

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

January 24, 2023

[REDACTED]  
ABODE CARE OF ALLENTOWN LLC  
[REDACTED]

RE: ABODE CARE OF ALLENTOWN  
2232 29TH STREET SW  
ALLENTOWN, PA, 18103  
LICENSE/COC#: 23039

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/20/2022, 12/21/2022 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:** ABODE CARE OF ALLENTOWN **License #:** 23039 **License Expiration:** 12/09/2023  
**Address:** 2232 29TH STREET SW, ALLENTOWN, PA 18103  
**County:** LEHIGH **Region:** NORTHEAST

**Administrator**

**Name:** [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

**Legal Entity**

**Name:** ABODE CARE OF ALLENTOWN LLC  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C 2 LP **Date:** 08/04/2012 **Issued By:** L&I

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 93 **Waking Staff:** 70

**Inspection Information**

**Type:** Full **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Renewal **Exit Conference Date:** 12/21/2022

**Inspection Dates and Department Representative**

12/20/2022 On Site [REDACTED]  
 12/21/2022 On Site [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 150 **Residents Served:** 89

**Secured Dementia Care Unit**

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

**Hospice**

**Current Residents:** 3

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 89  
**Diagnosed with Mental Illness:** 0 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 4 **Have Physical Disability:** 2

**Inspections / Reviews**

12/20/2022 - Full

**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 01/15/2023

Inspections / Reviews *(continued)*

01/17/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 01/24/2023

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 01/23/2023

01/24/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 01/24/2023

Reviewer: [REDACTED] Follow-Up Type: Not Required

51 - Criminal Background Check

1. 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 was hired on 1/12/22; the home did not have documentation of a criminal background check for staff person A.

Plan of Correction

Accepted [redacted] - 01/17/2023)

Immediate action: On 12/13 Executive Director provided an education on Criminal background checks in accordance with OAPSA.

An Audit was conducted on all employees on 12/13-12/15. All files are in compliance with OAPSA.

Plan of Correction: Executive Director will work alongside of Administrative Assistant to review all files by end of day three orientation to ensure background checks are obtained within the allotted timeframe.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] 01/24/2023)

54a - Direct Care Staff

2. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 1. Be 18 years of age or older, except as permitted in subsection (b).
- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
- 3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Staff persons A, B, and C are direct care workers. The home did not have documentation that staff persons A, B, and C have high school diplomas, a GED, or active registry as a certified nurse aide.

Plan of Correction

Accepted [redacted] - 01/17/2023)

Immediate action: On 12/13 Executive Director provided an education to Administrative and Lead team regarding interview process and required documentation of High School diploma, GED or active CNA.

An Audit was conducted on all employees on 12/13-12/15. All files are in compliance with 2600.54A

Plan of Correction: Executive Director will work alongside of Administrative Assistant to review all files by end of day three orientation to ensure background checks are obtained within the allotted timeframe.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

63a - First Aid/CPR Training

3. 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.

63a - First Aid/CPR Training (continued)

Description of Violation

The home has a census of 89 residents, requiring that at least 2 staff persons with certified training in First Aid and CPR (FA/CPR) be scheduled for each shift. On the following shifts the home did not meet this requirement:

- █/22—2nd and 3rd shifts did not have any verified staff with FA/CPR training
- █/22—2nd and 3rd shifts had only 1 verified staff person with FA/CPR training.
- █/22—2nd shift had only 1 verified staff person with FA/CPR training; 3rd shift had no staff with verified FA/CPR training.

Plan of Correction

Accept (█ - 01/17/2023)

Immediate action: On 12/18 Executive Director provided an education to Administrative, Wellness and Lead team on the CPR to resident ratio. Education will continue as census increases and facilitated by the Director of Wellness and Executive Director.

An Audit was conducted on all employees on 12/19-12/20. All files are in compliance with 2600.63a. CPR scheduled Class for 2/28/2023.

Plan of Correction: Executive Director will work alongside of Wellness and Lead Team Assistant to review and keep CPR Compliance for all team members.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (█ - 01/24/2023)

65d Initial Direct Care Training

4. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department approved direct care training course and passing of the competency test.

Description of Violation

The home did not have documentation that staff person C passed the department's required direct care competency test.

Plan of Correction

Accept (█ 01/17/2023)

Immediate action: On 12/18 Executive Director provided an education to Administrative and Lead team regarding New Employee orientation process and required DCS training before the team members starts the first day on the neighborhoods. DCS training is established and requires completion by day three of NEO.

An Audit was conducted on all employees on 12/13-12/15. All files are in compliance with 2600.65d

Plan of Correction: Executive Director will work alongside of Administrative Assistant to review all files by end of day three orientation to ensure the DCS training is complete before the " First day on the Floor."

