

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

August 28, 2026

[REDACTED]
SAUCON VALLEY MANOR INC.
[REDACTED]
[REDACTED]

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

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/16/2026 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: SAUCON VALLEY MANOR

License #: 20581

License Expiration: 05/14/2027

Address: 1050 MAIN STREET, HELLERTOWN, PA 18055

County: NORTHAMPTON

Region: NORTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: SAUCON VALLEY MANOR INC.

Address:

Phone:

Email:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 298

Waking Staff: 224

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint

Exit Conference Date: 06/16/2026

Inspection Dates and Department Representative

06/16/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 201

Residents Served: 188

Secured Dementia Care Unit

In Home: Yes

Area: n/a

Capacity: 100

Residents Served: 62

Hospice

Current Residents: 34

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 187

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 110

Have Physical Disability: 2

Inspections / Reviews

06/16/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 07/19/2026

08/06/2026 - POC Submission

Submitted By:

Date Submitted: 08/10/2026

Reviewer:

Follow-Up Type: Document Submission Follow-Up Date: 08/10/2026

Inspections / Reviews (*continued*)

08/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/10/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

As per interviews with staff, the home enacted their emergency procedures on the afternoon of [REDACTED] due to issues with one of the home's smoke detectors being inoperable. The home did not report this incident to the department until [REDACTED] at 3:22 p.m.

Repeated violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/05/2026)

The facility respectfully disagrees with this citation but we will continue to comply with regulation 2600.16c. A reportable incident was submitted on 6/7/26 by Administration, in accordance with regulatory requirements. The incident report clearly indicated that an emergency call was placed to the guardian regarding the fire alarm system. This report was submitted as an initial report, as the facility was awaiting information from Guardian regarding the cause of the system trouble and what corrective actions were required to resolve it. The facility submitted the report promptly and followed the appropriate reporting protocol. The facility immediately initiated fire watch protocols as a precautionary measure as the system was functioning and the alarms sounding throughout the facility. An addendum to the initial report was sent by Administration on 6/16/26 at the time the inspectors were on site clarifying that fire watch was being done. Please note that no residents were placed at risk, and the fire alarm system remained 100 % operational despite the trouble signal.

To ensure continued compliance with reportable incident requirements, the following protocol have been implemented:

- All initial reportable incident submissions will now include the following statement "initial report—awaiting additional information" when applicable. In addition, Administration will ensure that follow up reports are submitted promptly once additional information is received from Guardian, or any other contractors or emergency personnel. Administrator or designee appointed by the Administrator will also conduct monthly audits of all incident reports beginning 7/1/26 and will continue the audits for the next 90 days. The audits will confirm the following:*

All reportable incidents are submitted within required timeframes

Initial reports include the above stated notation in the report when additional information is pending

Follow up reports are completed promptly and accurately

Any discrepancies identified during these audits will be corrected immediately and addressed with staff person who completed the state report.

In addition, Administration and those employees responsible for completing reportable incidents were retrained by the Administrator on July 17, 2026 on the importance of filling out incident reports in detail as well properly documenting the report if the incident correlates with another regulation using this particular incident report as an example as the facility did all the steps in implementing the fire watch but did not document that until the 2nd report at the time the inspectors were on site. (please see attached training sign in sheet as well as the information that was reviewed at the time of the training.)

The Administrator is responsible for ensuring implementation ongoing compliance with this Plan of Correction for regulation 2600.16c

16c - Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: 07/19/2026

Implemented [REDACTED] - 08/28/2026)

130g - Smoke Detector Repair

2. Requirements

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On the afternoon of [REDACTED], the home's smoke detector head near room [REDACTED] was found to be inoperative. The system was not repaired as of [REDACTED].

Plan of Correction

Accept [REDACTED] - 08/05/2026)

On 6/7/26, the facility identified a trouble signal resulting in a trouble signal on the fire alarm panel after the fire alarm had gone off. The panel indicated that there was an issue with one the smoke detector heads. An emergency call was placed to Guardian immediately and a reportable incident was completed and sent to the Department regarding the false alarm and that an emergency service call was placed. The facility began fire watch per the 2600 regulations as a precautionary measure. Guardian responded to the facility on the same day to assess the fire alarm panel and began troubleshooting the issue.

