pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE ATRIUM OF ALLENTOWN LLC**
LEGAL ENTITY

To operate **THE ATRIUM OF ALLENTOWN**
NAME OF FACILITY OR AGENCY

Located at **5767 CETRONIA ROAD, ALLENTOWN, PA 18106**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **103** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 30**

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 **April 11,** **2025** until **October 11,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **230501**

ISSUING OFFICER

Juliet Marsala
ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via Email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 11, 2025

[redacted]
Partner
The Atrium of Allentown LLC
[redacted]

RE: The Atrium of Allentown
5767 Cetronia Road
Allentown PA 18106
License # 23050

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 20, 2024, November 21, 2024, January 28, 2025 and January 29, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 23050) dated December 9, 2024 to December 9, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. Additionally, your license dated December 9, 2024 to December 9, 2025 is REVOKED. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated December 9, 2024 to December 9, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 11, 2025 to October 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with Choose an item., must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department

of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE ATRIUM OF ALLENTOWN* **License #:** *23050* **License Expiration:** *12/09/2025*

Address: *5767 CETRONIA ROAD, ALLENTOWN, PA 18106*

County: *LEHIGH* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *THE ATRIUM OF ALLENTOWN LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *10/02/2020* **Issued By:** *upper macungie township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *112* **Waking Staff:** *84*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *11/21/2024*

Inspection Dates and Department Representative

11/20/2024 - On-Site: [redacted]

11/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served:** *82*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *N/A* **Capacity:** *30* **Residents Served:** *25*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *82*

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

Have Mobility Need: *30* **Have Physical Disability:** *0*

Inspections / Reviews

11/20/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/21/2024*

01/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/13/2025*

01/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/27/2025*

03/24/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The licensing inspection summaries (LIS) dated 8/28/24, 6/5/24, 2/15/24, and 12/6/23 were not posted in a public conspicuous area of the home. (Day 1 - 11/20/24)

The 55 PA Code Chapter 2600 regulations were not posted in a public conspicuous area of the home. (Day 1 - 11/20/24)

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

On 11/21/2024 immediately following the inspection the regulations book was moved to the lobby area and placed on display in accordance with the DHS regulations 2600.3.c. At the next annual quality management plan meeting scheduled for February the committee will review the process of the building walk-throughs to ensure that the book and other required items are posted and maintained. The Executive Director or Designee will be responsible for on going compliance.

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented ([redacted] - 01/31/2025)

16c - Written Incident Report

2. 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

Resident #1 did not receive the prescribed 8am medications on 11/15/24. The home did not submit an incident report to the Department regarding the medication error. (Day 2 - 11/21/24)

Repeat violation: 6/5/24

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/22/2024 The Executive Director reported the medication error to BHSL. On 12/05/24. On 11/23/24 the Regional Director provided an education to the Executive Director on 2600.16c and the internal reporting procedure to ensure ongoing compliance. On 12/16/2024 The Executive Director held a education with all medication associated on assuring all residents receive their medication and what results in a reportable incident The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Not Implemented ([redacted] - 03/06/2025)

16d - Final Incident Report

3. Requirements

2600.

16d - Final Incident Report *(continued)*

16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On 10/28/24 at 9:00am, Resident #2 had an unwitnessed fall and the resident was taken to the hospital, the home submitted an initial incident report on 10/28/24 at 5:58pm. The home did not submit a final report to the Department. (Day 2 - 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/21/2024 immediately following the inspection, the Executive Director submitted the final report for Resident # 2. On 11/22/24 the Regional Director completed a training with the new Executive Director on the DHS regulation 2600.16.d and the internal reporting procedures to ensure ongoing compliance. The Executive Director held a education on 01/10/2025 with the Director of Wellness, Wellness Coordinator and Memory Care Coordinator on 2600.16d The Executive Director and Director of Wellness will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

