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

July 16, 2026

[redacted]
SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC
[redacted]

RE: SACRED HEART SENIOR LIVING BY SAUCON CREEK
4851 SAUCON CREEK ROAD
CENTER VALLEY, PA, 18034
LICENSE/COC#: 21675

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/13/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SACRED HEART SENIOR LIVING BY SAUCON CREEK* **License #**: *21675* **License Expiration**: *12/17/2026*

Address: *4851 SAUCON CREEK ROAD, CENTER VALLEY, PA 18034*

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

Administrator

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

Legal Entity

Name: *SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/27/2005* **Issued By**: *Upper Saucon Twp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *05/13/2026*

Inspection Dates and Department Representative

05/13/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *45*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *16* **Have Physical Disability**: *0*

Inspections / Reviews

05/13/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/14/2026*

06/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/24/2026*

Inspections / Reviews *(continued)*

07/16/2026 Document Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2026*

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

185a - Implement Storage Procedures

1. 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

On [redacted] the narcotic count sheet for the 2nd floor medication cart was not initialed by the off going staff person at 7:00 a.m., and the oncoming night shift staff person at 11:00 p.m.

On [redacted] the narcotics count sheet for the 3rd floor medication cart was not initialed by the off going staff person at 7:00 a.m.

Plan of Correction ***Accept[redacted] - 06/22/2026)***

SACRED HEART SENIOR LIVING BY SAUCON CREEK
PLAN OF CORRECTIONS FOR 2600.185.a
WEYHILL INSPECTION MAY 13TH, 2026
Facility ID: 21675

Violation: 2600.185.a Implement Storage Procedures: 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: On 5/1/26 the narcotic count sheet for the 2nd floor medication cards was not initialed by the off going staff person at 7:00AM, and the oncoming night shift staff person at 11:00PM.
On 5/3/26 the narcotics count sheet for the 3rd floor medication cart was not initialed by the off going staff person at 7:00AM.

IMMEDIATE PLAN OF CORRECTION
Remind all medication management staff of the importance of completing accurate documentation, including initialing narcotic count sheets during shift changes.
Conduct a mandatory in-service training session with all med techs and nurses on June 10th, 2026 to reinforce proper procedures for medication storage, access, and documentation.
Initiate a 7-day audit of all narcotic count sheets to identify additional documentation issues.
Assign the Director of Nursing to oversee daily monitoring of medication documentation compliance for the next week after the June 10th, 2026 training. Afterwards, weekly audits for the first three months and then transition to twice a month checks
PLAN OF CORRECTION
1. Policy and Procedure Review and Update
• Review current medication storage and documentation policies for clarity regarding staff initials at shift changes.
• Update policies as needed to emphasize the requirement for immediate initialing of narcotic sheets post-count.
• Distribute revised policies to all licensed nursing and medication staff and obtain acknowledgment of receipt and understanding.
2. Implementation of Storage Procedures
• Standardize documentation processes, including checklists or electronic systems, to ensure staff initial narcotic sheets at the correct times.
• Designate accountable staff responsible for completing and verifying medication documentation during each shift.
• Supervisors will perform daily audits and provide immediate feedback to ensure compliance.

185a - Implement Storage Procedures (continued)

3. Staff Training and Education
• Incorporate training on medication storage and documentation into ongoing staff education programs.
• Utilize case scenarios to reinforce correct documentation practices during training.
• Maintain documentation of all training sessions, including attendance and topics covered.
4. Follow-Up and Monitoring
• Continue weekly audits of medication documentation for three months.
• Hold monthly meetings to review compliance and address ongoing issues.
• Submit a compliance report to the regulatory agency upon completion of corrective actions.

5. Prevention Measures
• Conduct random spot-checks of medication carts and documentation.
• Integrate medication documentation compliance into staff performance evaluations.

Responsible Parties:
Administrator
LPN Wellness Director

Timeline for Completion:
• Staff training: June 10th, 2026
• Ongoing monitoring: Weekly audits for the first three months and then transition to twice a month checks by the LPN Wellness Director.
If the above plan of correction is accepted. The following protocol/policy will be reviewed by the designees.
The following have reviewed and understand the plan for the review of documentation on medication narcotic forms and the June 10th, 2026 training with med techs and nurses, and the below designees will ensure to implement and maintain compliance.
Administrator: [redacted]*, LPN*
Signature: _____ Date:_____
LPN Wellness Director: [redacted]*, LPN*
Signature: _____ Date:_____

Licensee's Proposed Overall Completion Date: *06/11/2026*

Implemented [redacted] ***- 07/16/2026)***