

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

October 14, 2025

[REDACTED] OPERATIONS ASSISTANT
COLUMBIA HANOVER OPCO, LLC
[REDACTED]
[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 07/16/2025, 07/23/2025 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: *THE VERO AT BETHLEHEM* License #: *23163* License Expiration: *08/15/2025*
 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 Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *177* Waking Staff: *133*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint, Incident* Exit Conference Date: *07/23/2025*

Inspection Dates and Department Representative

07/16/2025 - On-Site: [REDACTED]
 07/23/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *140* Residents Served: *139*

Secured Dementia Care Unit
 In Home: *Yes* Area: *n/a* Capacity: *36* Residents Served: *36*

Hospice
 Current Residents: *4*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *139*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *38* Have Physical Disability: *2*

Inspections / Reviews

07/16/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/23/2025*

09/08/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *10/02/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/15/2025*

Inspections / Reviews (*continued*)

09/16/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/02/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 09/26/2025

10/14/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/02/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

44g - Telephone Number

1. Requirements

2600.

44.g. The telephone number of the Department’s personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the secured dementia care unit in the home. .

Plan of Correction

Accept ([redacted] - 09/08/2025)

The required posting per regulation 2600.43g are posted outside the Memory Care Dining Room.

-On 7/17/2025, the telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline was posted in a conspicuous and public place in the secured dementia care unit in the home by the Administrator.

-By 8/29/2025, the Administrator shall educate the department managers on regulation 2600.44g. Documentation shall be kept.

-Beginning 9/1/2025, the administrator or designee shall weekly audit for required postings. This audit shall occur X 4 weeks, then monthly ongoing for 3 months.

- To ensure consistent adherence to Regulation 2600.44g, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.44g.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented ([redacted] - 10/01/2025)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A began working in the home on [redacted] The home did not request the staff Person's Pennsylvania State Police Criminal Background check until [redacted].

Plan of Correction

Accept ([redacted] - 09/08/2025)

- This regulation is important to protect the safety of the residents in our home. It is important to ensure the safety of our vulnerable residents. Background checks have consistently been done by the home with in the first 30 days of employment and have been checked annually by DHS inspectors.

-Starting 8/15/2024 and going forward background checks will be done by Administrator or designee prior to first day of employment.

-Administrator audited all employee files from last 6 months on 8/16/25 to ensure all files had a background check.

51 - Criminal Background Check (continued)

-By 8/29/2025, the administrator shall educate the Business Office Manager on regulation 2600.51. Documentation shall be kept.

- Beginning 9/1/2025, the administrator will continue to monitor for ongoing compliance by checking new hire files prior to filing.

-To ensure consistent adherence to Regulation 2600.51, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.51.

Licensee's Proposed Overall Completion Date: 08/29/2025

Implemented () - 10/01/2025

82c - Locking Poisonous Materials**3. 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

Eczema Care, with a manufacturers label indicating "if swallowed get help or contact a poison control center right away," Colgate Total Toothpaste with a manufacturers label indicating "If more than is used for brushing is accidentally swallowed, get medical help or contact a Poison Control center right away", Lotrimin with a manufacturers label indicting " If product is swallowed, get medical help or contact a Poison Control Center right away", and roll on antiperspirant with a manufacturers label indicating ""if accidentally swallowed get medical help or contact a Poison Control Center right away", were unlocked, unattended, and accessible in the unlocked bathroom cabinet of apartment #15. Peridontax with a manufacturers label indicating "If more than is used for brushing is swallowed get help or contact a Poison Control Center right away". was found unlocked, unattended and accessible in the bathroom of apartment #1. Not all the residents of the home, including the residents residing in apartment #15 and apartment #1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept () - 09/08/2025

-This regulation is important to protect the safety of the residents in our home. It is important to ensure the safety of our vulnerable residents. Immediately following the inspectors walk through on 7/16/25 the noted poisonous materials were removed and locked in coordination with the regulation by the Assistant Health Care Director.

