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

May 26, 2026

[redacted], LEGAL ENTITY
MERAKEY PENNSYLVANIA
[redacted]

RE: MERAKEY PENNSYLVANIA
515 DELAWARE AVENUE
BETHLEHEM, PA, 18015
LICENSE/COC#: 22401

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/21/2026 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: *MERAKEY PENNSYLVANIA* **License #**: *22401* **License Expiration**: *06/11/2026*

Address: *515 DELAWARE AVENUE, BETHLEHEM, PA 18015*

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

Administrator

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

Legal Entity

Name: *MERAKEY PENNSYLVANIA*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *R-4* **Date**: *04/23/2012* **Issued By**: *Fountain Hill Borough*

Staffing Hours

Resident Support Staff: *22* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/21/2026*

Inspection Dates and Department Representative

04/21/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *5*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

04/21/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/17/2026*

05/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/20/2026*

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

Inspections / Reviews *(continued)*

05/14/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2026*

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

05/26/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2026*

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

65a - FS Orientation 1st Day

1. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, whose first day of work was [redacted] did not receive 1st day orientation on the following topics: Evacuation procedures, Staff duties & responsibilities during a fire drill, Designated meeting place and fire safe area, Smoking safety procedures/policy, Location & use of fire extinguishers, Smoke detectors & fire alarms, Telephone use, and notification of emergency service.

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

Immediate Solution/Corrective Actions: The Administrator reviewed fire safety and emergency procedures with Staff Member A on 5/7/26, which included a review of evacuation procedures, staff duties and responsibilities during a fire drill, designated meeting place and fire safe area, smoking safety procedures/policy, location and use of fire extinguishers, smoke detectors and fire alarms, telephone use, and notification of emergency services. This review was documented as an orientation sheet. Please see attached.
Moving forward, the Administrator reviewed and updated the new hire Orientation Packet to ensure Fire Safety and Evacuation Procedures that include items 1-7 are completed on Day 1 of orientation. A copy of the orientation training will be kept in the staff member's training binder. The Administrator will review each new hire orientation packets to ensure all new hires receiving required regulatory trainings prior to allowing the staff member to be scheduled on the floor. Please see attached.
Monitoring: The Adult Services Director will complete a monthly review of staff training binders for 3 months/90 days to ensure orientation is completed and documented. If any issues arise, it will be addressed through individual supervision with the Administrator.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.

65b - Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person A did not complete training in the following topics: Resident rights, Emergency medical plan, Mandatory reporting of abuse- OAPSA, reportable incidents and conditions.

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

Immediate Solution/Corrective Actions: The Administrator reviewed Resident Rights, the Emergency Medical Plan, Mandatory Report of abuse under OAPSA, and incident reporting and conditions with staff member A on 5/9/26. This review was documented. Please see attached.
Moving forward, the Administrator reviewed and updated the new hire orientation packet to ensure orientation includes a review of resident rights, the emergency medical plan, mandatory reporting under OAPSA, and incident reporting and conditions. A copy of the orientation training will be kept in the staff member's training binder. The Administrator will review each new hire orientation packets to ensure all new hires receiving required regulatory trainings prior to allowing the staff member to be scheduled on the floor. Please see attached.
Monitoring: The Adult Services Director will complete a monthly review of staff training binders for 3 months/90 days to ensure orientation is completed and documented. If any issues arise, it will be addressed through individual supervision with the Administrator.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented (- 05/26/2026)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff Person B did not receive training in fire safety, by a fire safety expert, or staff trained in fire safety during training year 2025.

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

Immediate Solution/Corrective Actions: The Administrator reviewed Fire Safety training with staff member B on 5/8/26. This review was documented. Please see attached.
Moving forward, the Administrator developed an annual training packet for each staff member that will be kept in a training binder. The Administrator will schedule Fire Safety training annually and each staff member will complete a sign-off sheet in their training binder. Please see attached.
Monitoring:. The Administrator will review each annual training packets monthly to ensure all staff receive required regulatory trainings. The Adult Services Director will complete a monthly review of staff training binders for 3 months/90 days to ensure annual trainings are completed and documented. If any issues arise, it will be addressed through individual supervision with the Administrator.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented (- 05/26/2026)

65g - Annual Training Content *(continued)*

85d - Trash Receptacles

4. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:18 a.m., there were 2 uncovered, unattended trash cans in the kitchen.
At 9:24 a.m. the trash cans in the second-floor shared bathrooms 1 & 2 did not have a lid.

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

Immediate Solution/Corrective Actions: The Administrator removed all trashcans without lids from the facility upon discovery 4/23/26 and purchased new trash cans with lids. The Administrator will add signage to each trash can noting the lid must be closed at all times by 5/15/26.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.85(d-e). This review was documented. Please see attached.
The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of trash cans/lids. Staff on each shift will complete the Daily Checklist and note any issues. Please see attached.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented (- 05/26/2026)

85e - Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 12:24 p.m., the lid to the dumpster containing garbage was opened allowing access of insects and rodents.

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

Immediate Solution/Corrective Actions: The Administrator requested a new dumpster from Republic trash company that will be delivered to the home on 5/11/26. The Administrator will add signage to the dumpster noting the lid must be closed at all times 5/15/26. Please see attached.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.85(d-e). This review was documented. The Administrator reviewed and updated the staff's Daily Shift Checklist to include a check of the dumpster. Staff on each shift will complete the Daily Checklist and note any issues.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

85e - Trash Outside Home *(continued)*

Implemented ([redacted] - 05/26/2026)

86a - Ventilation

6. Requirements

2600.
86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

At 9:22 a.m., the bathroom near room 303 had an exhaust fan that was inoperable and had no window or other source of ventilation.
Repeated Violation: 7/23/2025.