The facility was actively working with Guardian from 6/7/26 through 6/16/26 to locate the parts required to correct the trouble condition and restore the smoke head to full functionality. The delay in repair was due to Guardian's process of identifying and obtaining the necessary components. Please be aware that even with the trouble signal present, the fire alarm system remained fully functional during this time, and the alarm was sounding throughout the facility. Please note that the system is no longer in trouble as indicated in attached photo of the panel.

During this time the fire alarm panel was checked daily to ensure that there were no additional trouble signatures. To ensure continued compliance with 2600.130(g) and prevent delays in future repairs:

- The Director of Maintenance is working with Management to obtain pricing for a system upgrade or full replacement from multiple fire alarm companies.
- The facility is evaluating options to ensure faster response times and improved system reliability.
- The facility will maintain documentation of all service calls, vendor communications, and repair timelines.

In addition, Maintenance will continue to conduct weekly fire alarm system checks to ensure no new trouble conditions arise. Maintenance will review all trouble signals will be with Administration within 24 hours.

The Administrator and Director of Maintenance are responsible for ensuring timely repairs and ongoing continued compliance with regulation 2600.130g

Licensee's Proposed Overall Completion Date: 07/19/2026

Implemented [REDACTED] - 08/27/2026)

183b - Meds and Syringes Locked

3. 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.

183b - Meds and Syringes Locked (continued)**Description of Violation**

At approximately 11:42 a.m. a packet of Juven was observed on Resident [REDACTED]'s nightstand. As per interviews with staff the medication was removed from the medication cart and placed on the resident's nightstand. The resident is not assessed to self-administer medications as per the resident's medical evaluation dated [REDACTED]

Plan of Correction**Accepted [REDACTED] - 08/06/2026)**

Medication was found on Resident [REDACTED]'s nightstand during the inspection. The resident is not capable of self administering the medication as per Resident [REDACTED] medical evaluation, making the medication improperly stored and accessible in violation of §2600.183(b).

Immediate corrective action was taken on 6/16/26 at the time of the inspection. The medication was promptly removed from the resident's nightstand and secured in the locked medication storage area by the Med Aide. The Medication Aide involved received immediate counseling regarding proper medication security, handling expectations, and adherence to regulatory requirements. (please see attached sign in sheet for the above re-training) Effective 6/17/26, Medication Aides are required to complete weekly medication cart audits utilizing a standardized checklist. (please see attached example of a blank checklist as well as one completed during the weekly audits) The checklist includes verification of:

- Proper medication storage
- Accurate labeling and dating
- Integrity of medication packaging
- Confirmation that no medications are left in resident rooms

Completed checklists are submitted weekly to Administration or the Nursing Supervisor. Administration reviews all checklists to ensure audits are completed consistently and to address any identified concerns promptly.

Also effective 6/17/26, Administration conducts weekly resident room spot checks to ensure full compliance with §2600.183(b). (please see attached log) These checks confirm:

- No medications are left in any resident's room
- Residents who cannot self administer per physician order do not have access to any medication
- Any concerns identified are corrected immediately and documented

Administration signs off on each weekly room check log and follows up with staff as needed. Weekly administrative spot checks will continue for 60 days to ensure sustained compliance.

On 6/24/26, all Medication Aides and Nursing staff completed refresher training on regulation 2600.183b at the facilities monthly training which covered: (please see attached training notification to staff)

- Regulation 2600.183(b)
- Proper medication security and handling
- Procedures to prevent medications from being left in resident rooms
- Correct completion and submission of the weekly medication cart audit checklist
- Documentation and reporting expectations

Training attendance was placed in staff personnel files.

The Administrator is responsible for ensuring implementation, oversight, and ongoing compliance with this Plan of Correction.

Licensee's Proposed Overall Completion Date: 07/19/2026**Implemented [REDACTED] - 08/27/2026)**

185a - Implement Storage Procedures

4. 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 [REDACTED] is prescribed blood sugar checks 4 times daily at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m.

