

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

September 28, 2026

[REDACTED], ADMINISTRATOR
SOUTH MOUNTAIN MEMORY CARE LLC
201 SOUTH SEVENTH STREET
EMMAUS, PA, 18049

RE: SOUTH MOUNTAIN MEMORY CARE
201 SOUTH SEVENTH STREET
EMMAUS, PA, 18049
LICENSE/COC#: 22721

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/19/2026 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: SOUTH MOUNTAIN MEMORY CARE

License #: 22721

License Expiration: 09/17/2026

Address: 201 SOUTH SEVENTH STREET, EMMAUS, PA 18049

County: LEHIGH

Region: NORTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: SOUTH MOUNTAIN MEMORY CARE LLC

Address: 201 SOUTH SEVENTH STREET, EMMAUS, PA, 18049

Phone:

Email:

Certificate(s) of Occupancy

Type: I-1

Date: 02/14/2018

Issued By: Emmaus Borough

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 42

Waking Staff: 32

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 08/19/2026

Inspection Dates and Department Representative

08/19/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 28

Residents Served: 21

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 28

Residents Served: 21

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 21

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 21

Have Physical Disability: 0

Inspections / Reviews

08/19/2026 Full

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 09/07/2026

09/17/2026 - POC Submission

Submitted By:

Date Submitted: 09/22/2026

Reviewer:

Follow-Up Type: POC Submission

Follow-Up Date: 09/24/2026

Inspections / Reviews (*continued*)

09/21/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/22/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/28/2026

09/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/22/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

1. 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 9:22 a.m. and 9:31 a.m., resident records were unlocked, unattended, and accessible in the nursing office.

Plan of Correction

Accept ([REDACTED] - 09/17/2026)

Nurse was called on the walkie system to immediately assist a staff member with a resident and inadvertently left door open. Nursing office door has automatic lock so when door is closed it is locked. A verbal reminder was provided to Nursing Director. A document was also distributed to all staff on 8/27, included with employee paystubs, with corrective actions for violations received as a further means of education to staff. All paystubs from that paydate have been collected and therefore all staff have received document.

Upon identification of the violation, all resident records located in the nursing office were immediately secured.

The Administrator reviewed the requirement for confidentiality and security of resident records with nursing and applicable staff. When resident records are in use, staff will maintain direct supervision of the records. Staff will not leave resident records unattended or accessible when leaving the nursing office.

The nursing office will remain securely locked when authorized staff are not present. Staff have been instructed that securing resident records is required at all times, as individuals other than authorized staff may not be permitted access to this information.

The Administrator will conduct and document 2x weekly checks, at random, of the nursing office and resident record storage area for four weeks to verify that resident records are appropriately secured and confidentiality is maintained. Any identified concerns will be corrected immediately and additional staff education will be provided as necessary.

*(Audit Chart attached) *additional date during week of 9/14 still to complete.*

(Memo to staff attached- which includes all violations)

(Inspection report corrective Action distributed to staff on 8/27 attached)

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented ([REDACTED] - 09/28/2026)

65i - Training Record

2. Requirements

2600.

- 65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record (continued)

Description of Violation

The 2025 training records for the Older Adults Protective Service Act, Abuse, and Resident Rights trainings completed in January, Safe Management Techniques training completed in February, Incident Reporting training completed in April, Dementia Executive Functioning and Communication training completed in June, Fire Protection and Emergency Plan for Evacuation training completed in November, did not indicate the training source or the length of time of the course.

Plan of Correction

Accept () - 09/17/2026)

SMMC's trainings are distributed at the beginning of each month. Staff are required to complete the training during the month designated, on their own time, so majority of trainings do not take place at one specific time/date. Training content is generated from web content, the Relias training platform and other educational information, compiled to produce trainings materials. For compliance purposes, all trainings will list "Applicable web content" for the training source as there are multiple web sources this information was compiled from over the years as trainings evolve. The attached ANNUAL training calendar is included with staff trainings and includes necessary information. Additionally, the MONTHLY training record has been updated to include the specific date each employee completes the training, and the source and length of time of each training.

(Updated Annual Training Calendar attached)

(Updated Monthly Training Record attached)

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented () - 09/28/2026)

105g - Lint Removal and Duct Cleaning

3. 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

On 8/19/26, there was an approximate two-inch accumulation of lint in the lint trap of the dryer in the laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept () - 09/17/2026)

Lint is removed after each load. A deep clean takes place each night where 11-7 MT uses tool to remove any residual lint as an added precaution and sign off on this measure.

The specific area that lint was observed is over a circuit connection that staff indicate they actively avoid as to not disconnect the circuit connection, which will make the dryer non-functional if disconnected. It was explained to staff that this is a fire hazard regardless and if the connection is disabled, it's easily reconnected. The risk of disconnecting circuit does not outweigh the risk of fire. Staff are understanding of verbal education and have implemented this practice immediately.

