pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN INC**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR II**
NAME OF FACILITY OR AGENCY

Located at **313 S. WALNUT ST., BATH, PA 18014**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **78**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **October 17, 2025** until **October 17, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **205260**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

EMAILING DATE: OCTOBER 17, 2025

[redacted]
[redacted]
Alexandria Manor of Allentown
[redacted]
[redacted]

RE: Alexandria Manor II
313 South Walnut Street
Bath, Pennsylvania 18014
License #205260

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 17, 2025, July 21, 2025 and July 25, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

October 15, 2025

[redacted]
ALEXANDRIA MANOR OF ALLENTOWN INC
[redacted]

RE: ALEXANDRIA MANOR II
313 S. WALNUT ST.
BATH, PA, 18014
LICENSE/COC#: 20526

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/17/2025, 07/21/2025, 07/25/2025 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: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration**: *08/04/2025*

Address: *313 S. WALNUT ST., BATH, PA 18014*

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

Administrator

Name: [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/27/1998* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *07/28/2025*

Inspection Dates and Department Representative

07/17/2025 - On-Site: [redacted]
07/21/2025 - Off-Site:
07/25/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *78* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *49*

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

Have Mobility Need: *4* **Have Physical Disability**: *2*

Inspections / Reviews

07/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/18/2025*

Inspections / Reviews *(continued)*

08/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/01/2025*

09/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/04/2025*

10/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2025*

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

On 7/3/25 at approximately 8:00 P.M. the home's fire alarm was activated. The local fire department responded to the home and all residents were evacuated. The home did not report this incident to the department until 7/25/25.

Repeat violation: 8/13/24

Plan of Correction ***Do Not Accept [redacted] - 08/25/2025)***

Corrected as soon as this was brought to my [redacted] attention.

Admin was on vacation in [redacted] at time of fire alarm; [redacted] was educated on the importance of proper and timely written incident reporting in regard to regulation 16c - Written Incident Report on 7/25/25.

Moving Forward:

Designee will immediately contact administrator when something within the facility occurs that requires any type of emergency personnel. [redacted] will do random audits with staff and residents upon return from not being in the facility in regard to any type of emergency personnel arriving. [redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Upon becoming aware of the fire alarm activation of 7/3/2025 [redacted], personal care home administrator, who is the responsible person to fix the lack of reporting issue of 7/3/2025, notified the Department of Human

16c - Written Incident Report (continued)

Services on 7/25/2025 of the incident via telephone and email communication. A copy of this notification is attached.

The immediate solution was verifying a fire alarm had occurred on 7/3/2025 and once verified making proper notification to the Department of Human Services. This responsibility is the personal care home administrator's responsibility. During times of absence of the administrator a person will be designated by the personal care administrator who will be responsible for this action- specifically to written incident report. This is effective as of 8/28/2025.

The designated person in the absence of the administrator will be responsible for notifying the Department of Human Services and notifying the personal care administrator as soon as possible. The designated person will be made aware of this responsibility each time the administrator is not available to assure the designated person is aware of this responsibility during her absence.

At the time of this occurrence the administrator had designated [redacted] to be the responsible party. [redacted] neglected to follow this direction. [redacted] was educated on the importance of proper and timely written incident reporting in regard to regulation 16c on 7/25/2025 by [redacted]. All future designees by the personal care home administrator will be educated on their role to include expectations related to 16 c Written Incident Report.

As of 8/27/2025 all staff have been educated by [redacted], [redacted] including maintenance, kitchen/housekeeping, DCS on 16 c Written Incident Report and the importance of reporting any incidents to the personal care home administrator or their designee in their absence and what are reportable incidents and explaining policy regarding reports to management so they may properly report to DHS.. DCS staff were also educated on the need to include these reportables upon completion of shift report.