17 - Record Confidentiality

4. 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 9:55am the Electronic Medication Administration Records (EMAR's) on the upper-level medication cart by room 226 was unlocked, and unattended. The narcotic count book was also located on top of the medication cart unlocked and unattended. The EMAR's and narcotic count book contain confidential information of the residents. (Day 1 - 11/20/24)

At approximately 10:24am, the Secured Dementia Care (SDCU) medication cart near room 117 had a narcotic count book unlocked and unattended on top of the medication cart. The narcotic count book contains confidential information of the residents.
(Day 1 - 11/20/24)

Repeat Violation: 12/6/23 et al

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/24 while inspectors on site the narcotic book was put away in order to secure resident confidentiality. The Executive director did a reeducation on 12/16/2024 and retraining with medication associates on the policy and procedure on maintaining confidentially and protecting resident records to as it relates to 2600.17. As of 01/30/25 a new procedure will be in place that requires the Director of Nursing to complete daily walk throughs and spontaneous checks to ensure ongoing compliance. On or before 01/30/25 the new Director of Wellness will be

17 - Record Confidentiality (continued)

educated on this daily procedure and expectation. The Executive Director and Director of Wellness will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/30/2025*

Implemented (- 01/31/2025)

25c10 - Advance Notice

5. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
10. A statement that the resident is entitled to at least 30 days' advance notice, in writing, of the home's request to change the contract.

Description of Violation

An interview with Regional Director A indicated that the home does not handle any of the residents personal finances since February or March of 2024. At this time the contract was changed, the home did not give the residents a 30 day notice of the contract change. (Day 1 - 11/20/24)

Plan of Correction ***Accept (- 01/06/2025)***

On 12/05/2024 The Executive Director sent a letter to residents and families informing them of a new policy that the home will no longer manage resident finances and that in accordance with personal care home regulations. We are providing them a 30 day notice of the policy change The Executive Director will educate all activities staff on the new policy. As of 01/05/2025 if a resident needs assistance with making purchases for leisure or for necessities the home may purchase the item on behalf of the resident in accordance with the policy charge back only if permission is granted in advance by the resident Power of Attorney or designated responsible person. The Executive Director and Activities Director will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented (- 01/31/2025)

28e - Death of a Resident

6. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #3 passed away in the home. The financial accounting summary for the month of indicated a payment of $4850.00 for the resident's room and board and for medication administration fees. The family of resident #3 cleared the room of the resident's belongings on The total refund required to be issued to the resident's family was $2340.00 based on a refund for days in The amount of the refund that was issued by the home was $2190.37 on . (Day 2 - 11/21/24)

28e - Death of a Resident (continued)

Plan of Correction ***Accept (- 01/17/2025)***

On 11/21/2024 following the inspection the Executive Director requested a new check to be issued in the amount $149.63 for the difference that is owed. On 11/23/2024 a form has now been implemented by the Executive Director on discharging residents that is submitted to billing for accuracy. On 11/23/2024 there will be a new process in place for that requires the Executive Director to check refunds amount in discharged resident records to ensure ongoing compliance. The Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented (- 01/31/2025)

51 - Criminal Background Check

7. 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

The Administrator's hire date was [redacted] the Pennsylvania State Police Criminal Background check was not completed until 11-20-24. (Day 1 - 11-20-24)

Repeat Violation: 12/6/23 et al

Plan of Correction ***Accept (- 01/17/2025)***

On 11/20/2024, while inspectors on site, the Executive Director's Criminal History Check was run. By 12/15/2024 a new policy and procedure will be implemented into the community regarding the hiring process specific to an Executive Director that will include the Regional Director or Home Office Designee to be responsible to run the Criminal Background check for all new Executive Directors prior to their first date of hire. The Executive Director will be responsible for completing all other criminal background checks on new hires prior to their onboarding day The Regional Director or home office Designee and Executive will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented (- 01/31/2025)

