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

October 27, 2026

[redacted], OPERATIONS ASSISTANT
COLUMBIA HANOVER OPCO LLC
[redacted]

RE: THE VERO AT BETHLEHEM
4700 BATH PIKE
BETHLEHEM, PA, 18017
LICENSE/COC#: 23163

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/01/2026 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: *THE VERO AT BETHLEHEM* **License #**: *23163* **License Expiration**: *08/15/2027*

Address: *4700 BATH PIKE, BETHLEHEM, PA 18017*

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

Administrator

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

Legal Entity

Name: *COLUMBIA HANOVER OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/09/2023* **Issued By**: *Hanover Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *174* **Waking Staff**: *131*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *09/01/2026*

Inspection Dates and Department Representative

09/01/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *137*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflection* **Capacity**: *36* **Residents Served**: *34*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *137*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *37*

Have Physical Disability: *1*

Inspections / Reviews

09/01/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/03/2026*

10/16/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/19/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/20/2026*

Inspections / Reviews *(continued)*

10/27/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/19/2026*

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 approximately 9:41a.m. the personal care home chart room door was unlocked and accessible. The room contains the residents' records and other confidential information of the residents.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

Immediate action taken was that the chart room door was closed and locked.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting regulation 2600.17 and the importance of keeping the door locked. Documentation shall be kept

On 9/14/26, the Residence Director purchased a Key Pad lock for the chart room door. On 9/16/26, the Key pad was delivered and installed on the chart room door. Picture will be maintained.

Beginning 10/5/26, the Residence Director or designee shall audit the chart room door daily for 1 week then weekly for 4 weeks to ensure that it is closed and locked. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home did not have carbon monoxide detectors installed near the commercial gas dryer in the main laundry or near the gas furnace located in the secure dementia care unit as required by the Care Facility Carbon Monoxide Alarms Standards Act.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

On 9/2/26, Maintenance Director installed carbon monoxide detectors in the commercial laundry room and near the gas furnace in the secured dementia unit. Picture to be maintained.

On 9/2/26, the Residence Director educated the Maintenance Director on the 2600.18 regulation. Documentation shall be maintained.

18 - Compliance With Laws (continued)

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.18. Documentation shall be kept.

Beginning 10/5/26, the Administrator or Designee shall audit all laundry and furnace rooms weekly for 4 weeks to ensure carbon monoxide detectors are in working order. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #2 requires assistance with changing their brief in the morning and in the evening before bed. During a resident interview, resident #2 reported that they frequently have to wait long periods of time before staff respond to their call bell to provide assistance. The call bell response time record for August 2026 indicates that the response times to resident #2's call bell was more than 15 minutes on the following dates and times: 8/6/26 at 7:19 a.m., 8/12/26 at 10:03 p.m., 8/19/26 at 6:30 p.m., 8/20/26 at 2:07 p.m., 8/20/26 at 10:19 p.m., 8/23/26 at 7:25 a.m., 8/27/26 at 10:21 p.m., 8/30/26 at 7:35 a.m., and 8/31/26 at 7:31 a.m.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

Immediate action taken was that Resident #2's care was moved to first on the resident assistant's assignment to avoid delay in care.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on the regulation and the importance of responding to call bell times promptly. Documentation shall be kept

Beginning 10/5/26, the Residence Director or designee will review Resident #2's call bell record daily for 1 weeks then weekly for 4 weeks. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/21/26 resident #1 reported to staff that their purse was stolen from their room. Resident #1 had a camera installed in their room at the time and the video showed staff person B taking the resident's trash can with the purse in it out of the room and returning with an empty trash can. According to staff person C, they viewed the video and also confirmed the resident's trash bag was found in a trash receptacle without the purse in the bag. Resident #1 stated that there was approximately $115 in cash in their purse at the time.

Plan of Correction ***Accept (- 10/16/2026)***

On 9/7/26, the Regional Director of Operations educated the Administrator and Health Care Director on 2600.42b. Documentation maintained.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.42b. Documentation shall be kept.

On 10/1/26, the resident was reimbursed by the home for cost of the purse and its contents.

Beginning 10/5/26, the administrator or designee shall interview five residents weekly for 4 weeks and then monthly for 2 months to inquire about safety and if needs are being met. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented (- 10/27/2026)

54a Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person D does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 10/16/2026)***

Staff Member D voluntary resigned from position with home on

On 9/7/26, the Regional Director of Operations educated the Administrator and Customer Service Associate on regulation 2600.54a.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.54a.

54a - Direct Care Staff (continued)

Documentation shall be kept.

By 10/9/2026, the Residence Director or designee shall audit current staff records to ensure current direct care staff have either a high school diploma, GED or active registry status on the PA nurse aide registry. Documentation shall be maintained.

Starting 10/5/2026, the Residence Director or designee will review all new staff paperwork to ensure that 200.54a is met. This will continue weekly for 4 weeks. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 9:47 a.m. there were two garbage bags on the floor outside the door to resident room 216.

At approximately 2:30 p.m. the box spring in resident #4's room was dirty and stained with a reddish/brown color.

At approximately 2:19 a.m. there was a brown substance identified as feces on the toilet handle and on the light switch next to the sink in resident #5 and Resident #6's shared bathroom.

At approximately 2:19 p.m. there was an unlabeled green toothbrush and a blue hairbrush stored on the bathroom countertop in resident #7 and resident #8's shared bathroom.

