

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

January 22, 2025

[REDACTED]  
ARDEN COURTS OF ALLENTOWN PA LLC  
[REDACTED]  
[REDACTED]

RE: ARDEN COURTS (ALLENTOWN)  
5151 HAMILTON BOULEVARD  
ALLENTOWN, PA, 18106  
LICENSE/COC#: 21787

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/10/2024, 12/26/2024 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:** ARDEN COURTS (ALLENTOWN) **License #:** 21787 **License Expiration:** 06/16/2025  
**Address:** 5151 HAMILTON BOULEVARD, ALLENTOWN, PA 18106  
**County:** LEHIGH **Region:** NORTHEAST

## Administrator

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

## Legal Entity

**Name:** ARDEN COURTS OF ALLENTOWN PA LLC  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

## Certificate(s) of Occupancy

**Type:** C-2 LP **Date:** 06/07/1995 **Issued By:** L&I

## Staffing Hours

**Resident Support Staff:** 0 **Total Daily Staff:** 98 **Waking Staff:** 74

## Inspection Information

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 12/26/2024

## Inspection Dates and Department Representative

12/10/2024 - On-Site: [REDACTED]  
 12/26/2024 - Off-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

**License Capacity:** 56 **Residents Served:** 49

## Secured Dementia Care Unit

**In Home:** Yes **Area:** Entire Home **Capacity:** 56 **Residents Served:** 49

## Hospice

**Current Residents:** 7

## Number of Residents Who:

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 49  
**Diagnosed with Mental Illness:** 0 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 49 **Have Physical Disability:** 0

## Inspections / Reviews

12/10/2024 Partial

**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 01/19/2025

Inspections / Reviews *(continued)*

01/22/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/22/2025

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document Submission*

01/22/2025 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/22/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. On [redacted] resident [redacted] was observed grabbing the [redacted] of a [redacted] resident. The incident was documented in the resident's care notes. On [redacted] a care note indicates resident [redacted] was "reaching for residents in inappropriate areas". The home did not report the suspected abuse to the Area Agency on Aging as required.

Plan of Correction

Accept [redacted] - 01/22/2025)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [redacted] by the Executive Director provided re-training to staff on the requirements of proper reporting procedures for resident abuse.

To enhance the currently compliant operations, on [redacted] the Resident Services Coordinator or designee will provide a checklist for immediately reporting of suspected abuse by [redacted].

Effective 01/15/2025 the Resident Care Director or designee will review incident reports and resident care notes in daily morning meeting and will remain ongoing to maintain compliance with immediately reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [redacted] - 01/22/2025)

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 [redacted] was admitted to the home on [redacted]. On [redacted] resident [redacted] was observed grabbing the [redacted] of a female resident. The incident was documented in the resident's care notes. On [redacted] a care note indicates resident [redacted] was "reaching for residents in inappropriate areas". The home did not report the suspected abuse to the department's regional office as required.

On [redacted], and [redacted], the home failed to administer [redacted] to Resident [redacted] as the medication was not on hand. The home failed to report the medication errors to the Northeast Regional Office as required.

## 16c Written Incident Report (continued)

## Plan of Correction

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Executive Director reviewed facility protocol with staff to ensure all incidents and medications errors are reported within the required 24 hour timeframe. Staff have been instructed to report any incidents or medication errors to the Resident Services Coordinator who will then ensure the report is made to the departments regional office.

To enhance the currently compliant operations, on 01/15/2025 the Resident Services Coordinator or designee will provide mandatory trainings on reporting procedures including reviewing the requirements under regulations 2600.16c. These trainings will be upon hire and annually.

Effective 01/15/2025 the Resident Services Coordinator or designee will perform weekly audits x4 then monthly x2 through 04/23/2025 to maintain ongoing compliance with reporting an 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, and to follow the guidelines in § 2600.15 (relating to abuse reporting covered by law). Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] 01/22/2025)

## 42b - Abuse

## 3. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

## Description of Violation

On [REDACTED] resident [REDACTED] was observed grabbing the [REDACTED] of a [REDACTED] resident.

On [REDACTED] at around 2pm, resident [REDACTED] pushed resident [REDACTED] in the dining room, causing resident [REDACTED] to fall to the floor.

On [REDACTED] resident [REDACTED] was swinging their hand at resident [REDACTED] attempting to hit resident [REDACTED]. Resident [REDACTED] suffered a cut to their lip and a scratch to their neck as a result.