54a - Direct Care Staff

8. 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 member B hired [redacted] has a high school diploma from [redacted]. The home did not submit a waiver to the Department regarding the non US diploma. (Day 1 - 11/20/24)

54a - Direct Care Staff *(continued)*

Plan of Correction ***Accept (- 01/16/2025)***

On 11/21/2024 Staff person B was removed from providing direct care. Staff person B will not be permitted to work as a direct caregiver unless and until staff person B meets the DHS educational requirement. In the Interim Staff person B will be retained as an Environmental Service Associate. On 11/23/2024 the regional director provided training to the Executive Director to review regulation 2600.54.a and the internal hiring process. On or before 01/30/25, the Executive Director will conduct an audit of all employee files to ensure compliance with the regulation 2600.54.a. The Executive Director or designee will be responsible to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/30/2025*

Implemented (- 01/31/2025)

57d - Waking Hours

9. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 11/10/24 the home served 79 residents 30 of which have mobility needs. The home is required to have 81.75 hours of direct care staffing hours available from 7am-11pm. Only 75 hours were available on 11/10/24 from 7a-11pm. (Day 1 - 11/20/24)

Plan of Correction ***Accept (- 01/16/2025)***

On 11/22/2024 The Executive Director, Wellness Coordinator and Director Wellness was educated by the Regional Director on the minimal staff requirements based on the regulations 2600.57.d. which includes how to properly calculate staffing for changes in mobility. On 11/22/2024 the Executive Director reviewed all the staff schedules for the next month to ensure adequate staffing is maintained on all shifts in accordance with 2600.57. d. As of 12/30/24 a new Director of Nursing was hired, and she was also trained on the staffing requirements on 01/07/25 to ensure ongoing compliance. The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented (- 01/31/2025)

63a - First Aid/CPR Training

10. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 11/8/24 the home served 77 residents and are required to have 2 persons certified in First Aid and CPR at all times. From 7am-3pm only one person was certified in First Aid and CPR. From 11pm-7am only one person was certified in First Aid. (Day 1 - 11/20/24)

On 11/9/24 the home served 78 residents and are required to have 2 persons certified in First Aid and CPR at all

63a - First Aid/CPR Training (continued)

times. From 11pm-7am only one person was certified in CPR and no one was certified in First Aid. (Day 1 - 11/20/24)

On 11/10/24 the home served 79 residents and are required to have 2 persons certified in First Aid and CPR at all times. From 7am-3pm and 11pm-7am only one person was certified in First Aid and CPR. (Day 1 - 11/20/24)

Repeat Violation: 12/6/23 et al

Plan of Correction ***Accept (- 01/16/2025)***

On December 13, 2024, A CPR & First Aid class was held to ensure that an adequate number of staff are CPR and First Aid certified to meet the scheduling needs in accordance with regulations 2600.63.a. As of 11/24/25 The Director of Wellness and Wellness Coordinator will submit bi-weekly schedules to the Executive Director in advance identifying adequate staff certified in CPR and First Aid on each shift. As of 11/24/25, the Executive Director or Director of Wellness will be responsible to review schedules bi-weekly in advance to ensure ongoing compliance. The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented (- 01/31/2025)

65a - FS Orientation 1st Day

11. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.

Description of Violation

Direct care staff member C whose first day of work was , did not receive 1st day fire safety orientation. (Day 1 - 11/20/24)

Direct care staff member D whose first day of work was , did not receive 1st day fire safety orientation. (Day 1 - 11/20/24)

Plan of Correction ***Accept (- 01/16/2025)***

11/20/2024 following the inspection the Regional Maintenance Director held a fire safety training on 11/22/2024 with Staff Member C and Staff Member D and on 11/22/24 the Regional Director held a fire Safety training with all staff to ensure compliance. All new hires since 11/22/24 have completed fire safety training. This will be reviewed in the next annual quality plan review. The Executive Director will be responsible for ongoing compliance.