An audit will be completed after any reportable incident to ensure timely and accurate notification was made and follow up of regulation 16C for a period of 6 months. The audits will be performed by the personal care home administrator. Audits of the shift reports will also be completed daily x one month and monthly x 6 months for the purpose of identifying any potential reportable incidents. Audits will be completed by the personal care home administrator. Jacqueline Burns, personal care home administrator, is responsible for full ongoing compliance.

16c - Written Incident Report *(continued)*

Licensee's Proposed Overall Completion Date: *08/28/2025*

Update: *09/02/2025*

Please attach training, audits

Evidence of Completion ***Implemented (- 09/22/2025)***

See attached.

17 - Record Confidentiality

2. 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 9:50 a.m. the Privacy Coding from the Licensing Inspection Summary dated /24 was noted in the home's inspection binder located in the main lobby and accessible to the general public.

At 1:00 p.m. 3 resident records were noted on the conference room table. The room was unlocked, unattended, and the records were accessible to unauthorized persons.

Repeat violation: 8/13/24

Plan of Correction ***Do Not Accept - 08/25/2025)***

Privacy coding was corrected and removed day of inspection from inspection binder. Binder was also audited day of inspection to ensure proper compliance with regulation 17.

The resident records were on the conference room table due to licensing inspection that was taking place that day.

was educated by the Nazareth Alexandria Manor of the importance of regulation 17 Record Confidentiality on 8/1/25

Assistant to admin of bath facility was educated by of bath facility of the importance of regulation 17 Record Confidentiality on 8/11/25

Moving Forward:

Assistant to admin of bath facility will audit inspection/citation summaries before places them in inspection binder to ensure full compliance starting 8/11/25 or when new summaries are available.

Assistant to admin of bath facility will collect all records from DHS inspectors when leaving conference room and exiting the facility moving forward to ensure all records are properly protected under regulation 17. is responsible for full ongoing compliance.

17 - Record Confidentiality (continued)

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Upon notification on 7/17/2025 [redacted] removed the privacy coding from the inspection binder. Upon notification at exit survey on 7/17/2025 [redacted] secured the resident records from the conference room. Immediately post exit conference the facility was also checked by the personal care home administrator Jacqueline Burns to assure all other resident records were secured. The personal care home administrator is responsible for fixing and monitoring compliance.

[redacted] assistant to administrator at Nazareth Alexandria Manor of regulation 17 Record Confidentiality on 8/1/2025 with emphasis on inspection surveys posted to not contain privacy coding and emphasis on resident records to be secure and not left unattended in unlocked areas of the facility. Education also included the need to secure records behind a locked door.

Assistant to the administrator, [redacted] was educated by [redacted] home administrator of regulation 17 Record Confidentiality on 8/11/25 with emphasis on inspection surveys posted to not contain privacy coding and emphasis on resident records to be secure and not left unattended in unlocked areas of the facility. Education also included the need to secure records behind a locked door.

As of 8/27/2025 all staff including maintenance, kitchen/housekeeping, DCS have been educated on regulation 17 with emphasis on how important confidentiality and privacy is, privacy with inspection privacy coding and securing resident records. All staff received copies of this regulation and education on the regulation and facility policy. Emphasis on locking doors to secure records, closing out computer screens, and not leaving any confidential resident information where it could be accessed inappropriately. This training was provided by personal care home [redacted].

17 - Record Confidentiality (continued)

When posting inspection citation summaries both the assistant to administrator or designee and the administrator will check to assure privacy coding is not included in the posting prior to being placed in the folder so that there is a two person check system to assure confidentiality with posting information

Audits of the posting will be completed by the personal care home administrator weekly x 6 months to assure inspection information is in place and without confidential information included.

Audits of the facility will be done daily x 6 months by the personal care home administrator or designee to assure that all resident information is secured and remains confidential. [redacted] *is responsible for full compliance.*

Licensee's Proposed Overall Completion Date: *08/28/2025*

Update: *09/02/2025*

Please attach training, audits

Evidence of Completion ***Implemented*** [redacted] ***09/22/2025)***

See attached.

