

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

August 15, 2025

[REDACTED]  
LW ALLENTOWN OPCO LLC  
[REDACTED]

RE: LEGEND PERSONAL CARE AND  
MEMORY CARE OF ALLENTOWN  
6043 LOWER MACUNGIE ROAD  
MACUNGIE, PA, 18062  
LICENSE/COC#: 23139

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/02/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN* License #: *23139* License Expiration: *11/25/2025*

Address: *6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* Region: *NORTHEAST*

**Administrator**

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

**Legal Entity**

Name: *LW ALLENTOWN OPCO LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-1* Date: *05/18/2018* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *75* Waking Staff: *56*

**Inspection Information**

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

Reason: *Complaint, Incident, Interim* Exit Conference Date: *07/02/2025*

**Inspection Dates and Department Representative**

*07/02/2025 - On-Site* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *100* Residents Served: *55*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *secured* Capacity: *40* Residents Served: *17*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *55*

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

Have Mobility Need: *20* Have Physical Disability: *0*

**Inspections / Reviews**

**07/02/2025 Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/01/2025*

**08/08/2025 - POC Submission**

Submitted By: [REDACTED] Date Submitted: *08/14/2025*

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/15/2025*

Inspections / Reviews (*continued*)

08/15/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/14/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

5a3 - Long Term Care Ombudsman Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 3. Representatives of the Long-Term Care Ombudsman Program.

Description of Violation

On [redacted] at 1:00p.m., and on [redacted], around 1:30p.m., the ombudsman requested access to Resident [redacted]'s Electronic Medication Record. The MedTech's on duty denied being able to print the information so that it could be reviewed. On [redacted], at 2:00p.m. the ombudsman asked Staff A for access to the records again, Staff A denied the ombudsman immediate access.

Plan of Correction

Accept [redacted] 08/04/2025)

- 1. Resident #1's Electronic Medication Record was sent to the Ombudsman on 7/30/25 by the Healthcare Director.
- 2. The Healthcare Director will educate the Administrator and staff by 8/15/25 on regulation 2600.5.a.3 The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to: Representatives of the Long-Term Care Ombudsman Program. Documentation shall be kept.
- 3. Beginning on 8/4/25, the Healthcare Director/Designee will review ombudsman records request to ensure they are provided immediately upon receiving the written/documented consent of the older individual or legal representative.
- 4. To ensure consistent adherence to Regulation 2600.5.a.3, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 8/14/25 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 09/02/2025

Implemented [redacted] - 08/15/2025)

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted], the home had a census of 54 residents, with 17 residents residing in the Secured Dementia Care Unit and requiring constant SV while outside of the locked unit. There are 4 residents requiring an assist of 2 for transferring, and 21 residents requiring an assist of 1 to transfer. 3 staff persons worked from 11:00p.m. to 7:00a.m. on each of these days. The home is not scheduling an adequate number of staff on 3rd shift to safely evacuate all residents in the event of an emergency.

Plan of Correction

Accept [redacted] - 08/08/2025)

- 1. Unable to resolve staffing on identified dates of 6/13/25 - 6/14/25.
- 2. By 8/15/25 the Healthcare Director/Designee will assess current residents in the Secured Dementia Care Unit for transfer and assistance needs to ensure adequate staff is provided on 11:00p.m. to 7:00a.m. on each day.
- 3. The Administrator will educate the Healthcare Director and Assistant Healthcare Director by 8/15/25 on Requirements 2600.60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's

60a Staff/Support Plan (continued)

assessment and support plan. Documentation shall be kept.

4. Beginning on 8/4/25, the Administrator/Designee will review staffing schedules daily for 30 days to ensure that the community had the adequate overnight staff available in case of a fire.

5. To ensure consistent adherence to Regulation 2600.60 (a), compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 8/14/25 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 09/02/2025

Implemented [redacted] - 08/15/2025)

132c - Fire Drill Records

3. Requirements

2600.

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 record for the drill conducted on [redacted] at 2:45a.m indicated that 12 staff persons participated in the fire drill. Staff A indicated that 4 staff persons participated in the drill. The fire drill record indicates that on [redacted], 51 residents were present for the fire drill but only 6 evacuated. Staff indicated that 49 residents evacuated for this drill.

Plan of Correction

Accept [redacted] - 08/04/2025)

1. On 7/8/25 the Administrator corrected the fire drill record for the drill conducted on 1/18/25 to indicate that 4 staff persons participated in the drill. On 7/8/25 the Administrator corrected the fire drill record for the drill conducted on 5/10/25 to indicate that 49 residents evacuated for this drill.

2. By 8/5/25 the Administrator/Designee will review the prior 6 months of fire drill logs to ensure that the number of staff who participated in the fire drill and the number of residents who were evacuated reflects accurate.

3. The Administrator will educate the Maintenance Director by 8/15/25 on regulation 2600.132(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. Documentation shall be kept.

4. Beginning on 8/4/25, the Administrator/Designee will review monthly fire drill logs to ensure that the records include the necessary information as required by Regulation 2600.132 (c).

5. To ensure consistent adherence to Regulation 2600.132 (c), compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 8/14/25 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 09/02/2025

Implemented [redacted] - 08/15/2025)

## 132h - Designated Meeting Place

**4. Requirements**

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

**Description of Violation**

*During the fire drill on [REDACTED] at 4:02p.m., 2 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Staff interviews revealed if a resident does not want to evacuate, a pillow is put in the door to ensure other staff know the resident was still in the room and did not evacuate for the drill.*

**Plan of Correction**

Accept [REDACTED] 08/04/2025)

1. Unable to correct the identified deficiency.
2. By 8/15/25 the Administrator/Designee will educate the residents that Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. Documentation shall be kept.
3. The Administrator/Designee will educate staff by 8/15/25 on regulation 2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. Documentation shall be kept.
4. Beginning on 8/4/25, the Administrator/Designee will review monthly fire drill logs to ensure that the records are filled out correctly.
5. To ensure consistent adherence to Regulation 2600.132 (h), compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 8/14/25 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 09/02/2025

Implemented [REDACTED] - 08/15/2025)

## 227c - Support Plan Revision

**5. Requirements**

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

**Description of Violation**

*Resident [REDACTED] assessment was completed on [REDACTED] and indicates that the resident does receive Hospice services; however, the resident's support plan did not indicate what hospice was doing for the resident.*

**Plan of Correction**

Accept [REDACTED] - 08/04/2025)

1. Resident #1's support plan was reviewed by the Healthcare Director on 7/30/25 and updated to indicate the services provided by hospice.
2. By 8/25/25, the Healthcare Director/Designee will review residents' support plans to ensure they accurately reflect the residents' needs.
3. The Administrator will educate the Healthcare Director and Assistant Healthcare Director by 8/15/25 on regulation 2600.225(c) The resident shall have additional assessments as follows: Annually, If the condition of the resident significantly changes prior to the annual assessment and at the request of the Department upon cause to believe that an update is required. Documentation shall be kept.
4. Healthcare Director/Designee will educate the wellness staff by 8/15/25 on communicating changes in residents' care as it occurs. Documentation shall be kept.

**227c - Support Plan Revision (continued)**

5. Beginning on 8/4/25, the Administrator will review newly completed assessment plans weekly for four weeks to ensure they accurately reflect the residents' needs.
6. To ensure consistent adherence to Regulation 2600.227(c), compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 8/14/25 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 09/02/2025

Implemented [REDACTED] - 08/15/2025)