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

June 3, 2026

[redacted] ADMINISTRATOR
SALISBURY BEHAVIORAL HEALTH LLC
[redacted]

RE: SALISBURY BEHAVIORAL HEALTH
513 LEHIGH STREET
ALLENTOWN, PA, 18103
LICENSE/COC#: 21674

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/01/2026 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: *SALISBURY BEHAVIORAL HEALTH* **License #**: *21674* **License Expiration**: *03/26/2026*

Address: *513 LEHIGH STREET, ALLENTOWN, PA 18103*

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

Administrator

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

Legal Entity

Name: *SALISBURY BEHAVIORAL HEALTH LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/15/1999* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *19* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/01/2026*

Inspection Dates and Department Representative

04/01/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *20* **Residents Served**: *19*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *19* **Are 60 Years of Age or Older**: *12*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

04/01/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/01/2026*

05/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/21/2026*

Inspections / Reviews *(continued)*

05/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/02/2026*

06/03/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

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

18 - Compliance With Laws

1. 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

At approximately 9:25 a.m., the batteries in the home's carbon monoxide detector located in the dining room were not dated to indicate when they were last changed as required by the Care Facility Carbon Monoxide Alarms Standards Act.

Plan of Correction ***Accept (- 05/14/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. On 4/29/2026 maintenance changed/replaced all carbon monoxide detector in the facility. They are now all dated to indicate when they were last changed as required by the Care Facility Carbon Monoxide Alarms Standards Act. Also moving forward maintenance will complete and document the monthly maintenance checks. There is a check that specifically ask about the carbon monoxide alarms. (please see attached) The administrator will monitor that these checks are being completed and documented monthly.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented (- 06/03/2026)

102i - Soap Dispenser

2. Requirements

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

At 11:56 a.m., the soap dispenser in Bathroom C was empty.

Plan of Correction ***Accept (- 05/14/2026)***

Immediately on 4/1/26 staff filled the soap dispenser in bathroom C. A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Our facility recognizes the importance of complying with Regulation 102.i. To support this requirement, a shift task sheet has been developed for Direct Support Professionals to complete during each shift. (please see attached) This task sheet includes prompts to check all bathroom soap dispensers to ensure they are adequately stocked with hand soap. The administrator will review these task sheets on a weekly basis to monitor completion and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented (- 06/03/2026)

102k - No Common Towel

3. Requirements

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

Description of Violation

At approximately 11:00 a.m., there were no paper towels, a working mechanical hand dryer, or other sanitary means

102k No Common Towel (continued)

of hand drying in the second floor bathroom located in the hallway perpendicular to the elevator.

Plan of Correction ***Accept (- 05/14/2026)***

Immediately on 4/1/26 staff put paper towels in the second floor bathroom. The administrator contacted maintenance and the hand dryer was repaired on 4/2/26.
A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Our Facility recognizes the importance of complying with Regulation 102.k. To support this requirement, a shift task sheet has been developed for Direct Support Professionals to complete during each shift. This task sheet includes prompts to ensure all hand dryers are in working order. The administrator will review these task sheets on a weekly basis to monitor completion and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented (- 06/03/2026)

107b - Emergency Procedures

4. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

Description of Violation

The home's written emergency procedures include that staff will begin fire watches should there be an issue with the home's fire system. On 3/31/26 at 9:40 a.m. the home's fire panel displayed an error message stating "heat detected: dishwasher." Through interviews with staff it was determined that fire watches were not initiated upon staff discovering the fire panel was displaying the error message.

Plan of Correction ***Accept (- 05/29/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Staff were trained on the written emergency procedures that included that staff will begin fire watches should there be an issue with the home's fire system. (please see attached) On 4/1/26 the administrator contacted S&H Incorporated and they came out and repaired the fire panel on 4/10/26 please see attached proof/ invoice confirming repair and fire panel working normally.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented (- 06/03/2026)

132e - Fire Drill Sleeping Hours

5. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 2/27/26 at 3:07 a.m., The previous sleeping hours fire drill was conducted on 8/5/25 at 11:20 p.m.

Plan of Correction ***Accept (- 05/14/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and

132e Fire Drill Sleeping Hours (continued)

the plan of correction for continued compliance. Our facility recognizes the importance of complying with Regulation 132.e. To support this requirement, a Personal Care Home (PCH) Administrator Checklist has been developed for the Administrator or Assistant Administrator to complete on a bi weekly basis. (please see attached) This checklist includes a section requiring a review of the monthly fire drills to ensure they are completed accurately and remain in compliance with the Department of Human Services (DHS) regulations.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 06/03/2026)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.
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

Resident #1's initial medical evaluation dated [redacted] did not include if the residents needs could be met by the personal care home or if the resident would need care in a skilled nursing facility.

Plan of Correction ***Accept ([redacted] - 05/14/2026)***

Immediately residents #1 medical eval was updated to include the missing information. (please see attached) A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Our facility recognizes the importance of complying with Regulation 141.a. To support this requirement, a Personal Care Home (PCH) Administrator Checklist has been developed for the Administrator or Assistant Administrator to complete on a bi weekly basis. This checklist includes a section requiring a review of medical evaluation forms to ensure they are completed accurately and remain in compliance with Department of Human Services (DHS) regulations.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 06/03/2026)

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)*

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

The home permit's smoking in the designated smoking area located in the back parking lot of the home. At approximately 9:00 a.m., 20 cigarette butts were observed on the ground in the designated smoking area.

Repeat violation: 4/22/25

Plan of Correction ***Accept ([redacted] - 05/14/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Our facility recognizes the importance of complying with Regulation 144c1. To support this requirement, a shift task sheet has been developed for Direct Support Professionals to complete during each shift. (please see attached) This task sheet includes prompts to complete smoking area check twice per shift. The administrator will review these task sheets on a weekly basis to monitor completion and ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 06/03/2026)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #2 was prescribed a PRN order for Naproxen 500 mg tablets. The medication was discontinued in October 2025. However, resident 3's March 2026 and April 2026 medication administration records still lists the medication as a current order.

Plan of Correction ***Accept ([redacted] - 05/29/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. PCH Staff understand the importance of regulation 187a. Effective immediately and moving forward, DSP staff will conduct an audit of all temporarily prescribed PRN medication. Instructions to discontinue once exhausted will be documented and inventoried by DSP staff counting them daily at the beginning and end of every shift. This audit will be conducted in the same manner as controlled medications. This enhanced level of oversight will ensure prompt discontinuation when the medication count reaches zero. All staff that are trained to administer medication were retrained on 4/17/26 on "Lesson 8: Discontinuation and the implementation of the new process" (please see attached) The Lead DSP staff is responsible for auditing the Current Inventory report via QuickMar for any medications with a balance of ZERO on a bi-weekly basis. The administrator will conduct monthly checks that the current inventory checks are completed and the residents MAR has no discontinued PRN's listed. (please see attached)

Licensee's Proposed Overall Completion Date: *05/21/2026*

Implemented ([redacted] - 06/03/2026)

224a Preadmission Screen Form

10. 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

Resident #1 was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 05/14/2026)***

A staff meeting was held on 4/20/26 where the administrator reviewed the regulations, violations we received and the plan of correction for continued compliance. Our facility recognizes the importance of complying with Regulation 224.a. To support this requirement, a Personal Care Home (PCH) Administrator Checklist has been developed for the Administrator or Assistant Administrator to complete on a bi-weekly basis. (please see attached) This checklist includes a section requiring a review of the preadmission screenings to ensure they are completed accurately and remain in compliance with the Department of Human Services (DHS) regulations.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 06/03/2026)