pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SAUCON VALLEY MANOR INC.**
LEGAL ENTITY

To operate **SAUCON VALLEY MANOR**
NAME OF FACILITY OR AGENCY

Located at **1050 MAIN STREET, HELLERTOWN, PA 18055**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **201** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 100**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 14,** **2026** until **May 14,** **2027** ,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **205810**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: May 14, 2026

Saucon Valley Manor Inc.
1050 Main Street
Hellertown, Pennsylvania 18055

RE: Saucon Valley Manor
License # 205810

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on April 15, 2026 and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

May 11, 2026

SAUCON VALLEY MANOR INC.
1050 MAIN STREET
HELLERTOWN,, PA, 18055

RE: SAUCON VALLEY MANOR
1050 MAIN STREET
HELLERTOWN, PA, 18055
LICENSE/COC#: 20581

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SAUCON VALLEY MANOR* **License #**: *20581* **License Expiration**: *09/27/2026*

Address: *1050 MAIN STREET, HELLERTOWN, PA 18055*

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

Administrator

Name:

Legal Entity

Name: *SAUCON VALLEY MANOR INC.*
Address: *1050 MAIN STREET, HELLERTOWN,, PA, 18055*
Phone:

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *300* **Total Daily Staff**: *530* **Waking Staff**: *398*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *04/15/2026*

Inspection Dates and Department Representative

04/15/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *201* **Residents Served**: *117*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *100* **Residents Served**: *73*

Hospice

Current Residents: *34*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *126*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *113* **Have Physical Disability**: *2*

Inspections / Reviews

04/15/2026 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2026*

05/07/2026 - POC Submission

Submitted By:
Follow-Up Type: *Bypass Document Submission*

Inspections / Reviews *(continued)*

05/11/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *05/07/2026*

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

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

At 3:15pm, Resident #1 utilizes a bedside mobility device, which had an uncovered opening that was approximately 15 inches wide by 12 inches long.

Repeated Violation: 2/4/2026, 12/3/2025, et al.

Plan of Correction ***Accept (█ - 05/06/2026)***

Inspectors from the Bureau of Human Services Licensing (the "BHS") carefully inspected over thirty (30) bed canes/enablers at the Facility during inspection at issue. Each was properly secured. However, of those inspected, one enabler (while properly secured) had the cover taken off. The Facility submits that this citation should not be considered a repeat violation under 2600.81(b), on account of the inspections that occurred on February 4, 2026, and December 13, 2025. During both of those inspections, the Bureau of Human Services Licensing found that bed canes/enablers were not secured and had no issue with covers. The citation relating to the cover is separate and distinct from enablers not being secured. Thus, the facility requests that the 2600.81(b) citation is not deemed a repeat violation.

Plan of Correction:
In response to the cover issue raised during the inspection in question, immediate corrective action was taken at the time of the inspection and the bed cane/enabler for Resident # 1 was immediately covered by the on duty Personal Care Assistant. Inspectors also viewed all other bed canes/enablers in the facility during the inspection and confirmed that each one was properly covered and secured. To ensure continued compliance:
(i) One member of the Facility's Maintenance Department will conduct weekly checks on all bed canes to verify that they are both secured and covered. The Maintenance Staff Member will document these checks and sign off weekly.
a) The Administrator will review the Maintenance Log after the Maintenance Staff Member inspection, confirming that all checks have been completed, and thereafter sign the log.
(ii) Each morning, the Personal Care Aides will conduct a walk through the Facility to assess each room, including the enablers and covers to the enablers. If the enablers and/or covers to the enablers are not secure/covered, The Personal Care Aide will take immediate corrective action.
a) Administration will remind any resident with an unsecure and/or uncovered enabler of the importance of ensuring that the enabler remains covered and in place.
(iii) Each evening during 11pm to 7am shift, the Personal Care Aides will conduct a walk through the Facility to assess each room,

81b - Resident Personal Equipment (continued)

including the enablers and covers to the enablers. If the enablers and/or covers to the enablers are not secure/covered, the Personal Care Aide will take immediate corrective action.
a) Administration will remind any resident with an unsecure and/or uncovered enabler of the importance of ensuring that the enabler remains covered and in place.
(iv) Effective April 16, 2026, the Facility implemented a policy (prospectively) that requires new residents to purchase a specific enabler that the Facility's Administrator has selected. This enabler maintains an already attached cover, which prevents residents from removing covers. Further, in implementing this policy, all enablers will be of the same size, manufacturer, type, and model.
a) Administration will confirm the correct enabler is purchased by the new resident. If not, the new resident's assigned contact will be informed of the same and will be provided ten (10) days to order the facility approved enabler.
b) Should ten (10) days pass and the Facility approved enabler is not provided to the facility, the Facility will proceed with purchasing the facility approved enabler.
c) Once received, the enablers and covers will be installed and secured by Maintenance Staff.