--By 9/5/2025, the Healthcare Director shall educate current staff on regulation 2600.82c, documentation shall be kept.

-Beginning 9/2/2025, the Assistant Health Care Director will conduct bi-weekly audits for 3 months to ensure regulation compliance.

-To ensure consistent adherence to Regulation 2600.82c, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.82c.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented () - 10/01/2025

101j7 - Lighting/Operable Lamp

4. 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

Resident #1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/16/25, the Maintenance Director placed an operable lamp by resident 1's bedside.

-By 9/19/20, the administrator shall educate current associates on regulation 2600.101j7, documentation shall be kept.

-By 9/5/2025, the administrator or designee shall audit resident bedrooms for an operable lamp by the bedside. Any further findings shall be corrected at time of audit.

-Beginning 9/8/2025, the administrator or designee shall audit 10 resident bedrooms weekly X 4 weeks for an operable lamp.

-To ensure consistent adherence to Regulation 2600.101j7, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.101j7.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/01/2025)

103g - Storing Food

5. Requirements

2600.

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

Description of Violation

On 7/16/25 at approximately 4:00 p.m., the ice cream in the kitchen's ice cream freezer was opened and unsealed.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/17/25, The Dining Services Manager ordered FDA approved plastic cover ice cream lids, lids received on 7/28/2025 and placed on ice cream containers by the Dining Services Manager.

-By 9/5/2025, the Dining Services Manager shall educate dining associates on regulation 2600.103g, documentation shall be kept.

-Beginning 8/25/2025, the Dining Services Manager or designee shall perform a weekly audit X 4 weeks of the ice cream containers.

-To ensure consistent adherence to Regulation 2600.103g, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.103g.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/01/2025)

123b - Emergency Procedures Posted

6. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (█) - 09/08/2025)

-This regulation is important to protect the safety of the residents in our home. It is important to ensure the safety of our residents. The home's emergency procedures are located in the living room of the home. As per the inspector's recommendation, on 8/15/25 the Administrator placed a sign at the receptionist desk stating where the home's emergency procedures can be located.

-By 8/29/2025, the administrator shall educate the department managers on regulation 2600.123b, documentation shall be kept.

-Beginning 9/2/2025, on a weekly basis, the administrator or designee shall audit the placement of the sign and the Emergency procedures.

-To ensure consistent adherence to Regulation 2600.123b, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.123b.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/01/2025)

132g - Fire Drills Days/Times**7. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills in the afternoon hours as evidenced by the following drills: The fire drills conducted on 3/22/25, 4/11/25, 5/20/25 and 6/7/25 were all held between the hours of 1:35 p.m. and 3:03 p.m.

Plan of Correction

Accept (█) - 09/16/2025)

-Unable to correct previous fire drill times.

-By 8/29/2025, the administrator shall educate the Maintenance Director on regulation 2600.132g, documentation shall be kept.

-On 9/12/2025, the Maintenance Director held the fire drill at 11:05am. Documentation shall be kept.

-Beginning 9/1/2025, the administrator shall review fire drill records within 24hours of drill and prior to filing.

-To ensure consistent adherence to Regulation 2600.132g, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.132g.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented (█) - 10/01/2025)

171b5 - First Aid Kit

8. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the home's vehicle used to transport residents does not include thermometer.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/18/2025, the Health Care Director replenished the vehicle's first aid kit with a thermometer.

-On 7/18/2025, the Health Care Director audited the remaining first aid kits for required items, any further findings corrected at time of audit.

-By 9/19/2025, the administrator or designee shall educate the health and wellness staff on regulation 2600.171b5, documentation shall be kept.

-Beginning 9/2/2025, the Health Care Director shall audit the first aid kits weekly X 4 weeks, then monthly ongoing for required items.

-To ensure consistent adherence to Regulation 2600.171b5, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.171b5.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/01/2025)

181f - Record of Medication**9. Requirements**

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

Resident #2 has been assessed to self-administer medications. Resident #2's record did not include a current list of medications. The list in the resident's record did not include Systane Eye Drops and Fluticasone Nasal Spray which were found in the resident's room on the morning of 7/16/25.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/17/2025, the Healthcare Director confirmed current medications with resident 2 and resident 2's physician, the medication record was updated to reflect current physician orders.