65a - FS Orientation 1st Day *(continued)*

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

81b - Resident Personal Equipment

12. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2 has an enabler bar attached to a board which slides between the mattress and the bed frame of the resident's bed. The enabler bar was not securely attached to the bed frame to prevent the bar from sliding and creating a gap between the bed and the bar. The gap creates a possible limb or head entrapment. (Day 2 - 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

On 11/21/2024 immediately following the inspection the Maintenance Director ensured the enabler bar in the resident's 2 room was properly secured. On 12/13/2024 The Executive Director will have a training with all Direct Care Staff and the Maintenance Director that when making daily shift rounds they should check all enablers to assure they are secure to the residents bed. This task will be noted on the residents task sheet for any applicable resident. Direct Care Staff will be required to report immediately to the Director of Wellness, Executive Director and Maintenance Director any issues with the bed enablers and will be expected to complete a work order to document report. The Maintenance Director or designee will be required to immediately secure the enabler or address any concerns.

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented ([redacted] - 01/31/2025)

85a - Sanitary Conditions

13. Requirements

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

Description of Violation

A cardboard box containing cartons of ready-made scrambled eggs was observed in the refrigerator of the home's kitchen. The box was caked with dried, liquid scrambled egg mixture that had leaked and spilled out on the bottom of the cardboard box. (Day 2 - 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 immediately following the inspection the Dining Director disposed of the egg carton that was unsanitary. On 11/26/24 the Executive Director and Dining Director did education with all dining and kitchen staff on regulation 2600.85.a on sanitary conditions shall be maintained. On 12/15/24 a new procedure was put in place for the Dining Director or designee to complete daily walk throughs of all storage areas to ensure all food is properly stored, labelled and in accordance with 2600.85a to ensure ongoing compliance. The Executive Director, Dining Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

85a - Sanitary Conditions *(continued)*

Not Implemented ([redacted] - 01/31/2025)

88a - Surfaces

14. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

A large puddle of water was noted on the floor to the left of the hot water heater in the mechanical room in the basement. (Day 1 - 11/20/24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/22/24 following the inspection the Maintenance Director corrected the condensation issue that cause the puddle of water. On 11/25/2024 the new Regional Director of Maintenance will have a new procedure to complete daily physical site rounds to the boiler room and to the other mechanical rooms to ensure all systems are properly working and in good repair and clean. The Moving forward, Executive Director and Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 01/31/2025)

89b - Hot Water Temperature

15. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The temperature of the hot water in the bathroom of room 219 measured 134°F. The temperature of the hot water in the bathroom of room 220 measured 131°F. (Day 2 - 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 Immediately following the inspection the Regional Maintenance Director adjusted the temperature for Room 219 and 220 to meet safe guidelines in accordance with 260089b. On Dec 5, 2024, the Maintenance Director did an audit on rooms for water temperatures and corrected temperatures in other rooms that were found to be deficient. As of 01/01/25 a new procedure will be in place for the Maintenance Director to check randomly 10% of rooms monthly to ensure adequate temperature is maintained. The Maintenance Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/13/2025

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

103e - Left Overs

16. Requirements

103e - Left Overs *(continued)*

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

In the refrigerator located in the home's kitchen, the following food items were found stored with no label to indicate the contents or the date the items were stored in the refrigerator: A block of sliced cheese wrapped in plastic wrap, a metal container of mayonnaise, and a metal container of mashed sweet potatoes. (Day 2- 11/21/24)

In the freezer located in the home's kitchen, the following food items were found stored with no label to indicate the contents or the date the items were stored in the freezer: A bag of frozen, breaded chicken balls, and two plastic bags of frozen French fries. (Day 2- 11/21/24)

Repeat Violation: 12/6/23 et al

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

11/21/2024 immediately following the inspection the dining director disposed of the unlabeled and improperly stored food. On 11/26/25 the Executive Director did an education with the Dining Director, dining staff and kitchen staff on DHS regulations 2600.103.e. On or before 12/15/25 a new procedure will be place requiring the Dining Director to complete daily walk throughs of all food storage areas to ensure ongoing compliance. The Executive Director, Dining Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