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan dated [redacted] */25 identifies the resident requires the use of a Hoyer lift for transfers. Based on interviews with multiple staff members and the resident, only one staff member is often completing Hoyer lift transfers due to not having enough staff. The home and the manufacturer recommend two people use the lift for transfers.*

The home currently serves 50 residents with 4 residents having mobility needs. Three residents require an assist of one transferring out of bed and Resident #1 requires an assist of 2 for transferring from bed to their wheelchair using a Hoyer lift. The home routinely schedules 3 direct care staff for 2 twelve-hour shifts. The home has an evacuation time of 13 minutes designated by the local fire chief on 04/11/25. Based on the layout of the building and the residents on the second floor "memory" area requiring verbal queuing and supervision, the home does not have adequate staff to

60a - Staff/Support Plan (continued)

safely evacuate the residents in the event of an emergency.

Plan of Correction ***Do Not Accept [redacted] - 08/25/2025)***

All staff educated by 8/17/25 regarding the safety and importance of regulation 60a - Staff/Support Plan.

All staff educated by 8/17/25 regarding the safety and importance of using two people to operate Hoyer lift transfers.

According to our fire safety expert that provides our fire safety letter and areas of refuge per that letter, he believes as well as we do that, we can safely evacuate in an emergency with the ability to choose from 3-4 fire refuge locations depending on where the emergency is located.

Moving Forward:

Out of abundance of caution and with respect to our licensing agency we have a plan in place to add additional staff. One staff member has been hired with a start date of 8/18/25 and second staff member start date pending return of criminal background check. [redacted] is responsible for full ongoing compliance.

Hoyer lift transfer signature sheet was started on 7/29/25, two staff members sign with date and time when used.

Hoyer lift transfer signature sheets, along with unannounced Hoyer lift competency audit to be completed weekly times 4 weeks then monthly times 5 months for full compliance by either myself [redacted] with a start date of 8/19/25. [redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/18/2025*

Update: *08/25/2025*

Please address when and how many staff members will be working each shift, and how this will be monitored

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it

60a - Staff/Support Plan (continued)

from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Resident # 1 support plan checked to assure the plan included that the Hoyer lift requires a two person assist per facility and manufacturer recommendation by the [redacted] on 7/17/2025.

All resident support plans were checked and updated to include if they transfer with a Hoyer lift shall have a two per assist with all Hoyer transfers. In additional all were checked regarding present status for evacuations. This was completed by [redacted] on 8/25/2025.

All staff educated by 8/17/2025 by the [redacted] regarding safety and importance of regulation 60 a Staff/Support plans with emphasis on the use of two people to operate Hoyer lift transfers. This education included the use of a Hoyer lift transfer signature sheet begun on 7/29/2025 having the two persons who transferred with a Hoyer lift to sign and date and time when used for accountability.

Hoyer lift transfer signature sheets will be audited weekly x 4 weeks and monthly x 5 months for full compliance and will be completed by the personal care home administrator or designee beginning on 8/19/2025. Unannounced Hoyer lift competency audits will be completed weekly x 4 and monthly x 5 by [redacted].

All staff were also educated by 8/17/2025 on fire evacuation procedure and expectations related to time frame to complete evacuation and safe staff monitored evacuation by Jacqueline Burns Personal care home administrator.

Moving forward all support plans will be updated as new DME's are completed to ensure updates are completed in all areas including assistance required for evacuations. This is completed by the personal care home administrator, [redacted] and is ongoing as they are completed.

Audit of monthly fire drills and actual fire drills will be completed by personal care home administrator or designee at least monthly with emphasis on evacuation time and safe monitoring of residents included at the evacuation zone. Fire drill has been completed for the month of August with an evacuation time of 9 mins and 18 seconds.

We have hired an additional night shift staff as of 8/26/2025 thus having four staff members scheduled for 6:30 pm-7 am shift. Any calls off as always will be worked on to assure coverage by another staff member or person on call either the administrator or assistant to the administrator.