## Plan of Correction

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate actions were taken to address the incidents on [REDACTED] by the Executive Director. Staff were instructed to monitor Resident [REDACTED] closely and intervene promptly to prevent aggressive actions towards other residents. Resident [REDACTED] 1 was placed on Q15 minute checks. On [REDACTED] Resident [REDACTED] was assigned to another house at the time of the incident with approval of POA. On [REDACTED] Resident [REDACTED] was sent to ED for psych evaluation, returned back to facility and placed on Q15 minute checks and was consulted by psychiatry services. Resident [REDACTED] sent to ED for evaluation due to falling, returned from ED, no injuries and placed on Q15 minute checks. Residents [REDACTED] and [REDACTED] reside in different houses.

**42b Abuse (continued)**

To enhance the currently compliant operations, on 01/15/2025 the Resident Services Coordinator or designee will educate staff regarding regulation 42.b. resident may not be neglected, intimidated, physically or verbally abused, mistreated, subject to corporal punishment or disciplined in any way, with a completion date of 01/24/2025.

Effective 01/15/2025 the Resident Care Director or designee will review incident reports and resident care notes in daily morning meeting and will remain ongoing to maintain ongoing compliance with not neglecting, intimidating, physically or verbally abusing, mistreating, subjecting to corporal punishment or disciplining residents in any way. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Implemented [REDACTED] - 01/22/2025)

**42x - Safeguard****4. Requirements**

2600.

42.x. A resident has the right to a system to safeguard a resident's money and property.

**Description of Violation**

On [REDACTED] during a routine narcotic count at the 11pm shift change, the home discovered that a bottle of [REDACTED] belonging to resident [REDACTED] was missing from the medication cart, along with the narcotic count sheet for the bottle of pills.

**Plan of Correction**

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Resident Services Coordinator who conducted an investigation to locate the missing medication and narcotic count sheet. The investigation began on [REDACTED]. Additionally, all medication carts were audited to ensure no other discrepancies existed. The missing item was reported to the Department of Human Services on 11/13/24. Staff involved in the medication management process were retrained on narcotic substance control log on 11/14/24.

To enhance the currently compliant operations, on 11/14/2024 the Resident Services Coordinator or designee reviewed protocols and re educated with licensed staff and medication technicians about narcotic counts, requiring two staff members to verify and sign off on narcotic counts at each shift change, with a completion date of 11/15/2024.

Effective 01/15/2025 the Resident Services Coordinator or designee will perform controlled substance audits weekly x 4 and monthly audits x2 of narcotic counts through 04/23/2025 to maintain ongoing compliance with providing each resident a system to safeguard each resident's money and property. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 01/22/2025)

142a - Secure Medical Care

5. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On [REDACTED] the hospice aide providing care for resident [REDACTED] noticed a large abrasion on the resident's left side rib cage area and reported it to the home's staff. Resident [REDACTED] had a fall documented on [REDACTED] with no injuries reported. The home could not determine when the laceration occurred, but it was determined that the wound was not treated immediately. The resident's injury was not treated until [REDACTED] when the hospice nurse arrived to assess the resident and prescribed an antibiotic ointment.

Plan of Correction

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Resident Services Coordinator to educate staff to ensure seeking immediate medical assessment and treatment following any reported injuries.

To enhance the currently compliant operations, on 01/16/2025 the Resident Services Coordinator or designee will educate licensed staff on the importance of timely updates to resident assessment and support plan documentation, with a completion date of 01/24/2025.

Effective 01/16/2025 the Resident Services Coordinator will perform audits of incident reports and resident assessments weekly x4 weeks and monthly x2 months through 04/23/2025 to maintain ongoing compliance with assisting each resident with securing medical care if a resident's health status declines, and to document the resident's need for the medical care, including updating the resident's assessment and support plan. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 01/22/2025)

187b - Date/Time of Medication Admin.

6. 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

On [REDACTED] resident [REDACTED] medication was not available in the medication cart to be administered. Staff initialed the medication administration record (MAR) on [REDACTED] at 8am and 8pm for this medication indicating it was administered even though it was not.

Plan of Correction

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Resident Services Coordinator provided education to the licensed staff and medication aides immediately on unavailable medications process.