On [REDACTED] at 8:33 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 4:34 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 4:37 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 4:18 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 8:22 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 4:26 p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

Resident [REDACTED] is prescribed blood sugar checks 4 times daily 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. under sliding scale parameter.

On [REDACTED] at 7:27p.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

On [REDACTED] at 11:30 a.m., a blood glucose reading of [REDACTED] was obtained; however, the MAR documented a reading of [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/06/2026)

A blood glucose reading was obtained for a resident [REDACTED] and resident [REDACTED] however, the value was documented incorrectly on the Medication Administration Record (MAR), resulting in inaccurate documentation. On 6/16/26 the incorrect MAR entry was identified by the inspector at the time of the inspection. The staff member responsible was counseled regarding proper blood glucose documentation procedures and the importance of accuracy on the Medication Administration record. (see attached sign in sheet from the retraining.

To ensure continue compliance with regulation 2600.185a the facility has implemented the following:
Effective 6/17/26, Medication Aides are required to complete weekly medication cart audits utilizing a standardized checklist. (please see attached blank copy of checklist Med Aides are to complete as well as one completed during the weekly c checks. The checklist includes verification of but not limited to:

185a - Implement Storage Procedures (continued)

- Glucometer readings reviewed and match physician orders and MAR documentation

Completed checklists are submitted weekly to Administration or the Nursing Supervisor. Administration reviews all checklists to ensure audits are completed consistently and to address any identified concerns promptly.

In addition, Administration will conduct weekly spot checks for 60 days to ensure:

- Blood glucose readings are documented accurately
- MAR entries match glucometer readings
- Staff are following the revised documentation protocol

Any discrepancies identified during spot checks will be corrected immediately, documented, and addressed with staff. On 6/24/26 all Med Aides and Nursing staff received refresher on regulation 2600.185a at the facilities monthly training which covered: (please see attached training notification page to staff)

- Regulation 2600.185(a)
- Proper procedures for obtaining and documenting blood glucose readings
- The importance of accurate MAR documentation for resident safety

Training attendance was documented and placed in employee personnel files.

The Administrator is responsible for ensuring implementation and ongoing compliance with this Plan of Correction for regulation 2600.185a

Licensee's Proposed Overall Completion Date: 07/19/2026

Implemented [REDACTED] - 08/27/2026)

187b - Date/Time of Medication Admin.**5. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] to be applied twice daily at 8:00 a.m. and 8:00 p.m. Resident [REDACTED] May 2026 medication administration record does not include the initials of the staff person who administered the medication to the resident on [REDACTED] at 8:00 p.m. and [REDACTED] at 8:00 a.m. Staff interviews confirmed the medication was administered to the resident.

Repeated violation [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 08/06/2026)

Upon discovery of the missing initial on 6/16/26 the MAR was immediately reviewed and corrected. The staff member was counseled at the time of discovery regarding proper MAR documentation procedures and the importance of complete, accurate records.

To prevent ensure ongoing compliance with 2600.187(b), beginning on June 17, 2016 Med Aides are conducting weekly medication cart audits which includes verifying that all MARS are completed accurately and all medications given have been initialed by themed Aide who administered the medication. (please see attached blank copy of checklist Med Aides are to use as well as one completed during the weekly audits)

Administration will conduct weekly spot checks for 60 days to ensure that cart audits have been completed and everything is in compliance. Any issues or discrepancies on the Medication cart during the spot checks will result in

187b - Date/Time of Medication Admin. (continued)

immediate corrective action and retraining.

On 6/24/26 all Medication Aides and Nursing staff received refresher training on regulation 2600.187b during the facilities monthly training which included the following information: (please see attached notification to staff regarding the training held)

- Regulation 2600.187(b)*
- Proper MAR documentation procedures*
- The importance of accurate medication records for resident safety*
- The new self check and audit protocols*
- Documentation and reporting expectations*

Training attendance was documented and placed in the Employee personnel files.

The Administrator is responsible for ensuring implementation and ongoing compliance with this Plan of Correction for regulation 2600.187b

Licensee's Proposed Overall Completion Date: 07/19/2026

Implemented () - 08/27/2026)