60a - Staff/Support Plan (continued)

Day shift staffing includes three direct care staff that includes 2-day shift aides and one med tech. For all evacuations all staff are involved that are on duty and for day shift that at a minimum includes housekeeper and dietary staff leaving at least 5-day shift staff for evacuation. During the weekdays the facility also has an administrator/ assistant to administrator and activity staff member. Occasional maintenance personnel are also available to assist with evacuation. Day shift total staffing at a minimum is five staff and maximum can be nine staff in the facility at times to manage any evacuation situation.

Audit of staffing is an ongoing task of the administrator completed when the schedule is posted and is monitored and adjusted daily based on resident and staff needs.

[redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/28/2025*

Update: *09/02/2025*

Please attach training with staff

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 9:40 a.m. a 32 oz Clorox Disinfectant spray bottle with a manufacture's label indicating danger to humans and domestic animals, was unlocked, unattended, and accessible to residents in the lower-level storage room. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

At 9:40 a.m. a tube of Color Charm hair dye, with a manufacture's label indicating "harmful if ingested", was noted in an unlocked cabinet in the Beauty Salon located in the home's basement. The salon was also unlocked and unattended and accessible to residents. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat violation: 10/29/24, 8/13/24

Plan of Correction ***Accept [redacted] - 08/25/2025)***

Corrected day of inspections, doors were locked by maintenance.

82c - Locking Poisonous Materials (continued)

All staff educated by 8/17/25 regarding the safety and importance of regulation 82c - Locking Poisonous Materials.

Hair Salon/ Beauty Salon as of 7/18/25 have spring hinges on door jamb along with keypad lock that automatically locks door when closed.

Lower-Level Storage room as of 7/18/25 have spring hinges on door jamb along with keypad lock that automatically locks door when closed.

Moving Forward:

All areas will be randomly audited daily times 1 month for full compliance by either myself [redacted] with a start date of 8/11/25. [redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach training audits

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

At 9:20 a.m., a large puddle of feces was noted on the carpeting next to the door leading to the second-floor laundry room.

At 9:30 a.m. a black residue was noted on the floor of the shower located in the first-floor common bathroom in Hall "A".

At 9:15 a.m., four used towels and one used wash cloth were noted on the floor of the shower located in the first-floor common bathroom.

Plan of Correction ***Accept ([redacted] 08/25/2025)***

Housekeeping cleaned and corrected all three issues at time of inspection.

All staff educated by 8/17/25 regarding the safety and importance of regulation 85a - Sanitary Conditions.

85a - Sanitary Conditions (continued)

PCA/MedTechs were also educated on using proper used towel receptacle for safe hygienic practices after giving showers.

Housekeeping was educated on proper cleaning techniques regarding showers and other surfaces.

Moving Forward:

All common areas, bathrooms/shower rooms located in facility will be audited for proper sanitary conditions by [redacted] *or assistant to* [redacted] *three times a week for a duration of 6 months to maintain full compliance starting 8/11/25. Admin Jacqueline Burns is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Update: *08/25/2025*

Please attach trainings, audits

Evidence of Completion ***Implemented*** [redacted] ***- 10/02/2025)***

See attached.

90a - Landline Telephone

6. Requirements

2600.
90.a. The home shall have a working, noncoin operated, landline telephone that is accessible in emergencies and accessible to individuals with disabilities.

Description of Violation

The home does not have a working, non-coin operated landline telephone in the second-floor kitchenette and first and second floor common areas.

Plan of Correction ***Do Not Accept*** [redacted] ***- 08/25/2025)***

Corrected as of 8/4/25, new phones were placed on both second floors and first floors.

All staff educated by 8/17/25 regarding the safety and importance of regulation 90a - Landline Telephone.

Moving Forward:

All phones, on all floors will be audited to make sure they are available and in good repair weekly times 6 months for full compliance by either [redacted] *with a start date of 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please address the phone lines not being connected to make or receive phone calls.