**187b - Date/Time of Medication Admin. (continued)**

To enhance the currently compliant operations, on 01/15/2025 the Resident Services Coordinator or designee will provide re-training to medication aides and licensed staff on the proper procedures for documenting medication administration, with a completion date of 01/24/2025.

Effective 01/15/2025 the Resident Services Coordinator or designee will perform medication cart audits weekly x4 weeks and monthly x 2 months through 04/23/2025 to maintain ongoing compliance with ensuring the information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 01/22/2025)

**187d - Follow Prescriber's Orders****7. Requirements**

2600.

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

**Description of Violation**

Resident [REDACTED] has an order for [REDACTED], 3 tablets every 12 hours daily. On [REDACTED] and [REDACTED] the medication was not administered because it was unavailable in the medication cart.

**Plan of Correction**

Accept [REDACTED] - 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Resident Services Coordinator or designee to expedite the reorder of any missing medications.

To enhance the currently compliant operations, on 01/15/2025 the Resident Services Coordinator or designee will conduct education on medication administration protocols and documentation with licensed staff and medication aides, with a completion date of 01/24/2025.

Effective 01/15/2025 the Resident Services Coordinator or designee will perform cart audits weekly x4 and monthly x 2 months through 04/23/2025 to maintain ongoing compliance with ensuring the home must follow the directions of the prescriber. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 01/22/2025)

**188b - Medication Error Reporting****8. Requirements**

2600.

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

188b Medication Error Reporting (continued)

Description of Violation

On [redacted] and [redacted] resident [redacted] was not administered the prescribed medication [redacted], 3 tablets every 12 hours because the medication was not available in the medication cart. The home did not report the medication error to the prescriber as required.

Plan of Correction

Accept [redacted] - 01/22/2025)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [redacted] by the Resident Services Coordinator to notify the medication error to designated person, and the prescriber.

To enhance the currently compliant operations, on 01/15/2025 the Resident Services Coordinator or designee will provide education to licensed staff and medication aides to ensure proper procedures for medication errors, with a completion date of 01/24/2025.

Effective 01/15/2025 the Resident Services Coordinator or designee will perform weekly cart audits x 4 weeks then monthly x 2 months through 04/23/2025 to maintain ongoing compliance with ensuring a medication error must be immediately reported to the resident, the resident's designated person and the prescriber. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [redacted] - 01/22/2025)

234d - Support Plan Revision

9. Requirements

2600.

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

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. Resident [redacted] care notes indicate the resident made sexually inappropriate comments towards staff and was combative when redirected. Resident [redacted] was also observed grabbing other residents inappropriately. Resident [redacted] support plan dated [redacted] was not updated to reflect resident [redacted] need for increased supervision due to their behaviors.

Resident [redacted] had an altercation with resident [redacted] on [redacted]. Resident [redacted] had a history documented in the care notes of aggression and exit seeking behaviors. The support plan dated [redacted] was not updated to reflect the resident's combative behaviors.

Plan of Correction

Accept [redacted] - 01/22/2025)

In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [redacted] by the Executive Director to update the support plans for resident [redacted] and resident [redacted] to reflect their current behaviors and supervision needs.

To enhance the currently compliant operations, on 01/15/2025 the Executive Director or designee will provide staff training on the importance of timely updates to support plans, with a completion date of 01/24/2025.

## 234d Support Plan Revision (continued)

Effective 01/15/2025 the Executive Director or designee will perform monthly audits x3 months of 5 random residents through 04/23/2025 to maintain ongoing compliance with ensuring the support plan is revised at least annually and as the resident's condition changes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 01/22/2025)

## 252 - Record Content

## 10. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

## Description of Violation

Resident [REDACTED] face sheet does not indicate whether the resident has any identifying marks.

## Plan of Correction

Accept [REDACTED] 01/22/2025)

In response to the violation on [REDACTED] by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on [REDACTED] by the Executive Director updating Resident #8's face sheet to include all required identity information, including identifying marks.

To enhance the currently compliant operations, on 01/15/2025 the Executive Director or designee will review all resident records to ensure completeness and accuracy. The Executive Director or designee will conduct review of all resident records, and any missing information will be promptly updated. Staff training on the importance of maintaining complete and accurate resident records will be conducted, with a completion date of 01/24/2025.

Effective 01/15/2025 the Executive Director or designee will perform monthly audits for 3 months on new admissions and pick random 5 residents through 04/23/2025 to maintain ongoing compliance with ensuring each resident's record includes, including race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] 01/22/2025)