Department of Human Services
Bureau of Human Service Licensing

March 24, 2022

[redacted], ADMINISTRATOR

RE: COUNTRY MEADOWS OF ALLENTOWN
430 NORTH KROCKS ROAD
BUILDING 1
ALLENTOWN, PA, 18106
LICENSE/COC#: 22693

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/07/2021, 07/08/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *COUNTRY MEADOWS OF ALLENTOWN* **License #**: *22693* **License Expiration**: *08/31/2021*

Address: *430 NORTH KROCKS ROAD, BUILDING 1, ALLENTOWN, PA 18106*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/29/2010* **Issued By**: *Upper Macungie Twp*

Staffing Hours

Resident Support Staff: *47* **Total Daily Staff**: *159* **Waking Staff**: *119*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/08/2021*

Inspection Dates and Department Representative

07/07/2021 - On-Site:
07/08/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *60* **Residents Served**: *37*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *65*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *47* **Have Physical Disability**: *3*

Inspections / Reviews

07/07/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/15/2021*

12/15/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/22/2021*

12/20/2021 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/27/2021*

03/03/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/13/2022*

03/24/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

65a - FS Orientation 1st Day

1. 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:

Description of Violation

The home could not locate verification that Staff person A, Staff person B, and Staff person C received the trainings required by this regulation.

Plan of Correction ***Accept***

All co-workers hired by Country Meadows complete an Onboarding process that includes the requirements of regulation 65a. While documentation regarding this training could not be produced at the time of inspection, staff persons A, B and C all had this on their respective first days of employment. Staff person A was re-trained in fire safety on 10/4/2021. Staff person B was trained on fire safety on 3/12/2021. Both staff person B and C will be scheduled to attend fire safety re-training prior to November 30th, 2021. The Talent and Development coordinator will ensure that supporting documentation be retained. Talent and Development Coordinator and Executive Director will monitor for ongoing compliance.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Evidence of compliance is required.
Documents for Staff members listed must be provided to demonstrate compliance. If they are no longer employed, please note. If any new employees have been hired since the inspection, please provides an example of compliance as well.
AG, 3-3-22

Document Submission ***Implemented***

Documentation attached includes: 2 additional training sheets to show that fire training was done on day 1. Also for 65a, Staff Member C (Gabrielle Ordiway) is no longer a CM co-worker.

101j7 - Lighting/Operable Lamp

1. 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 did not have access to a source of light that can be turned on/off at bedside at time of inspection.

Plan of Correction ***Accept***

Resident #1 had a lamp located at the foot of the bed per the resident's request. Lamp was immediately relocated to the resident's bedside. Staff retrained on the need for bedside lamp on 11/9/2021. Executive Director will routinely monitor for compliance.

Completion Date: *11/15/2021*

101j7 - Lighting/Operable Lamp *(continued)*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Evidence of compliance is required.

A photo of the lamp and staff training will be necessary in this situation.

AG, 3-3-22

Document Submission ***Implemented***

Resident 1 is no longer a CM resident so there is no lamp to take a picture of anymore for this particular resident.

Staff Training Attached.

121a - Unobstructed Egress

1. 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 emergency exit door located near the home's dining room required excess force to open.

Plan of Correction ***Accept***

Director of Maintenance made an adjustment to the push bar on 7/8/2021 which allows the door to open with less force. Director of Maintenance and Executive Director will check exit doors on a monthly basis for ease of egress.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Evidence of compliance is required.

Copies of the monthly audits will be needed to verify the POC.

AG, 3-3-22

Document Submission ***Implemented***

Attached.

124 - Notice to Fire Department

1. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's notice to the fire department, dated 11/3/2020, states that 35 residents reside in the SDCU, and 32 residents

124 - Notice to Fire Department (continued)

reside in Personal Care, for a total of 67 residents. However, per the current census of the home, there are 37 resident residing in the SDCU, and 28 residents in Personal Care, for a total of 65 residents. The letter is not current to the number of residents currently residing in the home's evacuation needs.

Plan of Correction ***Accept***

As per conversation with [redacted] on 11/12/21, this violation is being removed due to no requirement listed within the regulation to put the actual census in the notification to the fire department.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Implemented***

No further documentation needed

Update: *03/03/2022*

This violations will be withdrawn in the FINAL STAGE.

AG, 3-3-22

125a - Combustible Storage

1. Requirements

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

Description of Violation

There was a small piece of cardboard wedged between the leftmost dryer and the wall in the laundry area located in the personal care community, posing a possible fire hazard.

Plan of Correction ***Accept***

The small piece of cardboard was immediately removed from between the leftmost dryer and wall. Staff was re-trained on combustible storage on 11/9/21. Staff will check the area around the dryer when checking the lint traps. Director of Maintenance and Executive Director will monitor for ongoing compliance.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Evidence of compliance is required.
Copies of staff sign in sheets and training material and the monthly monitoring will be needed to verify compliance.
AG, 3-3-22

Document Submission ***Implemented***

Attached.

130f - Testing Smoke Detectors

1. Requirements

2600.
130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

Per staff interviews, it was determined that the home is not testing their smoke detectors and fire alarms monthly for operability.

Plan of Correction ***Accept***

This violation can be removed with proof of record showing our fire system is monitored daily per correspondence with inspector. Proof was emailed.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Please be so kind to re-send. I can not seem to locate or recall seeing.

AG, 3-3-22

Document Submission ***Implemented***

Attached

185a - Implement Storage Procedures

1. 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

Resident #2 has a PRN order for [redacted]. This medication was unavailable in the medication cart at time of inspection.

Resident #3 has an order to have their blood glucose tested 3 times daily. On 6/25/2021 at 4:09pm, Resident #3's blood glucose reading in the monitor was 98. A blood sugar reading of 110 was incorrectly transcribed on the MAR.

Plan of Correction ***Accept***

The physician for Resident #1 was contacted and a discontinue order was obtained for the [redacted] on 7/9/2021. Nurses and Medication Associates were re-trained on 7/8/2021 on medication storage and transcription of glucometer readings. Monthly audit will be completed to ensure compliance. Assistant Director of Nursing, Director of Nursing, and Executive Director will monitor for ongoing compliance.

Completion Date: *11/15/2021*

Document Submission ***Not Implemented***

No further documentation needed

185a - Implement Storage Procedures *(continued)*

Document Submission ***Not Implemented***

No further documentation needed

Update: *03/03/2022*

Evidence of compliance is required.
A copy of the training material and the sign in sheet(s) for med techs and licensed staff if appropriate will be needed, as well as copies of the monthly audits done since the annual renewal to demonstrate compliance.

AG, 3-3-22

Document Submission ***Implemented***

Attached