105g - Lint Removal and Duct Cleaning

17. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The dryer vents exiting the building from the 2nd floor above the SDCU, had a buildup of lint on the vent that exits the building, causing a possible fire hazard. (Day 1- 11-20-24)

Repeat Violation: 2/15/24, 12/6/23 et al

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

11/20/2024 while inspectors on site, the Regional Maintenance Director cleared the vent that had buildup of lint. On 11/20/25 the Maintenance Director was educated on 2600.105g by the Executive Director. On or before 11/25/24 a new Policy and Procedure will be place for the Maintenance to complete daily physical site walk throughs that include checking all the dryer vents. Moving forward the Executive Director, Maintenance Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 01/31/2025)

107b - Emergency Procedures

18. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include any of the required content under this regulation. (Day 2 -11/21/24)

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

On 11/21/2024 following the inspection the Executive Director. updated the Emergency Preparedness Plan with specific policies related to the Atrium of Allentown. On 11/21/2024 the book was placed in a conspicuous area for staff access. On before 12/30/2024 there will be training done by the Executive director with all staff to review the policies and location of the Emergency Plan Binder. The Executive Director will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented ([redacted] - 01/31/2025)

107d - Procedure Emergency Management Agency Submission

19. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the home's local emergency management agency in Upper Macungie Twp. The home has no documentation that their written emergency procedures was submitted. (Day 2 - 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/26/2024 The Executive Director submitted our emergency management plan to the Upper Macungie Twp Emergency Management Manager. On 12/09/24 the Emergency Management Township Manager accepted the emergency plan.
This will be reviewed annually during the annual Quality Plan review process in order to ensure ongoing

107d - Procedure Emergency Management Agency Submission (continued)

compliance. Moving forward the Executive Director or designee will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

121a - Unobstructed Egress

20. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit to the outside of the building in stairwell 3 had an 8-inch round by approximately 6 inch high piece of cut metal pipe in front of the door, preventing immediate egress in the event of an emergency. (Day 1 - 11-20-24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/20/2024 while inspectors on site the Maintenance Director removed the metal pipe from the door. On or before 11/25/2024 there will be a new procedure for the Maintenance Director that will require daily walk throughs to ensure we are in compliance with regulation 2600.121.a. The Executive Director and Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 01/31/2025)

123b - Emergency Procedures Posted

21. 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 and the local municipalities are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 following the inspection the Executive Director the emergency procedures were posted in a conspicuous and public place. As of 11/22/24 the Executive Director will have a new procedure to adhere to that to complete a daily check on the Emergency Procedure book and other required documents and posting under 2600.123b as well as other regulations that require items to be posted. The Executive Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

132c - Fire Drill Records

22. Requirements

2600.

132c - Fire Drill Records *(continued)*

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill logs do not indicate how many staff participated in the fire drill conducted on 4-17-24 at 12:44pm. (Day 1 11-20-24)

Repeat Violation: 12/6/24 et al

Plan of Correction ***Accept (- 01/16/2025)***

On 11/20/2024 immediately following the inspection the Executive Director updated the fire log to reflect the number of staff participating in the fire drill on 04/17/24. The Executive Director entered into a contract with [redacted] Fire Safety Cooperation as of 01/01/25. [redacted] is a corporation that specializes in facilitating fire drills, training and maintaining the fire log. [redacted] will maintain the facilities fire log, drills and trainings in alignment with regulation 2600.132c. The Executive Director and Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented (- 01/31/2025)

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

Resident #2's most recent Documentation of Medical Evaluation (DME) was completed on [redacted] (Day 1 - 11-20-24)

