

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

May 15, 2026

[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 04/07/2026 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: *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: *04/11/2011* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *79* Waking Staff: *59*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *04/07/2026*

Inspection Dates and Department Representative

04/07/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *75* Residents Served: *45*

Secured Dementia Care Unit
 In Home: *Yes* Area: *NA* Capacity: *36* Residents Served: *17*

Hospice
 Current Residents: *8*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *45*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *34* Have Physical Disability: *2*

Inspections / Reviews

04/07/2026 - Full

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *04/30/2026*

Inspections / Reviews *(continued)*

05/06/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/08/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/11/2026

05/15/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/08/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 9:05A.M., the home did not have a copy of the 2600 regulations posted in a conspicuous and public place in the home.

Plan of Correction

Accept (█) - 05/04/2026)

The violation occurred due to an oversight as the previous posting of the regulation was removed during painting of the lobby area and the regulations was not put back up after painting was finished. Immediate action was taken immediately following the inspection on 4/8/2026 and facility has posted the required regulations in a conspicuous and accessible location in the main lobby area along with all other licensing information which is visible and accessible to all residents and families/ visitors. Please see attached photo. To maintain ongoing compliance with regulation 2600.3(c) Administration has implemented a checklist beginning on 4/22/26 that is to be done weekly during morning facility walk through that includes all required postings such as resident rights, complaint procedures, emergency numbers, and applicable regulation to ensure that required postings remain present and accessible at all times. Any missing or damaged required postings will be immediately reposted at the time of the walk around. The Administrator will be responsible for ensuring ongoing compliance with regulation 2600.3(c) 1

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

Implemented (█) - 05/15/2026)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:05A.M., the medications Senna S 8.6-50mg 8am and Oyster Shell Calcium 500mg 8am belonging to resident #1 were unlocked, unattended, and accessible lying on top of the first-floor medication cart in the home's dining room.

Plan of Correction

Accept (█) - 05/04/2026)

On 4/7/2026, the medication found on top of the cart in the dining room was immediately secured and put inside the medication cart and locked. This violation occurred due to Med Aide stepping away from █ cart to assist another resident in the dining room. The staff member stepped away from the cart without securing the medication, resulting in it being unlocked, unattended and accessible. The staff member who left the medication unattended was provided immediate counseling on medication administration policies and procedures by Administration and Med Trainer at the time of inspection. Med Aide received re-training on the Med Cart by facilities Med Trainer on 4/8/2026. To ensure continued compliance a reminder was posted on all med carts that carts all meds are to be put in the med cart and locked prior to leaving the cart for any reason. Mandatory staff training was held for the Med Aides on 4/28/26 to review proper medication cart management as well as HIPPA information. See attached photo of med cart and sign in sheet from staff training. In addition, weekly Med Cart Checks will be conducted by Nursing beginning on 4/22/26 and will be checked weekly by Administration. See attached walk around checklist. During

17 Record Confidentiality (continued)

the weekly checks if any noncompliance is found on the cart immediate corrective action will be taken and Med Aide will need to take refresher course on Medication Administration policies and procedures with the facilities Med Trainer. It will be the responsibility of the Administrator to ensure ongoing compliance with 2600.17

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

Implemented () - 05/15/2026

25b - Contract Signatures

3. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract, dated () for resident #3 was not signed by the resident.

Plan of Correction

Accept () - 05/04/2026

Please note that Resident #3's contract was not signed due to an oversight during the admission process. In which the staff member completing the admission did not verify that the resident had not signed the contract before filing the contract in Resident #3's file. On 4/7/26 immediate action was taken the resident home contract for Resident #3 was reviewed with the resident, signed, and dated and placed in the resident's file. To ensure ongoing continued compliance with regulation 2600.25 (b) any new admission's file will be re reviewed within 48 hours of admission by the staff member completing the admission. In addition, beginning on 4/21/26 Administration will review any new admission files on a weekly basis to ensure all has been completed and signed. The Administrator will be responsible to ensure ongoing compliance with 2600.25 (b).

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

Implemented () - 05/15/2026

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 2:15 p.m., the shared bathroom for two residents in Room 110 was observed to have fecal matter smeared on the wall next to the toilet and on the toilet seat.

Repeat Violation 5/1/25

Plan of Correction

Accept () - 05/04/2026

Immediate action was taken and the bathroom was immediately cleaned and sanitized and facility respectfully disagrees with the violation. The residents who share this bathroom are personal care residents who ring their call bell when toileting assistance is needed. The residents did not press their call bell prior to the room being inspected, therefore it is possible that the fecal matter occurred shortly prior to the inspector entering the room, and staff was not aware that the resident had accidentally smeared the fecal matter on the wall and on the toilet seat. In addition, the inspector checked multiple bathrooms and no fecal matter or any other sanitary condition was found in any other resident bathrooms. To ensure continued compliance with regulation 2600.85(a) and beginning on 4/22/26 daily inspections will be done by Housekeeping and Administration will check bathrooms on a weekly basis. Any

85a Sanitary Conditions (continued)

concerns with sanitary conditions will be addressed immediately. Please see attached daily and weekly log. The Administrator will be responsible for ensuring ongoing continued compliance with regulation 2600.85 (a).

