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

April 6, 2026

[redacted]
THE ATRIUM OF ALLENTOWN LLC
[redacted]

RE: THE ATRIUM OF ALLENTOWN
5767 CETRONIA ROAD
ALLENTOWN, PA, 18106
LICENSE/COC#: 23050

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/16/2025, 12/29/2025, 12/31/2025, 01/02/2026, 01/05/2026, 01/12/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE ATRIUM OF ALLENTOWN* **License #**: *23050* **License Expiration**: *12/05/2026*

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *119* **Waking Staff**: *89*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *01/12/2026*

Inspection Dates and Department Representative

12/16/2025 - On-Site: [redacted]
12/29/2025 - On-Site: [redacted]
12/31/2025 - Off-Site: [redacted]
01/02/2026 - Off-Site: [redacted]
01/05/2026 - Off-Site: [redacted]
01/12/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *30* **Residents Served**: *24*

Hospice

Current Residents: *8*

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: *30* **Have Physical Disability**: *2*

Inspections / Reviews

12/16/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/08/2026*

03/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/16/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/10/2026*

03/12/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/16/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/16/2026*

04/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/16/2026*

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

16c Written Incident Report

1. 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 has an order for [redacted] take ½ tablet by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was reported to the department on [redacted]

Resident #1 has an order for [redacted] take 1 tablet by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was reported to the department on [redacted]

Resident #1 has an order for [redacted], take 1 tablet by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was reported to the department on [redacted].

Resident #1 has an order for [redacted], take 1 tablet by mouth once daily at 9:00 p.m. On [redacted] the resident did not receive this medication, because it was not available on site. This was reported to the department on [redacted]

Resident #1 has an order for [redacted] take 2 tablets by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was reported to the department on [redacted]

Resident #1 has an order for [redacted], take 1 tablet by mouth daily at 9:00 a.m. On [redacted], the resident did not receive this medication because it was not available on site. This was not reported to the Department.

Resident #1 has an order for [redacted] tablet, take 1 tablet by mouth at 9:00 a.m. On [redacted], the resident did not receive this medication because it was not available on site. This was not reported to the Department.

Resident #1 has an order for [redacted] capsule, take 2 caps by mouth 3 times a day at 9:0 0a.m. and 3:00 p.m. On [redacted], the resident did not receive this medication because it was not available on site. This was not reported to the Department

Resident #1 has an order for [redacted], take 1 tablet by mouth daily at 9:00 a.m.. On [redacted] the resident did not receive this medication because it was not available on site. This was not reported to the Department.

Resident [redacted] has an order for [redacted] T, take 1 by mouth on the 8th of the month. This medication was administered on [redacted] This was reported to the Department on [redacted].

Repeat Violation: [redacted] et al

16c Written Incident Report (continued)

Plan of Correction ***Accept [redacted] - 03/12/2026)***

Immediately following the inspections conducted on 12/16/2025 and 12/29/2025, the Executive Director reported the medication error involving Resident #1 to the Department of Human Services (DHS) to correct the reporting deficiency.

On 12/16/2025, the Director of Wellness (DOW) reviewed Resident #1's medication orders and medication availability to ensure all medications were present and administered in accordance with the physician's orders. This review confirmed that medications were available and ensured there were no ongoing issues affecting this resident. The Executive Director implemented the following corrective actions to ensure compliance with incident reporting requirements and prevent recurrence:

On 12/30/2025, the Executive Director provided education to the Director of Wellness (DOW) and Assistant Director of Wellness (ADOW) regarding 55 Pa. Code §2600.16(c) incident reporting requirements, including the responsibility to report medication errors to DHS, notify the resident's physician, and notify the resident's family or responsible party.

On 12/30/2025, the Executive Director also conducted education with all Medication Associates, the Director of Wellness, and Assistant Director of Wellness regarding medication management procedures. Staff were instructed that Medication Associates must immediately notify the Director of Wellness if a medication is unavailable at the scheduled administration time.

On 12/30/26, all community staff were educated on incident reporting procedures and mandatory reporting responsibilities for all staff as per 2600.16c.

On 12/30/25 Medication Associates were further educated that any medication error, including a missed medication due to unavailability or any other reason, must be immediately reported to the Director of Wellness, Assistant Director of Wellness, or Executive Director so the required incident reporting process can be initiated. The process for reporting should be upon discovery an immediate oral report must be made to the DOW, ADOW or ED, followed by and end of shift written report will be placed in a designated area for follow up and record keeping by the DOW/ADOW/ED.

As of 1/30/26 the Director of Wellness or designee will be responsible for pulling a daily report from Tabular Pro the communities EMAR system to check medication administration records and generating medication reports to verify that medications are administered according to physician orders. If any deficiencies are identified, the incident reporting process will be initiated immediately to ensure compliance with 2600.14. These daily reviews will be kept by the Director of Wellness in [redacted] Office and made available to the Executive Director and department to review.

To ensure compliance with training requirements related to incident reporting, the Executive Director will audit all staff records for documentation of training on 55 Pa. Code §2600.16 incident reporting and medication administration procedures.

This audit of all applicable staff training records will be completed by the Executive Director on 03/8/2026

16c Written Incident Report (continued)

Any staff found to be missing required training will receive immediate re education, which will be documented in their personnel file. The Executive Director and Director of Wellness will be responsible for ongoing monitoring of compliance with medication administration procedures and incident reporting requirements.