Plan of Correction ***Accept (- 01/17/2025)***

On 11/20/2024 Following the inspection the Executive Director did a re-education with the Director of Nursing and the Wellness Coordinator on regulation 2600.141.b. On 12/6/2024 the Executive Director completed Residents 2 annual rasp. On or before 01/24/25 a resident DME's will be audited, and any noted deficiencies will be corrected. On 12/30/24 a new Director of Nursing was hired, and [redacted] was educated on 2600.141. and the current area of deficiency upon hire. As of 02/28/25 all DME's and RASPS will be uploaded into PCC in order to ensure better tracking and ongoing compliance. The Director of Nursing and Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented (- 01/31/2025)

162c - Menus Posted

24. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

A menu for the current week and the following week was not posted in the home. (Day 1 - 11/20/24)

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 following the inspection the Director of Dining reposted newly updated menus in the Dining room. On 11/22/2024 The Executive Director provided education to the Director of Dining. On 12/15/2024 all staff serving in the dining room will also be educated on regulation 2600.162.c to ensure that current menus are displayed at all times and are accessible to the residents. On 11/22/24 a new procedure will be in place for the Executive Director to complete daily walk site walk through to ensure all required items are posted. The Dining Director and Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Not Implemented ([redacted] - 01/31/2025)

183b - Meds and Syringes Locked

25. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 9:55am the upper-level medication cart by room 226 was unlocked, and unattended. (Day 1 - 11/20/24)

Repeat violation: 2/15/24, 12/6/24 et al

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/20/2024 While inspector was on site the medication cart was secured. On 11/20/2024 after the inspection the Medication Technician was counseled and retrained on the cart security and 183.b. regulation. On 12/16/2024 all medication techs received training on regulation 183.b. to ensure proper procedures are being followed. On 12/30/24 the new Director of Nursing was informed of this area of deficiency and will be observing staff daily and conducting spontaneous checks. Any areas of deficiency will result in immediate progressive disciplinary action in accordance with a new policy that will be affect as on or before 01/15/25. new daily procedure to ensure ongoing compliance. The Executive Director and the Director of Wellness will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented ([redacted] - 01/31/2025)

184a - Resident's Meds Labeled

26. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #4's Eliquis 5mg and Memantine Hydrochloride 10mg did not have a pharmacy label attached. (Day 2 - 11/21/24)

Plan of Correction ***Accept (- 01/16/2025)***

On 11/21/2024 following the inspection. The Director of Nursing put a new pharmacy label on Residents # 4 Eliquis. On 12/16/2024 The Executive Director did a education with all medication associates on regulations 2600.184.a. that all prescription medications shall be labeled with a pharmacy label. On or before 01/15/25 there will be a new procedure that will require the Director of Nursing or designee to complete weekly cart audits on all carts to ensure we are in compliance with regulations 2600.184.a. The Executive Director and Director of Nursing will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented (- 01/31/2025)

185a - Implement Storage Procedures

27. 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 homes policy is that the oncoming and off going staff person will count the narcotics and sign the narcotic master count sheet. On the following dates the staff members did not sign the sheet: oncoming staff on 11/14 and 11/20/24, off going staff member on 11/11, 11/13, 11/14, 11/17 and 11/19/24. (Day 2 - 11/21/24)

Plan of Correction ***Accept (- 01/16/2025)***

On 11/21/2024 and 11/22/24, following the inspection the Executive Director did a verbal immediate coaching and comprehensive retraining on 12/16/24 with all the medications associates on regulation 2600.185.a. On or before 01/15/25 a new procedure will be in place in which the new Director of Nursing or designee will do daily checks to ensure that the narcotic book is being signed and in compliance with regulation 2600.185.a. The procedure will require that any deficiencies result in a progressive disciplinary process for Medication Associates to ensure accountability, safety and ongoing compliance. The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Not Implemented (- 01/31/2025)

187c - Refusal of Medication

28. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #5 refused the prescribed lisinopril 10mg daily on 11/7/24, the prescriber was not notified regarding the refusal. (Day 2 - 11/21/24)

187c - Refusal of Medication (continued)