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).

90a - Landline Telephone (continued)

When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.

What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

New phones, landline with portable capability were placed on 8/4/2025 on both the first floor having two new phones and second floors also having two new phones including in the kitchenette. This was completed by the personal care home administrator.

[redacted] *was contacted by the owner of Alexandria Manor on 8/25/2025 due to issues with phone lines not being functional sporadically resulting in difficulty making or receiving calls.* [redacted] *confirmed on 8/26/2025 that all phone lines are fully functional. The administrator has performed daily audits of the phone lines to assure functioning and ability to connect and make and receive calls. As of 8/28/2025 all lines are functional.*

All staff were educated by [redacted] *on regulation 90 a landline telephone and the need for working phone system accessible during emergencies and accessible to individuals with disabilities. Education emphasized the need to report any phone system issues/ concerns immediately to the administrator.*

The facility has been in the process of updating the phone and internet systems with a tentative completion date of October 2025.

All phones on all floors will be audited daily by med techs to assure functioning phone lines and full compliance. The audit includes assuring phones are in place, daily checks for dial tones as well as calling into the facility to assure ability to access. Audits will also be completed by the administrator or designee twice weekly to ensure a functioning phone system. [redacted] *will review audits and is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/28/2025*

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

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 9:32 a.m. the dry storage area in the kitchen contained an unlabeled and undated 1-gallon zip lock bag of what appeared to be Saltine crackers.

Plan of Correction ***Accept [redacted] - 08/25/2025)***

Corrected at time of inspection and thrown into the trash.

All staff educated by 8/17/25 regarding the safety and importance of regulation 103e - Left Overs, How to identify and properly handle, label and store leftover food to preserve food safety in the facility.

All kitchenettes, kitchen and storage areas have been fully audited by [redacted] and found to be in compliance as of 7/18/25

Moving Forward:

Kitchen staff have been provided labels for usage when leftover food is present.

All areas will be randomly audited daily times 1 month, then weekly times 3 months for full compliance by either myself [redacted] or [redacted] with a start date of 8/11/25. [redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach training, audits

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

103g - Storing Food

8. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 9:32 a.m the dry storage area in the kitchen contained an unsealed 1-gallon zip lock bag of what appeared to be Saltine crackers.

Repeat violation: 8/13/24

Plan of Correction ***Accept [redacted] 08/25/2025)***

Corrected at time of inspection and thrown into the trash.

All staff educated by 8/17/25 regarding the safety and importance of regulation 103g - Storing Food.

103g - Storing Food (continued)

Kitchen, dry storage and refrigerator/freezer room have been fully audited and found to be in compliance as of 7/18/25

Moving Forward:

All areas will be randomly audited daily times 1 month, then weekly times 3 months for full compliance by either myself [redacted] *with a start date of 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach training, audits

Evidence of Completion ***Implemented*** [redacted] ***- 09/22/2025)***

See attached.

103i - Outdated Food

9. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 9:30 a.m. the kitchen dry storage area of the home contained a dented can of 48 oz College Inn Beef Broth.

Repeat violation: 10/29/24

Plan of Correction ***Accept*** [redacted] ***- 08/25/2025)***

Corrected at time of inspection and thrown into the trash.

All staff educated by 8/17/25 regarding the safety and importance of regulation 103i Outdated food. How to identify and properly handle, label and store food to preserve food safety in the facility.

Kitchen, dry storage and refrigerator/freezer room have been fully audited by [redacted] *and found to be in compliance as of 7/18/25*

Moving Forward:

All orders will be inspected by head cook on delivery day with an emphasis on dented cans are not to be stocked on shelf and not to be used. All areas will be randomly audited in the following days after delivery times 1 month, then weekly, following delivery days times 3 months for full compliance by either myself [redacted] *or* [redacted] *with a start date of 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

103i - Outdated Food (continued)

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach training, audits

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

141a 1-10 Medical Evaluation Information

10. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluation dated [redacted]/25 did not include the resident's height or weight.