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

Implemented [redacted] 05/11/2026)

95 - Furniture and Equipment

2. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The fire panel is reading trouble due to the inoperable smoke detector that has been inoperable for 3 weeks.
At approximately 10:20a.m. on the 1st floor secure dementia care unit C in an area accessible to residents, the electrical outlet in the wall between the juice machine and the enhanced water machine did not have a cover plate exposing the electrical components.

Plan of Correction ***Accept ([redacted] - 05/06/2026)***

First, the Facility contracts with [redacted] to provide maintenance related to the fire alarm system.
During the Facility's April 2026 fire drill, the fire alarm panel showed a trouble signal after the alarm in the in the Back B hallway did not activate. It is important to note that the fire alarm system was fully functional, and no trouble signals had been present in the preceding weeks.

The fire drill occurred on April 8, 2026, at 7:51am. Immediately upon recognizing

95 - Furniture and Equipment (continued)

failure of the Back-B hallway fire alarm, shortly after 8:00am, the Maintenance Director notified Guardian. Guardian informed the Maintenance Director that the next available service appointment was approximately three (3) weeks from the date of the call.

In accordance with regulatory requirements, the Administrator immediately initiated a fire watch and implemented the facility's fire watch procedures, which continued until the system was serviced. Staff were provided with the fire watch papers and were instructed that the area must be walked every thirty (30) minutes as per the regulations and the fire watch paper must be signed.

Further, on April 8, 2026 (the same day), the Administrator submitted an incident report to the Bureau of Human Services Licensing to report the fire alarm concern. Administration instructed the Medical Aides and Personal Care Aides to conduct fire watch rounds every thirty (30) minutes and, after doing so, to document the same in a fire watch log. Administration reviewed the logs each morning.

To ensure continued compliance, Maintenance will conduct internal assessments each week of the fire panels to allow for the earliest detection times and contact Guardian to initiate a service call. Maintenance will maintain a log that Administration will review for compliance after each weekly inspection. If any issues are recognized, the Maintenance Director is responsible for immediately contacting Guardian, submitting a service request, requesting immediate service from Guardian and notifying the Administration who will determine whether to implement the fire watch procedures and proceed to inform the Med Aides and Personal Care Aides of the specific area affected.

On April 28, 2026, Guardian serviced the specific fire panel/alarm in the BackB section and fully restored the service. Maintenance inspected the fire panel following the repair by Guardian to confirm that no trouble conditions remained. Thereafter, the Administrator then sent a final incident report to the Bureau of Human Services Licensing, together with a copy of the work order Guardian issued after the service call was completed.

On April 29, 2026, all staff received a "refresher" training by Administration and the Maintenance Director on the Facility's fire drill procedures, fire panel operation, recognition and reporting of trouble signals, and proper fire watch procedures. Reminder pamphlets will be provided to all staff members at each staff member meeting.

Further, the facility's Administrator is assessing the agreement with the [redacted], together with legal counsel and working with [redacted] to establish a 24- to 48-hour service request response time, regardless of cost.
If Guardian is unable to assure such service, the Administrator, together with legal counsel, will conduct an assessment of other fire alarm service providers to determine which, if any, can meet a shorter service call wait time.

During the BHS' inspection on April 15, 2026, it was noted that an electrical outlet

95 - Furniture and Equipment (continued)

was found without a cover plate. Immediate corrective action was taken on the day of inspection. Specifically, the Maintenance Assistant (of the Maintenance Department) installed a new outlet cover plate. Following installation, the Maintenance Director inspected the outlet to ensure it was secure, intact, and safe for continued use. On April 29, 2026, the Maintenance Assistant conducted an inspection of all electrical outlets and on/off switches for lights throughout the entire facility. The purpose was to verify all the inspected devices were properly covered, intact, and securely fastened. No additional issues were identified during this inspection.

Each month, the Maintenance Assistant will conduct the same inspection as that conducted on April 29, 2026, document the same in a logbook, and the logbook will then be reviewed by the Administrator to confirm the entries.

On April 29, 2026, all staff received a "refresher" training by Administration and the Maintenance Director on the Facility's overall furniture and fixtures. If a staff member sees a concern with any piece of furniture or fixture, staff members were directed to inform the Maintenance Director (who will maintain a log of concerns staff members raise) and will immediately assign a member of the Maintenance Assistant to take corrective action and note the corrective action in the logbook.

Further, during the staff meetings of April 29, 2026, staff members were reminded that the weekly room inspections must include checking electrical outlets and reporting concerns per the above procedure. Staff members will be reminded of this at staff meetings, and this will become part of the new staff member training when a new staff member is hired.

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

Implemented ██ - 05/11/2026)

132c - Fire Drill Records

3. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

On 2/25/26, the fire drill log indicates the evacuation start time of 11:02a.m. and completion time of 11:11a.m. but the fire drill log documents the total evacuation time for the drill as 11 minutes and 30 seconds.