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (█ - 01/24/2023)

81b - Resident Personal Equipment

5. Requirements

2600.

81b - Resident Personal Equipment (continued)

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

The bed in resident room [redacted] had an enabler bar attached to it that was uncovered. The width between the bars was greater than 4 3/4 inches resulting in a possible entrapment risk.

Plan of Correction

Accept [redacted] - 01/17/2023)

Immediate action: On 12/17 Executive Director provided education during the All-team meeting to team members and Therapy services on regulation 81.b.

An Audit was conducted on all on rooms 12/18-12/22 to ensure bed enablers greater than 4/3/4 are covered to prevent entrapment.

Plan of Correction: Executive Director is responsible for working alongside entire Wellness team and Therapy to ensure when new orders for bed enablers are ordered we try all other alternatives, if resulting in bed enabler it must have a cover.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The trash can lid in the shared bathroom of room [redacted] had dried excrement on it.

Plan of Correction

Accept [redacted] - 01/17/2023)

Immediate action: On 12/17 Executive Director provided an education at All Team Meeting regarding sanitary conditions, what to look for and expectations while providing care.

An Audit was conducted during rounds on 12/18-12/22. All trash cans and items cleaned and scrubbed throughout the community. A regular schedule for routine cleaning and daily cleaning established.

Plan of Correction: Executive Director will work alongside of Department Directors Assistant to review all files by end of day three orientation to ensure background checks are obtained within the allotted timeframe.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

101j7 - Lighting/Operable Lamp

7. 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

The lamp next to the left side bed in room [redacted] was not operable at the time of the inspection as well as the lamp next to the bed in room [redacted]

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction

Accept (JH - 01/17/2023)

Immediate action: On 12/17 Executive Director provided an education at the All-Team Meeting regarding 2600.101 and room check requirements.

An Audit created and conducted on rounds employees on 12/18-12/22. All residents have operable and adequate light on the bedside table.

Plan of Correction: Executive Director will work alongside of entire team on monthly audits to ensure all residents have bedside lighting.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

121a - Unobstructed Egress

8. 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 door leading from the 1st floor main dining area to the enclosed courtyard was not labeled with a sign to indicate it is not an exit. The courtyard adjacent to this dining area does not have a means to exit and is not a fire safe area. Also, the gate leading from the memory care courtyard did not fully open when unlatched. The door was impeded from being fully opened by the ground.

Plan of Correction

Accept [redacted] - 01/17/2023)

Immediate action: On 12/17 at All team meeting, Executive Director provided an education to Maintenance Director and All team members on observing the requirements of 2600.121. On 1/14/2022 Maintenance Director adjusted and fixed the fence.

An Audit will continue monthly by Maintenance Director.

Plan of Correction: Executive Director will work alongside of Maintenance Director and team members to audit and ensure community compliance.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home's fire drill logs indicate that required sleeping hour fire drills were conducted on 4/15/22 at 6:28am and 11/4/22 at 4:00am, more than 6 months apart.

Plan of Correction

Accept [redacted] 01/17/2023)

Immediate action: On 12/10 Executive Director reviewed the regulation of 2600.132e with Maintenance Director.

An Audit was conducted on 12/11 on the past years fire drills.

Plan of Correction: Executive Director will work alongside of the Maintenance Director to ensure fire drills are held on different dates, and within six months for sleeping hours.

132e - Fire Drill Sleeping Hours (continued)

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [REDACTED] - 01/24/2023)

183e - Storing Medications

10. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Three unopened [REDACTED] belonging to resident #1 were found stored in the medication cart rather than in the refrigerator as required.

Plan of Correction

Accept [REDACTED] - 01/17/2023)

Immediate action: Education provided by Director of Wellness and Executive Director on 12/17/22 to educate the Med Techs on unopened insulin pens requiring stored in the refrigerator.

An Audit was conducted on all med carts on 12/18 to ensure all unopened pens are stored in the medication locked refrigerator. Audit will continue weekly with med cart audit.

Plan of Correction: Director of Wellness and Wellness team will work alongside med techs to ensure weekly audits are complete and unopened pens are stored properly.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [REDACTED] - 01/24/2023)

184a - Resident's Meds Labeled

11. 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.

Description of Violation

The [REDACTED] belonging to resident #2 was stored in the medication cart without a pharmacy label attached to it.

Plan of Correction

Accept [REDACTED] - 01/17/2023)

Immediate action: Education provided by Director of Wellness and Executive Director on 12/17/22 to educate the Med Techs on resident labels of all medications under the 2600.184a.

An Audit was conducted on all med carts on 12/18 to ensure all medications are properly labeled according to the regulation. Audit will continue weekly with med cart audit.

