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: 1 2 Date: 11/13/2005 Issued By: Dept. L&I

Staffing Hours

Resident Support Staff: 2 Total Daily Staff: 324 Waking Staff: 243

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint, Incident Exit Conference Date: 12/17/2025

Inspection Dates and Department Representative

12/03/2025 On Site: [REDACTED]
12/04/2025 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 201 Residents Served: 196

Secured Dementia Care Unit

In Home: Yes Area: Memory Care Capacity: 100 Residents Served: 77

Hospice

Current Residents: 34

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 195
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 126 Have Physical Disability: 2

Inspections / Reviews

12/03/2025 Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/01/2026*

01/12/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/15/2026*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/16/2026*

03/24/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *01/15/2026*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

81b - Resident Personal Equipment

2. 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

On [REDACTED], at approximately 11:23 a.m., the enabler bar on the side of Resident [REDACTED] bed was not secure. The enabler bar moves approximately 2 inches to 3 inches back and forth.

Plan of Correction

Accept [REDACTED] - 01/12/2026)

This was immediately corrected at time of inspection/ Maintenance resecured the enabler bar for resident number 6. To ensure continued compliance all nursing staff will check daily that all residents who have enable bars properly secured, that they are clean, in good repair and free of hazards. If they are not they will immediately notify maintenance. Nursing supervisors and administration will continue to check on during our weekly walk around.

Licensee's Proposed Overall Completion Date: 12/31/2025

Not Implemented [REDACTED] - 03/12/2026)

82c - Locking Poisonous Materials

3. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [REDACTED] at approximately 9:59 a.m. Aveeno Daily Moisturizing lotion with a manufacturer's label indicating " If swallowed, get medical help or contact a Poison Control Center right away " was located in a supply closet in the Secured Dementia Care Unit (SDCU) on Floor D near room 79, and was unlocked, unattended and assessable to residents. All residents in the Secured Dementia Care Unit (SDCU) have been assessed not capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 01/12/2026)

The supply closet was immediately locked and was corrected at time of inspection by nursing supervisor.. A sign has been posted on the door by administration that says ' Keep door locked at all times." All nursing staff was reminder on the importance of keeping the supply closet locked on all shifts. To ensure continued compliance all nursing staff will check daily that closet is locked at all times. Nursing supervisors and administration will continue to check on during our weekly walk around.

Licensee's Proposed Overall Completion Date: 12/31/2025

Not Implemented [REDACTED] - 03/12/2026)

103g - Storing Food

6. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 12/03/2025, at approximately 10:19 a.m. An unsealed clear plastic bag containing a rack of ribs was found in the kitchen walk-in freezer.

103g - Storing Food (continued)

Plan of Correction

Accept [redacted] - 01/12/2026)

The ribs were immediately thrown out by dietary department. Administration rereviewed the importance 103 g that all food must be stored in closed and sealed containers, & that it must have a date. This will be checked by dietary on a daily basis. Administration will check during weekly walk around.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 03/12/2026)

141b1 - Annual Medical Evaluation

8. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] does not have a current medical evaluation. Resident [redacted]'s most recent medical evaluation was completed on [redacted].

Resident [redacted] does not have a current medical evaluation. Resident [redacted]'s most recent medical evaluation was completed on [redacted].

Plan of Correction

Accept [redacted] - 01/12/2026)

Resident number 1 and residents number 4 both of their doctors are outside primary care providers. The home, has called, multiple times & faxed requesting the DMES. Please see most recent requests attached. We have asked for POAS to also help us get the paperwork needed. Attached is our most recent request. We will continue to pursue the paperwork. The homes understands that the resident has their right to choose what doctor they want to use, but If all else fails we can asked the resident if they will agree to see another provider just to get a DME to ensure compliance with regulation 141b1. This is being done by our wellness department, nursing department, front desk and administration.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/20/2026)

183d - Prescription Current

9. 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

On [redacted], at 1:42p.m., [redacted] prescribed for Resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted].

Plan of Correction

Accept [redacted] - 01/12/2026)

The medication was immediately removed from the med cart at time of inspection. by med aid. To ensure continued compliance all med aids will check med carts daily for any discontinued medications. Nursing supervisors will

183d - Prescription Current (continued)

check weekly during weekly audits.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 03/12/2026)

225c - Additional Assessment

11. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

An Annual Resident Assessment and Support Plan (RASP) was not completed for 2025 for Residents [redacted] and [redacted]. These residents also did not have RASPs from 2024 on record.

Resident [redacted]'s assessment, dated 2/17/25, indicates the resident is independent with transfers in/out of bed/chair and ambulation. However, staff interviews indicated the resident needs help at times. Staff interviews and the summary portion of the RASP indicate the resident needs assistance some days with a wheelchair for ambulation longer distances.

Plan of Correction

Accept [redacted] 01/12/2026)

Please see the attached RASPs to comply with 225c, they were completed by our RASP coordinator, with nursing, administration and front desk. Please see attached update to ensure that resident # 3 RASP is updated. Please note Resident #3 assignment sheet, did reflect the residents care needs.

To ensure continued compliance all RASP will be updated, as required by the regulations. To ensure continued compliance the RASP coordinator, front desk, wellness will continue to ensure continued compliance. Please see attached.

Licensee's Proposed Overall Completion Date: 12/31/2025

Not Implemented [redacted] - 03/23/2026)

233c - Key-Locking Devices

12. 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

On [redacted] at approximately 9:30a.m., the directions for operating the home's locking mechanism at the exit to the elevator of the Floor D Secured Dementia Care Unit (SDCU) was not conspicuously posted near the door.

Plan of Correction

Accept [redacted] 01/12/2026)

This was corrected at time of inspection by maintenance. The code was put up and posted by maintenance. Maintenance and nursing will be checking on a regular basis that codes are posted. Administration will be checking weekly during out weekly walk around.

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [redacted] - 01/20/2026)