Executive Director has checked this area on several occasions since inspection and compliance is maintained, area

105g - Lint Removal and Duct Cleaning (continued)

is free of lint.

(Lint removal log attached)

Licensee's Proposed Overall Completion Date: 09/16/2026

Implemented () - 09/28/2026)

231b - Medical Evaluation**4. Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the home on [REDACTED]. The home is an all-secure dementia care facility. The medical evaluations dated [REDACTED] and [REDACTED] do not include a diagnosis of Alzheimer's disease or other dementia.

Plan of Correction

Accept () - 09/21/2026)

Resident's physician updated DME on 9/3/2026 to include diagnosis of unspecified Dementia, located on page 4. Director of Nursing is now aware Mild Cognitive Impairment is not an appropriate diagnosis for admission. All other DME's were checked and all other residents have diagnosis of Alzheimer's or dementia. DOW will ensure compliance of all DME's for future admissions.

(New DME completed w/ Dementia diagnosis- page 4- Attached)

****This corrective action was not included on the document distributed as only the Director of Nursing or Administrator would be responsible for these updates. Both parties were present at time of exit interview/violation conference and are aware of corrective action.

Proposed Overall Completion Date: 09/16/2026

Resident DME's audited on 9/3/2026 for compliance after Resident 1's DME was corrected. Audit of admitting diagnosis and required information attached.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/28/2026)

233d - Electronic/Magnetic System**5. Requirements**

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

At 9:30 a.m., the gate located in the outdoor garden area courtyard opening into the side embankment was not

233d - Electronic/Magnetic System (continued)

locked with an electronic or magnetic locking system. The right-side door was able to be opened by lifting the metal pin and pushing the door open.

Plan of Correction**Accept () - 09/21/2026)**

SMMC has requested a consultation of a door specialist from Valley Builders, Builders Door to determine the most appropriate course of action.

This garden is NOT a secure area, given that there is only a 36 in railing that leads to a ground level flower bed on one full side of the area. The only way to access this garden from inside the building is a ramp that is behind TWO magnetic locked doors so residents are not able to access this area independently. SMMC does not allow residents to utilize this space without family or staff supervision as it is not secure. Residents are permitted to use this space with the accompaniment of staff or family as it is not a secure space. There would not be any time that a resident would be alone in this area.

SMMC maintains this gate as the only way for landscaping/maintenance services to access the outdoor garden area and was simply designed as a non-resident/staff access or exit point. This would also not be used as an intentional fire exit because there is an approximately 5 foot sloped drop on the other side of the gate which would not be a safe exit route for elderly or those with mobility issues.

This gate cannot be closed in as there would be no exterior access to this area for landscape, maintenance, etc. without going through the community, which is not feasible.

The consultation from Builder's Door will determine if the second (right door) of the gate can be removed and a permanent fence panel put in it's place. The left door, which has the mag lock will remain in place and functional.

The garden itself is far enough from the building to be considered a fire safe evacuation space/meeting place so it is unclear why a magnetic lock was ever required on the gate.

Staff were reminded of the non-secure nature of the garden and that residents must be attended/supervised at all times.

(Photo of 36 inch railing, confirming this is NOT a secure area that residents would use independently or unsupervised attached)

(Photo of doors 1 and 2 WITH mag locks that prevent residents from accessing this space attached.)

(Photo of hill from gate to ground level street attached.)

Gate will be assessed and fixed on 9/22/2026. Photo of solution will be provided. Approval for corrective action given on 9/27/2026 by [REDACTED] through phone call.

Policy indicating that residents are not allowed unsupervised in garden area at any time attached.

Licensee's Proposed Overall Completion Date: 09/18/2026

233d - Electronic/Magnetic System (continued)

Implemented () - 09/28/2026

234b - Support Plan Needs Elements

6. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan dated () for resident # 1 does not address the services that hospice provides to the resident.

Plan of Correction

Accept () - 09/21/2026

Resident's support plan does identify the resident's physical, medical, social, cognitive and safety needs as required by the regulation. A new RASP was completed as a significant change and resident's needs were implemented into the ADL's and care plan items of the RASP. Addendum has been updated to include specifics of additional resources hospice offers at this time. Director of Nursing audited charts of other hospice resident and updated RASP in accordance with regulation's interpretation by inspector. All RASPs are in compliance. Director of Nursing will ensure future residents admitted to hospice have sufficient documentation of supportive services.

****This corrective action was not included on the document distributed as only the Director of Nursing or Administrator would be responsible for these updates. Both parties were present at time of exit interview/violation conference and are aware of corrective action.

A significant change RASP update was completed on () when resident was admitted to hospice. RASP's contents were updated based on Resident 1's decline and new baseline status.

Addendum with expanded hospice services was added 9/3/2026.

Licensee's Proposed Overall Completion Date: 09/18/2026

Implemented () - 09/28/2026