Plan of Correction ***Accept (██ - 05/06/2026)***

During review of the fire drill documentation, it was noted by the inspectors that the recorded evacuation time was listed as 11 minutes and 30 seconds, which would exceed the maximum allowable evacuation time for the facility. Upon further review by Maintenance, it was determined to be a documentation error. The fire drill record clearly indicated that the drill began at 11:02 a.m. and concluded at 11:11 a.m., resulting in an actual evacuation time of

132c - Fire Drill Records (continued)

9 minutes, which is fully compliant with the 10 minute requirement under §2600.132(c). At the time of the exit interview when the the inspector reviewed the preliminary violation, Maintenance pointed out to the inspector that it was just a documentation error.
Immediate corrective action was taken by Maintenance and the fire drill log was corrected to indicate the correct amount to time it took to evacuate, to prevent future documentation errors, Administration conducted a review of all fire drill records for the previous 90 days to ensure accuracy and compliance. In addition, a double verification process has now been implemented which will begin with the May fire drill. All fire drill records will be reviewed and signed by a member of Administration to ensure accuracy and completeness. Administration will remain responsible for maintaining all required documentation and ensuring ongoing compliance with 55 PA Code §2600.132(c).

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

Implemented (█ - 05/11/2026)

183e - Storing Medications

4. Requirements

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.

Description of Violation

At approximately 3:00p.m., resident #2's Humalog Mix 75-25 insulin pen stored in the A floor medication cart was open and undated. According to the manufacturer's instructions, Humalog insulin should be discarded 28 days after opening. Resident #4's Lorazepam 0.5 mg medication card was tampered with and had a blue sticker on the back of the card to hold pill #11 in place due to the foil backing having been opened.

Plan of Correction ***Accept (█ - 05/06/2026)***

Immediate corrective action was taken upon identification of the medication concerns and undated Humalog pen was removed from use immediately by the Med Aide and Med Aide supervisor and replaced with a new pen, which was properly dated at the time of opening at the time of the inspection. The Lorazepam card, in which one pill had been taped in place, was also removed from the medication cart by the Med Aide and Med Aide Supervisor and replaced with a new, intact medication card obtained directly from the pharmacy. The Medication Aide involved was counseled regarding proper medication handling, labeling, and reporting procedures.
In addition, staff received refresher training on 4/29/26, which included the following topics: Proper dating of insulin pens and any medications requiring dating upon opening, maintaining medication packaging in its original, untampered condition, and documentation and reporting requirements under §2600.183(e)
To ensure continued compliance, a comprehensive audit of all medication carts and storage areas was completed on 5/4/26 to verify compliance to labeling, dating, and packaging standards. Moving forward, Med Aides will conduct weekly medication cart audits, which will be spot checked weekly by the Nursing Supervisors. Any medication found to be improperly labeled, undated, or compromised in any way will be removed immediately and reported to Administration for corrective action. Administration will remain responsible for ensuring ongoing compliance with §2600.183(e) and maintaining all required documentation.

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

183e - Storing Medications *(continued)*

Implemented [redacted] - 05/11/2026)

185a - Implement Storage Procedures

5. 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 is prescribed Eucerin Cream as needed and it was not available in the home at the time of inspection.
At 9:56a.m., resident room [redacted] contained an Oxygen canister stored unsecured directly on the floor.

Plan of Correction ***Accept [redacted] - 05/06/2026)***

Immediate corrective action was taken on 4/15/26 in which the missing PRN ordered Eucerin cream was obtained from the pharmacy immediately and placed in the medication cart by the Med Aide for resident #3 to use as ordered.
At the time of the inspection on 4/15/26, the oxygen canister that had been stored unsecured on the floor was placed in a designated oxygen storage container by Co- Administrator, where it was properly secured at the time of inspection.
To ensure continued compliance, staff received refresher training on 4/29/26, which covered the following topics: Requirements for maintaining all prescribed PRN treatments in the home, Proper storage and securing of oxygen tanks and other medical equipment, and Reporting procedures for missing medications or improperly stored equipment
A full audit of all PRN medications was completed on 5/4/26 by the Medication Aides to verify availability and proper storage of all prescribed treatments. In addition, all Personal Care Aides conducted room checks to ensure that all oxygen tanks were secured in approved holders or racks. These checks were spot verified by the Nursing Supervisor as well as Administration.
Moving forward, weekly medication audits will be conducted by Med Aides, and weekly oxygen storage checks will be completed during weekly room checks to ensure all canisters remain properly secured. Nursing Supervisors will perform routine spot checks to confirm that all PRN treatments remain available and that oxygen storage practices remain compliant.
Any future concerns regarding missing medications or improperly stored equipment will be reported immediately to Administration and corrected without delay. Administration will be responsible for ensuring ongoing compliance with all regulatory requirements.

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

Implemented [redacted] - 05/11/2026)