Plan of Correction: Director of Wellness and Wellness team will work alongside med techs to ensure weekly audits are complete and all medications are properly labeled.

Licensee's Proposed Overall Completion Date: 01/16/2023

184a - Resident's Meds Labeled (continued)

Implemented [redacted] 01/24/2023)

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 belonging to resident #3 was not calibrated to the correct month or day.

Resident #4 receives blood glucose monitoring four times daily. On the following dates the resident's blood glucose readings were incorrectly documented:

12/16/22 at 12:58pm the reading was [redacted] in the glucometer but was documented as [redacted].

12/17/22 at 8:34pm the reading was [redacted] in the glucometer but was documented as [redacted].

Plan of Correction

Accept [redacted] - 01/17/2023)

immediate action: Education provided on 12/17/22 to educate the Med Techs and diabetic certified team members on data entry of and accuracy of glucometer checks.

An Audit was conducted on all med carts on 12/18 to ensure all medications are labeled in accordance with regulation 185a. Audit will continue weekly with med cart audit.

Plan of Correction: Director of Wellness and Wellness team will work alongside med techs to ensure weekly audits are complete and all medications are labeled.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

187a - Medication Record

13. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

Description of Violation

Resident #5 has an order for blood glucose monitoring 3 times daily with insulin administered on a sliding scale. The home is not documenting the insulin units that are administered on the resident's Medication administration record (MAR).

Plan of Correction

Accept [redacted] - 01/17/2023)

Immediate action: Education provided by Director of Wellness and Executive Director on 12/17/22 to educate the Med Techs on observing and notifying the Wellness Director is noticing there is not an option to record the glucose numbers accurately.

An Audit was conducted 12/18/22 on all insulin administration and is recorded to ensure all orders have the appropriate drop down to record the insulin units. Audit will continue weekly with med cart audit.

Plan of Correction: Director of Wellness and Wellness team will work alongside med techs to ensure weekly audits are complete and all insulin units have the proper documentation.

187a - Medication Record (continued)

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

187b Date/Time of Medication Admin.

14. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6 has an order for [redacted] to be administered three times per week on Monday, Wednesday, and Friday. The MAR is initialed by staff on every day from [redacted] through [redacted] as if the treatment was administered every day. Staff have initialed the treatment on days when the medication was not ordered and not administered.

Plan of Correction

Accept [redacted] - 01/17/2023)

Immediate action: Education provided by Director of Wellness on 12/17/22 to educate the Med Techs on following physician orders with proper documentation.

Ongoing education will continue weekly at our newly established Med tech meeting once a week.

Plan of Correction: Director of Wellness and Wellness team will work alongside med techs to ensure weekly education and MAR review of proper documentation of ordered at The Med tech meeting.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented [redacted] - 01/24/2023)

187d Follow Prescriber's Orders

15. Requirements

2600.

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

Description of Violation

Resident #4 has an order for blood glucose checks 4 times daily with sliding scale insulin. On the following dates these errors were noted:

[redacted]/22: The [redacted] am reading was not completed

[redacted]/22; blood glucose reading at [redacted] pm was [redacted] requiring 4 units of insulin; 5 units administered

[redacted]/22; blood glucose reading at [redacted] pm was [redacted] requiring 5 units of insulin; 4 units administered

Resident #3 has an order for blood glucose readings 4 times daily with sliding scale insulin. On the following dates these errors were noted:

[redacted]/22: The [redacted] am reading was [redacted] requiring 4 units of insulin; 0 units administered

[redacted]/22: The [redacted] pm reading was [redacted] and 16 units of insulin were administered. The MAR indicates there is no order for sliding scale units for readings between [redacted] and [redacted] and the home did not have documentation that the prescriber ordered 16 units of insulin for this reading.

Resident #6 has an order for [redacted] two times daily; on [redacted] 22 the drops were not administered in the morning. Also, resident #6 has an order for [redacted] to be administered once daily. On [redacted] /22 and [redacted] /22 the cream was not administered.

## 187d - Follow Prescriber's Orders (continued)

**Plan of Correction****Accepted** [REDACTED] - 01/17/2023)

*Immediate action: Education provided on 12/17/22 to educate the Med Techs on following physician orders and understanding sliding scale.*

*An Audit was conducted on all med carts on 12/18 to review documentation of sliding scale.*

*Plan of Correction: Director of Wellness and Wellness team are working with a Diabetic certified Registered Nurse who will come in house three times a year for insulin training to provide education on what to look for and how to administer and understand sliding scales and proper documentation.*

*Director of Wellness will work alongside Wellness team Diabetic Trainer and Med tech trainer will work alongside to ensure med techs are following the directions of the provider.*

**Licensee's Proposed Overall Completion Date: 01/16/2023**

**Implemented** [REDACTED] - 01/24/2023)