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

Immediate Solution/Corrective Actions: The Administrator notified Merakey Facilities via work order of the inoperable exhaust fan on 4/27/26. An external company assessed the fan on 4/28/26 and is working on a replacement. The fan is expected to be replaced by the end of May. Please see attached.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.86(a). This review was documented. The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of ventilation fans. Staff on each shift will complete the Daily Checklist and note any issues.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

103e - Left Overs

7. 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 9:18 a.m. in the basement standing freezer there was a large bag of frozen meat balls, 2 large bags containing frozen chicken, and a large pack of frozen hot dogs that were unlabeled and not dated.

Repeated Violation: 7/23/2025.

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

Immediate Solution/Corrective Actions: Staff dated the food in the basement standing freezer the date of discovery on 4/23/26.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.103(e). This review was documented. The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of labeled and dated food in the refrigerator(s) and freezer(s). Staff on each shift will complete the Daily Checklist and note any issues.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues

103e - Left Overs (continued)

will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

103f - Refrigerator/Freezer Temps

8. 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.

Description of Violation

At 9:21 a.m., there was no thermometer in the freezer located in the dry storage room.

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

Immediate Solution/Corrective Actions: The thermometer was found under food packaging and was placed in a visible location in the freezer the date of discovery on 4/23/26.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.103(f). This review was documented. Please see attached.
The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of thermometers in the fridge(s) and freezer(s). Staff on each shift will complete the Daily Checklist and note any issues. Please see attached.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

121a - Unobstructed Egress

9. 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 9:16 a.m., there were 3 pallets resting against the exterior wall, and a hose and another pallet on the ground that blocked egress from the delivery door's fire exit.

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

Immediate Solution/Corrective Actions: The palettes were discarded from the property the date of discovery 4/23/26.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.121(a). This review was documented. Please see attached.
The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of egresses in the home. Moving forward, palettes will be discarded after unloading deliveries. Staff on each shift will complete the Daily Checklist and note any issues. Please see attached.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues

121a - Unobstructed Egress (continued)

will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

125a - Combustible Storage

10. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 9:15 a.m., there was an accumulation of 7 dryer sheets found behind the dryer and in close proximity to the exhaust vent.

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

Immediate Solution/Corrective Actions: The dryer sheets were removed from behind the dryer the date of discovery on 4/23/26. Merakey Facilities added a shelf above the washer and dryer to prevent items from falling behind on 5/8/26. Please see attached.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.125(a). This review was documented. Please see attached.
The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of the dryer/exhaust vent. Staff on each shift will complete the Daily Checklist and note any issues. Please see attached.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

131f - Fire Extinguisher Inspection

11. 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 3:14 p.m., the fire extinguisher that was in the facility car was not inspected by a fire safety expert.

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

Immediate Solution/Corrective Actions: The fire extinguisher located the facility car was inspected and tagged on 4/28/26. Please see attached.
The Administrator completed an in-service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.131(f). This review was documented. Please see attached.
The Administrator reviewed and updated the staff's Daily Shift Checklist to include a review of fire extinguishers in the home and facility car. Staff on each shift will complete the Daily Checklist and note any issues. Please see attached.
Monitoring: The Administrator will review Shift Checklists daily for completion and any noted environmental issues

131f Fire Extinguisher Inspection (continued)

will be corrected immediately or via a submitted work order to Merakey Facilities. The Adult Services Director will review the Checklists monthly for 3 months/90 days to ensure physical site standards are maintained.

Proposed Overall Completion Date: 05/17/2026

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

183e - Storing Medications

12. 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

Resident #2's Methylphenid 20 mg medication card was tampered with leaving a hole in the packaging and had tape on the back of the card holding tablet #27 in place.

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

Immediate Solution/Corrective Actions: Resident 2's Methylphenid 20 mg medication card was disposed of the date of discovery on 4/23/26.
The Administrator completed an in service training with all staff at the home on 5/12/26 that included a review of regulatory requirements of 2600.183(e). This review was documented. Please see attached.
Moving forward, staff will review blister packs during each medication pass to ensure there are no holes in the packaging. If an individual's medication is tampered with in any way, it will be immediately destroyed according to the "ABH Residential Disposal of Medications Policy." Please see attached.
Monitoring: A medication certified staff will complete a weekly medication review that includes a review. This review is documented on anauditing form. If any issues are found, they will be immediately reported to the Administrator for appropriate action

Licensee's Proposed Overall Completion Date: *05/17/2026*

Implemented ([redacted] - 05/26/2026)

190c - Record of Training

13. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff Person B's Medication Practicum dated 11/6/25 was not signed or dated by the Trainer.

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

Immediate Solution/Corrective Actions: The Administrator signed and dated the Medication Practicum form for Staff Person B on 4/23/26. Please see attached.
The Administrator completed an in service training with all staff at the home on 5/12/26 that included a review of

190c Record of Training (continued)

regulatory requirements of 2600.190(C). This review was documented. Please see attached.
Moving forward, The Administrator will complete a Medication Practicum with each staff member, and the staff member will sign and date the practicum form. A copy of the training form will be located in the Medication training Binder in the staff office.
Monitoring: The Administrator will review medication training binders at least weekly to track and monitor medication training documentation. If any documentation is missing, it will be addressed immediately by the Administrator.

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

Implemented ([redacted] - 05/26/2026)