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 following the inspection the Executive Director did an education with DON on regulation 2600.187.a. On 11/21/24 the Director of Nursing notified the prescriber of the resident's refusal. On 12/16/25 the Executive Director completed an education to all Medication Associates that included refusal of medications as it pertains to 2600.187.c. As of 01/07/25 the new Director of Nursing put a procedure in place that requires each medication associate to complete a report at the conclusion of each shift that requires the Medication Associate to log any resident medication refusals and turn into the Wellness Coordinator for follow up steps that includes notification to the prescriber. On or before 01/20/25 all Medication Associates will receive and acknowledge education of the new procedures. The new procedure will ensure that prescribers are notified promptly of any refusals in order to ensure ongoing compliance. The Director of Nursing or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented ([redacted] - 01/31/2025)

187d - Follow Prescriber's Orders

29. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 did not receive the prescribed 8am medications on 11/15/24. (Day 2 - 11/21/24)

Resident #5 has an order for lisinopril 10mg once daily, hold for systolic blood pressure (SBP) less than 120. On 11/9/24 at 8am the SBP was 119/65, the medication was administered and should have been withheld. (Day 2 - 11/21/24)

Repeat Violation: 2/15/24, 12/6/23 et al

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

On 11/21/2024 following the inspection the Director of Nursing did a coaching and a reeducation with the respective medication associates on regulation 2600.187.d On 11/22/24 the Executive Director reported to BHSL the medication errors for resident's #1 and #5. On 12/16/24 the Executive Director held medication associate training that included following prescriber's orders. On or before 01/15/25 a new procedure will be in place in which the new Director of Nursing or designee will pull daily missed medication report and audit medications with parameters weekly to check for deficiencies. If any deficiencies are apparent the Director of Nursing will immediately apply an appropriate level of education and/or progressive disciplinary process for Medication Associates to ensure accountability, safety and ongoing compliance. The Executive Director and Director of Nursing will be responsible for ongoing compliance. The Director of Nursing or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented ([redacted] - 01/31/2025)

188b - Medication Error Reporting

30. Requirements

188b - Medication Error Reporting *(continued)*

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 did not receive the prescribed 8am medications on 11/15/24. The home did not notify the prescriber regarding the medication error. (Day 2 - 11/21/24)

Plan of Correction ***Accept (- 01/16/2025)***

On 11/21/2024 following the inspection, the Wellness Coordinator reported to the medication error to the prescriber and family. On 11/22/24 the Executive Director reported the medication error to BHSL. On 11/22/24 The Executive Director did an education with DON and Wellness Coordinator on regulation 2600.188.b on the medication error shall be immediately reported to the resident, the residents designated person and the prescriber. On 12/16/24 the Executive Director held a Medication staff training and reviewed Medication error procedures including reporting procedures. On 12/30/24 a new Director of Nursing started the community and as part of her training the Executive Director provided education on 2600.16 reporting procedures and also provided information on the current areas of deficiencies that require immediate correction and her role and responsibilities. On or before 01/15/25 there will be a new procedure that requires the Director of Nursing or designee to check the daily missed medication report and sample 10% of EMARs to in order to determine if any medication errors took place. The procedure will include the process of reporting medication errors. The Director of Nursing or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 01/31/2025)

190c - Record of Training

31. 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 2024 annual practicum training record for staff person E, does not include completion date, student's signature and date of signature for student and trainer. (Day 2 - 11/21/24)

The home's 2024 annual practicum training record for staff person F dated 3/9/24, does not include the students signature. (Day 2 - 11/21/24)

The home's 2024 annual practicum training record for staff person H notes a pass date of 4/11/24, the last medication administration record review and medication observation was completed 10/24. (Day 2 - 11/21/24)

190c - Record of Training (continued)