-By 9/5/2025, the Healthcare Director shall audit remaining medication records of residents who self-administer medications to ensure medication records are current. Any further findings shall be corrected at time of audit.

-By 9/5/2025, the Healthcare Director shall educate associates who administer medications on regulation 2600.181f, documentation shall be kept.

-Beginning 9/8/2025, the Healthcare Director or designee shall audit self-administration medication records monthly to ensure changes in physician orders are captured.

-To ensure consistent adherence to Regulation 2600.181f, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.181f.

Licensee's Proposed Overall Completion Date: 09/26/2025

181f - Record of Medication (*continued*)

Implemented (█) - 10/01/2025)

190b - Insulin Injections

10. Requirements

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff Person C last received diabetic training on █. The staff member administered insulin to Resident #3 on the following dates and times:

Lispro 100 unit/ml kwikpen sliding scale: 6/1, 6/10, 6/15, 7/8 at 8:00 a.m.

Lispro 100 unit/ml kwikpen straight order: 6/1, 6/10, 6/15, 7/8, 8:00 a.m.

Lantus Solostar 100 units/ml pen: 6/1, 6/10, 6/15, 7/8 8:00 a.m.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/24/2025, staff person C was removed from insulin administration duties.

-By 9/15/2025, staff person C shall complete a Department approved diabetes patient education program.

-By 9/8/2025, the Healthcare Director shall audit remaining medication technician training files, any associates in need of training shall be removed from insulin administration duties and shall have training by 10/1/2025.

-By 9/2/2025, the administrator shall educate the Healthcare Director and Assistant Healthcare Director on regulation 2600.190b, documentation shall be kept.

-Beginning 9/2/2025, the Healthcare Director or designee shall perform monthly audits of medication technician training files.

-To ensure consistent adherence to Regulation 2600.190b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.190b.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/14/2025)

190c - Record of Training

11. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Person D does not include the signature of the staff member, or if the staff member was requalified to pass medications in the home for the annual practicum.

Plan of Correction

Accept (█) - 09/08/2025)

-On 7/24/2025, the Healthcare Director/medication administration trainer reviewed staff person D's training records, records were corrected to reflect passing of the annual practicum and also the staff member's signature.

190c - Record of Training (continued)

-By 8/29/2025, the Healthcare Director/medication administration trainer shall review current medication technician's training records for thoroughness and completeness. Any further findings to be corrected at time of audit.

-By 8/29/2025, the administrator shall educate the Healthcare Director and Assistant Healthcare Director on regulation 2600.190, documentation shall be kept.

-Beginning 9/2/2025, the Healthcare Director or designee shall perform monthly audits of medication technician training files.

-To ensure consistent adherence to Regulation 2600.190c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.190c.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/14/2025

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 directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit and by exit door near room 10 and outside in the Secure Dementia Care Unit on the gate door in the patio.

Repeat Violation 5/8/24 et al.

Plan of Correction

Accept (█) - 09/08/2025

-On 7/24/2025, the directions for operating the home's locking mechanism were posted near the door to the Dementia Care Unit, by the exit door near room 10 and outside the SDCU by the gate door in the patio by the Administrator.

-By 8/29/2025, The Assistant Healthcare Director shall audit the remaining secure doors for proper posting of operating the locking mechanism, any further findings shall be corrected at time of audit.

-By 9/25/2025, the administrator shall educate current staff on regulation 2600.233c, documentation shall be kept.

-Beginning 9/2/2025, on a weekly basis, the administrator or designee shall audit secure doors for proper posting of directions of operating the locking mechanisms.

-To ensure consistent adherence to Regulation 2600.233c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 9/25/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability. The quality management review shall include a review of all items specified in 2600.233c.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented (█) - 10/14/2025