At approximately 12:42 p.m., during the medication pass observation, staff person A attempted to administer a Quetiapine 25mg pill to resident #10 by handing the resident a medication cup containing the prescribed medication. The medication fell from the medication cup onto the resident's bed. The medication was picked up from the bed and administered to the resident.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

On day of inspection, garbage bags were removed from floor outside of resident's door by housekeeping. Resident was instructed to not leave their garbage in the hallway.

On day of inspection, substance was cleaned off of toilet handle and light switch by housekeeping.

On 9/2/26, the Resident's box spring was deep cleaned by housekeeping. Resident #4 will have a mattress cover

85a - Sanitary Conditions (continued)

put on.

On 9/2/26, the green toothbrush and hairbrush were labeled by Administrator

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.85a and the that violations found. Documentation shall be kept.

Beginning on 10/5/26, the Residence Director or designee shall audit 10 resident rooms weekly for 4 weeks and then monthly for 2 months for sanitary conditions. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

92 - Windows

7. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At 9:30 a.m. the door to the enclosed patio in the secure dementia unit was propped wide open with no screen to prevent infestation of insects and/or rodents.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

Immediate action was taken and the patio door was closed.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.92. Documentation shall be kept.

Beginning 10/5/26, the Residence Director or designee shall audit the patio door weekly for 4 weeks to ensure that it remains closed when not in use or has proper screening when open. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At approximately 2:15 p.m. resident #7's bedside lamp was unplugged and did not have an accessible outlet.

At approximately 2:25 p.m. resident #9 did not have bedside lighting.

Repeated violation: 7/23/2025 et al

Plan of Correction ***Accept (- 10/16/2026)***

On 9/2/26, the Resident Director ordered bedside lights for residents that didn't have an accessible outlet or no light.

On 9/3/26, the Maintenance Director installed bedside lighting.

On 9/7/26, the Regional Director of Operations educated the Administrator and Maintenance Director on regulations 2600.101j7. Documentation shall be maintained.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.101j7. Documentation shall be kept.

Beginning on 10/5/26, the Residence Director or designee shall audit 10 resident bedrooms weekly for 4 weeks then monthly for 2 months to ensure proper bedside lighting. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented (- 10/27/2026)

125a - Combustible Storage

9. Requirements

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

Description of Violation

At approximately 9:39 a.m., the external dryer duct of the Maytag dryer in the laundry room of memory care had a mustard-colored linen napkin on top of it.

Plan of Correction ***Accept (- 10/16/2026)***

Immediate action taken was that the linen napkin was removed from on top of the dryer.

On 9/7/26, the Regional Director of Operations educated the Administrator and Maintenance Director on

125a Combustible Storage (continued)

regulation 2600.125a. Documentation shall be maintained.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.125a. Documentation shall be kept.

Beginning on 10/5/26, the Residence Director or designee shall audit laundry rooms daily for 1 week and then weekly for 4 weeks to ensure combustible and flammable materials are not found near heat sources. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

181d -Storing Medication

10. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #1 self administers medications and stores medications in their room. During a resident interview medications were observed in blister packs on a table and the resident indicated that the rest of their medications were in a bag stored on the floor by the table. Resident #1 also indicated that they do not lock their door when they leave the room. Resident #1's medications are not stored in a safe, secure manner to protect against contamination, spillage, and theft.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

Immediate action taken was that the Resident #1 was re educated by the Residence Director on self administration procedures and medications were secured in a locked cabinet.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.181d. Documentation shall be kept.

Beginning 10/5/2026, the Health Care Director or Designee will audit all self medicating resident rooms weekly for 4 weeks and then monthly for 2 months to ensure that medications are properly stored. Resident education will happen when medications are found to not be stored properly. Documentation shall be maintained.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

183a - Original Containers and Injections

11. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

An interview with staff person A indicated that another staff person had told them that when a resident leaves the building and needs to take their medications with them the following procedures are followed: pop the medication out of the blister pack and put it in the envelope and label it with the resident's name and the directions for the medications.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

On 9/2/26, the Residence Director and Health Care Director educated staff person A on prescription medication procedures and keeping all medications in their original containers. Documentation shall be maintained.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.181d and the procedure we follow when a resident leaves the community. Documentation shall be maintained.

Beginning on 10/5/26, the Health Care Director or designee shall question 3 medication associates regarding prescription medication procedures weekly for 4 weeks to ensure compliance. Documentation shall be kept.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)

233c - Key-Locking Devices

12. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The keypad that operates the key locking device near room #10 notes the code is 4682#, however 4682 opens the door.

The keypad that operates the key locking device near room #3 notes the code is 9287#, however 9287 opens the door.

Plan of Correction ***Accept ([redacted] - 10/16/2026)***

On 9/2/26, the Residence Director updated the unlocking directions for both keypads to reflect the correct keypad code.

On 9/8/26, the Residence Director educated staff during the monthly all staff meeting on regulation 2600.233c. Documentation shall be maintained.

233c Key Locking Devices (continued)

Beginning on 10/5/26, the Residence Director or designee shall audit each SDCU door to ensure the appropriate code is posted and operable. Audit will continue daily for 1 week and then weekly for 4 weeks. Documentation shall be kept.

On 10/29/26, the Residence Director or designee, will review the above findings for 2600.17 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *10/16/2026*

Implemented ([redacted] - 10/27/2026)