Repeat violation: 10/29/24, 8/13/24

Plan of Correction ***Accept [redacted] - 08/25/2025)***

Senior Life nursing and social worker were made aware of the error and the importance of making sure all blocks are filled in with current information on DME.

All DME's were audited 7/18/25 by [redacted] and found to be in compliance.

[redacted] was educated [redacted] of the Nazareth Alexandria Manor of the importance of regulation 141a 1-10 Medical Evaluation Information.

Moving Forward:

All DME's will be audited when they arrive to facility by [redacted] to verify all required information is filled in and meets full compliance starting 8/11/25. [redacted]

141a 1-10 Medical Evaluation Information (continued)

[redacted] *will places copies of new, updated or yearly DME's when they become available in secondary DME binder and* [redacted] *will maintain original copy in resident file.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Evidence of Completion ***Implemented [redacted]/22/2025)***

See attached.

141b1 - Annual Medical Evaluation

11. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The home was unable to provide any prior or an updated medical evaluation for resident #3 who was admitted to the home on [redacted]/06.

The home was unable to provide any prior or an updated medical evaluation for resident #4 who was admitted to the home on [redacted]/22.

Plan of Correction ***Accept [redacted] - 08/25/2025)***

All DME's were audited 7/18/25 by [redacted] *found to be in compliance.*

DME's for resident #3 and resident #4 were completed on 7/22/25 by physician.

[redacted] *of the Nazareth Alexandria Manor of the importance of regulation 141b1 - Annual Medical Evaluation on 8/1/25*

Moving Forward:

No DME's will be removed from resident files regardless of timeframe or how far back in years they go in prevention of removing current information. [redacted] *will places copies of new, updated or yearly DME's when they become available in secondary DME binder starting 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Update: *08/25/2025*

Please attach updated DME's

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

185a - Implement Storage Procedures

12. 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

The glucometer for Resident #5 displayed a blood glucose reading of 244 on 7/17/25 at 6:00 a.m. A blood glucose reading of 263 was documented on the resident's Medication Administration Record for that date and time.

Repeat violation: 10/29/24

Plan of Correction ***Accept [redacted] - 08/25/2025)***

All blood glucose machine were audited 7/18/25 by [redacted] and found to be in compliance.

Staff member responsible for error was written up and All Medtech's were educated by 8/17/25 on the importance of proper documentation and transfer of numbers from blood glucose machine to computer MAR.

Moving Forward:

All blood glucose machines will be audited weekly times 6 months for full compliance by [redacted] with a start date of 8/11/25. [redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach warning to employee, audits

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.

227c - Support Plan Revision

13. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1's assessment and support plan dated [redacted]/25 lists personal care needs as maintaining hygiene including brushing hair, giving baths, clipping nails, etc. The resident reports only receiving bed bath wipe downs over the last 30 days. The plan does not designate the specific type of bath, and the resident is requesting regular showers with the assistance of staff in a shower chair.

Plan of Correction ***Do Not Accept [redacted] - 08/25/2025)***

Regular shower with shower chair was given on Monday July 21, 2025. Regular shower days are Wednesday and Saturdays of each week.

Resident#1 was educated on 7/21/25 regarding the importance of regular in shower room showering.

227c - Support Plan Revision (continued)

Since day of inspections 7/17/25, resident #1 has had the opportunity for 8 regular showers with shower chair and has refused all except initial regular shower on 7/21/25. Shower refusals forms attached. [redacted]
had a conversation with resident#1 to try and find out why [redacted] *refuses* [redacted] *showers, if* [redacted] *wanted a different day/time. Resident stated that sometimes* [redacted] *is tired, doesn't feel good, sometimes the shower makes* [redacted] *extra tired and* [redacted] *just doesn't want it.*

PCA/Med techs have been educated on the importance of proper showering hygiene and educated on shower refusals with proper documentation and making admin Jacqueline Burns or assistant to [redacted] *aware of refusals.*

Moving Forward:

Resident #1's RASP/support plan has been updated to reflect bed baths as the specific type of bath. Regular showers with shower chair will still be offered and encouraged with proper documentation follow up when refused. Showers will be audited weekly times 6 months for full compliance by either myself [redacted] *with a start date of 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please address long-term compliance will all support plans that will need to be updated, not just specific to the resident.