Plan of Correction ***Accept (- 01/16/2025)***

Following the inspection on, 11/21/2024 The Executive Director re-educated the Director of Nursing on training requirements and documentation for medication associates. On 11/21/24 the Director of Nursing had staff persons E sign completion date and sign annual practicum and the Director of Nursing also signed and dated. On 11/21/24 the Director of Nursing had Staff person F sign annual practicum training record. On or before 01/15/25 the new Director of Nursing will complete an audit of all Medtech training and will correct any deficiencies in accordance with 2600.190c. The Director of Nursing or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented (- 01/31/2025)

224a - Preadmission Screen Form

32. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #6's Preadmission screening form dated does not have an indication if the resident can safely use or avoid poisons. The indicator is blank. (Day 1 - 11-20-24)

Repeat Violation: 10/30/24

Plan of Correction ***Accept (- 01/06/2025)***

On 11/21/2024 immediately following the inspection the resident 6 pre-screen was corrected by the Director of Nursing to indicate that is unable to safely use or avoid poisonous materials. 12/15/2024 The Executive Director completed a prescreen audit to all resident files to ensure all pre-screens are accurate and thoroughly completed in accordance with regulations. Moving forward the Executive Director or designee will review all pre-screens prior to admissions to ensure ongoing compliance. The Executive Director and Director of Wellness will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented (- 01/31/2025)

225c - Additional Assessment

33. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

225c - Additional Assessment *(continued)*

Description of Violation

The annual Assessment portion of the Resident Assessment and Support Plan (RASP) dated [redacted] for Resident #2 only has page 3 completed. The assessment is not filled out in its entirety. (Day 1 - 11/20/24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/20/2024 following the inspection The Executive Director did an education with the Wellness Coordinator and Director of Nursing on regulation 2600.225c. On 12/30/24 a new Director of Nursing was hired. On or before 01/24/25 the Executive Director and Director of nursing will complete an audit on all residents on resident assessment support plans to ensure that every resident has a completed annual RASP as per 225c. If any deficiencies are detected the Director of Nursing, Executive Director or designee will be required to make corrections immediately. The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Not Implemented ([redacted] - 03/20/2025)

[redacted]

WITHDRAWN 4/2/25

[redacted]

231g - Non-Dementia Admission

36. Requirements

2600.

231.g. An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.

3. The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

231g - Non-Dementia Admission *(continued)*

Description of Violation

Resident #8 resides in the home's SDCU with [redacted]. Resident #8 does not have a diagnosis of Alzheimer's disease or other dementia. Resident #8 indicated during a resident interview that they do not know how to operate the keypad to exit the SDCU. Resident #8 indicated that staff and/or their family member helps operate the keypad when the resident wants to exit the SDCU. (Day 2 – 11/21/24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

On 11/21/2024 following the inspection, resident #8 was given the code again to the keypad and shown how to exit the secured unit. The resident was able to demonstrate that [redacted] knows the code and how to exit the secured dementia unit. However, [redacted] has verbally stated that [redacted] prefers the staff to open the door for [redacted] The resident is considered cognizant and does not require a secured dementia unit, but [redacted] prefers the services that are offered in the memory care unit. On 1/13/2025 The Executive Director updated the resident 8 rasp to show [redacted] knows the code but prefers staff to open the door. Moving forward the Executive and Memory Care Coordinator will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 01/31/2025)

234d - Support Plan Revision

37. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #9 resides in the SDCU and requires a pureed diet. The resident's RASP dated [redacted] does not indicate the resident's special diet or how the facility will meet the residents needs. (Day 1 - 11-20-24)

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

11/20/2024 following the inspection the Executive Director did correct the resident assessment and support plan to include the special diet. On 11/22/24 the Executive Director did an education with the Wellness Coordinator and Director of Nursing and all responsible for doing support plans on regulations 2600.234d. On or before 01/24/25, the Executive Director and Director of Nursing will complete and audit of all resident assessment and support plans to which will include checking all for special diets to be listed on any applicable care plans. The Executive Director and the Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 01/31/2025)