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

Implemented () - 05/15/2026)

105g - Lint Removal and Duct Cleaning

5. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At 9:43 a.m., there was an approximate 1/4 inch accumulation of lint in the lint trap of the second floor laundry room dryer. There were no clothes in the dryer at the time.

Plan of Correction

Accept () - 05/04/2026)

On 4/7/2026 the lint trap was immediately cleaned and was corrected at the time of inspection. To ensure ongoing continued compliance a new sign was placed on the dryers reminding staff that the lint must be cleaned after each use. Please see attached photo. In addition, laundry room will be checked on a weekly basis by Administration to ensure that lint logs are being completed and that lint is being cleaned from the dryer after use. (Please see attached log). It will be the responsibility of the Administrator to ensure ongoing compliance with regulation 2600.105(g)

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

Implemented () - 05/15/2026)

127a - Portable Space Heaters

6. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

At 9:47a.m, an electric portable space heater was in use in the basement's laundry room by staff.

Plan of Correction

Accept () - 05/04/2026)

Immediate action was taken on 4/7/26 and the electric portable space heater was immediately turned off and removed from the laundry room. A notice was put on the laundry room door that space heaters of any kind are not permitted. Please see attached photo. To ensure ongoing continued compliance weekly safety checks will be done throughout the building during Administration's weekly walk through. The Administrator will be responsible for ensuring continued compliance with regulation 2600.127a

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

Implemented () - 05/15/2026)

182b - Prescription Medication

7. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

Resident #4 who was not assessed to self-administer medications stated that they self-administered three tablets of Metoprolol Succinate ER 50 mg at 2:00 PM, after the medication was scheduled on the medication administration records for 8:01 a.m. and were left in the resident's room by staff member A.

Plan of Correction

Accept () - 05/04/2026

Immediate action was taken on 4/7/26 after the inspection and staff member A was counseled by Administrator and Med Trainer on Medication Administration policy. To ensure ongoing continued compliance Staff Member A was re-trained on medication Administration policies and procedures on 4/8/26. See attached training sheet. In addition, mandatory staff training was held for the Med Aides on 4/28/26 to review proper medication cart management. See attached sign in sheet. Administration will do weekly room checks to ensure that no medications are left in resident rooms who cannot self-administer. See attached log. Administrator will be responsible to ensure on going continued compliance with regulations 2600.182(b)

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

Implemented () - 05/15/2026

183b - Meds and Syringes Locked

8. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 9:05A.M., the medications Senna S 8.6-50mg 8am and Oyster Shell Calcium 500mg 8am belonging to resident #1 were unlocked, unattended, and accessible lying on top of the first-floor medication cart in the home's dining room.

Plan of Correction

Accept () - 05/04/2026

On 4/7/2026, the medication found on top of the cart in the dining room was immediately secured and put inside the medication cart and locked. This violation occurred due to Med Aide stepping away from [redacted] cart to assist another resident in the dining room. The staff member stepped away from the cart without securing the medication, resulting in it being unlocked, unattended and accessible. The staff member who left the medication unattended was provided immediate counseling on medication administration policies and procedures by Administration and Med Trainer at the time of inspection. Med Aide received re-training on the Med Cart by facilities Med Trainer on 4/8/2026. To ensure continued compliance a reminder was posted on all med carts that carts all meds are to be put in the med cart and locked prior to leaving the cart for any reason. Mandatory staff training was held for the Med Aides on 4/28/26 to review proper medication cart management. See attached photo of med cart and sign in sheet from staff training. In addition, weekly Med Cart Checks will be conducted by Administration beginning on 4/22/26. See attached walk around checklist. During the weekly checks if any noncompliance is found on the cart immediate corrective action will be taken and Med Aide will need to take refresher course on Medication Administration policies and procedures with the facilities Med Trainer. It will be the responsibility of the Administrator to ensure ongoing compliance with 2600.185a

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

Implemented () - 05/15/2026

185a Implement Storage Procedures

9. 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

At 2:00 P.M., resident #2 has an order for Acetaminophen 325 mg PRN and Lorazepam 0.5 mg PRN. However, these medications were not available in the home.

Repeat Violation 5/1/26

Plan of Correction

Accept (█ - 05/05/2026)

Violation occurred due to an oversight on the part of the Med Aide and █ accidentally did not re-order the medication from the pharmacy. Immediate action was taken and the medications were requested from the pharmacy and were delivered on the evening run on 4/7/26. Re-ordering of medications was re-reviewed with all med aides on 4/28/26. Nursing is conducting med cart audits and EMAR audits weekly and this is being doubled check by Administration during there weekly walk through and audit checks,. It is the responsibility of the Administrator to ensure that Med Aides are complying with regulation 2600.185a. Please see attached training sign in sheet as well as Administration walk through log.