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.

What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

227c - Support Plan Revision *(continued)*

Plan of Correction ***Accepted (09/02/2025)***

All RASP's/support plans have been audited as of [redacted]/25 by [redacted]. All are found to be in compliance as of 8/25/25.

All incoming staff will meet with exiting staff to go over the shift, daily shift reports will be completed/updated by Medtech's with all information from shift. [redacted] will audit shift reports the following day to maintain up to date information regarding any kind of status changes where updates to RASP/support plans are needed.

Weekly meetings will take place with kitchen staff, PCA's, medtechs and administrator to audit and follow up on any resident changes to ensure all information is properly documented in RASP/support plan.

[redacted] *is responsible for full ongoing compliance.*

Resident #1 received a regular shower with shower chair was given on Monday July 21, 2025. Regular shower days are Wednesday and Saturdays of each week.

Resident#1 was educated on 7/21/25 regarding the importance of regular in shower room showering.

Since day of inspections 7/17/25, resident #1 has had the opportunity for 8 regular showers with shower chair and has refused all except initial regular shower on 7/21/25. Shower refusals forms attached. [redacted]

had a conversation with resident#1 to try and find out why s[redacted] refuses [redacted] showers, if [redacted] wanted a different day/time. Resident stated that sometimes [redacted] is tired, doesn't feel good, sometimes the shower makes[redacted] extra tired and [redacted] just doesn't want it.

PCA/Med techs have been educated on the importance of proper showering hygiene and educated on shower refusals with proper documentation and making admin Jacqueline Burns or assistant to admin/ designee aware of refusals.

Moving Forward:

Resident #1's RASP/support plan has been updated to reflect bed baths as the specific type of bath. Regular showers with shower chair will still be offered and encouraged with proper documentation follow up when refused. Showers will be audited weekly times 6 months for full compliance by either myself [redacted] *or assistant to* [redacted] *with a start date of 8/11/25.* [redacted] *is responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *08/28/2025*

Update: *09/02/2025*

Please attach updated support plan

Evidence of Completion ***Implemented ([redacted] - 09/22/2025)***

See attached.

227h - Support Plan Refuse Sign

14. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #4 participated in the development of [redacted]r support plan on 4/24/25. The resident refused to sign the support plan. The home did not make a notation regarding the resident refusing to sign.

Plan of Correction ***Accept [redacted] - 08/25/2025)***

RASP/Support plan does include documentation that the resident refused and that the [redacted]) was made aware on 4/22/25

All RASP/support plans were audited by 8/15/25 by [redacted] and [redacted] ensure full compliance with regulation 227h.

[redacted] and [redacted] have been educated on the importance of regulation 227h - Support Plan Refuse Sign with the understanding of the need for clear documentation that states the resident refused and [redacted] was notified.

Moving Forward:

All resident refusals to sign their RASP/Support plan will be documented in chart notes in MAR's along with a note indicating the reason why the resident refused to sign with the time and date the[redacted] or family was notified and by which staff contacted the poa/family .
All efforts will be made to understand the reason for the resident refusal and to try to remedy any known issues and address them so the resident does sign the plan. However, the resident does have the right to refuse and it is the staff's responsibility to ensure documentation of that refusal.

Assistant to[redacted] will audit all new, yearly or significate change RASP/support plans as they become available starting 8/11/25.[redacted] is responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Update: *08/25/2025*

Please attach updated support plan

Evidence of Completion ***Implemented [redacted] - 09/22/2025)***

See attached.