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

Implemented (█ - 05/15/2026)

187d Follow Prescriber's Orders

10. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Amlodipine Besylate 5mg at 8:00AM. Resident #1 has a parameter to hold the medication if blood pressure is less than 110/70. However, resident #1's medication was not held on 4/1/26 when the blood pressure reading was documented as 90/50 and was not held on 4/7/26 when the blood pressure reading was documented as 104/48.

Staff member A initialed the medication administration record indicating administration of Metoprolol Succinate ER 50 mg; however, the resident's required blood pressure and heart rate were not documented, and the medication was not administered in accordance with prescribed parameters.

Staff member A failed to ensure proper administration and documentation of Metoprolol Succinate ER 50 mg (three tablets/150 mg) ordered to be taken by resident #4 every morning with parameters to hold if systolic blood pressure was less than 100 or heart rate was less than 65, as the medication was left in the resident's room and later self-administered by resident #4 not assessed to self-administer medications; additionally, the resident's blood pressure and heart rate were not obtained at the time of administration.

Repeat Violation 5/1/25

Plan of Correction

Accept (█ - 05/05/2026)

Immediate action was taken and staff person A was retrained on 4/8/26 on the following items: Proper documentation of blood pressure and heart rate, identifying medications with hold parameters, and medication

187d - Follow Prescriber's Orders (continued)

administration policies and procedures. To ensure continued compliance an all staff training or all Med Aides was held on 4/28/26 re-reviewing the above topics. Weekly Emar audits are being by Nursing and Administration will be checking to ensure that EMAR audits are being completed. Administrator is responsible for ensuring continued compliance. Please see attached training sheets and weekly Emar audit log from Administration

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

Implemented () - 05/15/2026)

227g -Support Plan Signatures

11. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Staff member B participated in the development of resident #6's annual support plan dated on 2/13/26. However, the assessor staff did not sign the support plan.

Plan of Correction

Accept () - 05/05/2026)

Immediate action was taken on 4/8/26 and Staff Member B who was the assessor reviewed the support plan of Resident # 6 and signed and dated the document. The corrected support plan was placed in the resident's record. To ensure on going continued compliance the unit clerk or designee will review all support plans prior to filing in the medical chart. Administration will check medical charts on a weekly basis to ensure all support plans are completed with dates, and signatures of assessor and resident. Please see attached audit checklist from Administration. It will be the responsibility of the Administrator to ensure continued compliance.

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

Implemented () - 05/15/2026)

231f - Assessed Annually

12. Requirements

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident #5's current annual assessment was completed on () However, it is unknown when the previous assessment was completed on.

Plan of Correction

Accept () - 05/06/2026)

The facility respectfully notes that this was a documentation error and the previous assessment was completed on time and reviewed during the current assessment process; however, the date was not transcribed onto the new assessment form. Immediate action was taken on 4/8/26 and the RASP coordinator reviewed the support plan of resident #5 and added the dates from Resident #5's previous assessment and was placed in Resident #5's medical chart. To ensure ongoing continued compliance the Unit clerk or designee will check all new assessments to ensure all dates are included prior to filing in the resident's medical chart. Administration will check medical charts on a weekly basis to ensure all assessments are dated and signed by the assessor as well as the resident; It is the

231f Assessed Annually (continued)

responsibility of the Administrator to ensure compliance with regulations 2600.231 (f)

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

Implemented () - 05/15/2026

233c - Key-Locking Devices

13. 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

At 9:30A.M., the directions for operating the home's locking mechanism were not conspicuously posted near the door from to the Secure Dementia Care Unit (SDCU) across from resident room 206.

Plan of Correction

Accept () - 05/06/2026

In regards to violation 2600.233c immediate action was taken and code was re posted in a conspicuous manner. To ensure continued compliance the administrator or designee will conduct weekly checks to verify that all codes too enter and exit the Secured Dementia Care Unit are posted and secured that they cannot be removed by one of the resident's residing on the unit. Any missing or damaged postings will be replaced immediately. The Administrator will be responsible to ensure ongoing continued compliance with 2600.233(c)

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

Implemented () - 05/15/2026

234e - Involvement/Participation

14. Requirements

2600.

234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

Resident #5's support plan was finalized on [redacted] Neither the resident nor the resident's designated person were involved in the development of the support.

Plan of Correction

Accept () - 05/06/2026

Please note for violation 2600.234 (e) The facility respectfully notes that this was a documentation error. The assessment was completed but accidentally filed in Resident # 5's medical chart prior to obtaining the signatures. On 4/7/26 after the inspection was completed, the assessment was reviewed with the resident. The required signature and dates were obtained and the corrected assessment was placed in Resident #5's medical chart. To ensure ongoing continued compliance the unit clerk or designee will check all assessment prior to filing in the medical charts to ensure all required information has been filled in including dates, assessor signature and resident and/or designated person signature. Resident assessments will be checked on a weekly basis by Administration to ensure compliance and the Administrator will be responsible for ensuring ongoing continued compliance with regulation 2600.234 (e)

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

Implemented () - 05/15/2026

234e - Involvement/Participation (*continued*)