The Director of Wellness will conduct routine reviews of medication administration records and medication reports to ensure medications are administered according to physician orders and that any medication errors are immediately identified and reported.

Any identified medication errors will be reported to DHS and the appropriate parties in accordance with 55 Pa. Code §2600.16(c).

The Executive Director will conduct periodic audits of incident reports and staff training documentation to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 04/06/2026)

185a - Implement Storage Procedures

3. 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 #1 has orders for the following medications; [redacted] take 1 tablet by mouth once daily at 9:00 p.m., [redacted] take ½ tablet by mouth once daily at 9:00 a.m., for [redacted] take 1 tablet by mouth once daily at 9:00 a.m., [redacted], take 1 tablet by mouth once daily at 9:00 a.m., [redacted]) take 2 tablets by mouth once daily at 9:00 a.m.,[redacted] take 1 tablet by mouth daily at 9:00 a.m., [redacted] tablet, take 1 tablet by mouth at 9:00 a.m., [redacted] tablet, take 1 tablet by mouth at 9:00 a.m., [redacted] capsule, take 2 caps by mouth 3 times a day at 9:00 a.m. and 3:00 p.m., [redacted] take 1 tablet by mouth daily at 9:00 a.m. The resident returned from the hospital on [redacted] at 6:00 p.m. According to the pharmacy receipt, these medications were not available on site until [redacted] at 7:09 p.m.

On [redacted] at 7:00 a.m. the incoming and outgoing staff member did not sign the narcotic count shift. On [redacted] the outgoing staff person at 7:00 p.m., did not sign the narcotic count sheet. On [redacted] at 7:00 p.m. the incoming and outgoing staff did not sign the narcotic count sheet. On [redacted] at 7:00 am and 7:00 p.m. the outgoing staff did not sign the narcotic count sheet. According to the facility policy, both the outgoing and incoming staff are to count the narcotics and initial the log to verify accuracy.

Repeat Violation [redacted] et al

Plan of Correction ***Accept [redacted] 03/03/2026)***

On 12/16/2025 The Executive Director did an education with the DOW and ADOW on regulations 2600.185a. on 12/17/2025 The Executive Director had a meeting with Pharmacy and have now implemented 2 deliveries a day a

185a - Implement Storage Procedures (continued)

morning delivery and a evening delivery. On 1/05/2025 The Executive Director and DOW meet with the med techs and they were coached on not signing the narcotic book. As of 1/30/2026 the medication associates are no longer work for Atrium. The 12/30 DOW and ADOW do daily checks on the narcotic books to ensure it is being signed. On 1/15/26 The Executive Director and DOW did an education with all med techs on Narcotic policy The DOW and ADOW will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *02/08/2026*

Implemented - 03/20/2026)

187a - Medication Record

4. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

On , Resident #1's medication record inaccurately indicates the resident refused the following medications; , take 1 tablet by mouth at 9:00 a.m., , take 1 tablet by mouth once daily at 9:00 a.m., capsule, take 2 (200 mg) by mouth 3 times daily at 9:00 a.m. and 3:00 p.m. and tablet, take 1 tablet by mouth at 9:00 a.m. These medications were unavailable on site and not delivered until at 7:09 p.m.

Resident #9 has an order for tablets twice daily: The medication administration record notes this order three times. One indicates take 1 tablet by mouth 2 times a day at 8:00 a.m. and 8:00 p.m. One indicates take 1 tablet by mouth 2 times a day 9:00 a.m. and 9:00 p.m., One indicates take 1 tablet by mouth 10:00 p.m. on only. According to the medication administration record, the resident received the medication 3 times a day on: 4 times a day on. , and . 5 times a day on: through through , and on . The medication administration record does not accurately reflect when the medication was administered.

Repeat Violation: et al

Plan of Correction ***Accept - 03/12/2026)***

Immediately, following the inspection residents #1 and #9 's medication list were reviewed by the Director of Wellness to ensure current compliance. On 12/30/2025 The Executive Director completed a coaching with DOW, and ADOW on regulation 2600.187a to ensure thorough understanding of the regulation. On 1/12/26 The Executive Director facilitated a training with all Med techs on regulation 2600.187.a Medication record and reviewed the communities medication policy. AS 1/30/26 the Director of Wellness or Designee will start a new process of pulling daily reports from Tabula pro to ensure compliance with medication administration according to physicians orders and to ensure proper documentation. The Director of Wellness will be responsible to address any areas of deficiency and apply appropriate corrective action if noted, that includes, notifying the Administrator, reporting to DHS if applicable and education or appropriate discipline to any staff responsible for documenting incorrectly on the resident record.

Licensee's Proposed Overall Completion Date: *03/10/2026*

187a Medication Record *(continued)*

Implemented [redacted] 03/20/2026)

187b Date/Time of Medication Admin.

5. 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] a printed copy of Resident #3's Medication Administration Record is blank for the following medications: [redacted] apply to L and R food daily at 8:00 a.m. on [redacted], Compression Stockings on at 8:00 a.m. [redacted] and [redacted] soft, on [redacted] at 8:00 p.m. [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted], on [redacted] at 8:00 p.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., Apply Ice pack on [redacted] at 8:00 p.m., 12/6/25 at 8:00 a.m., 12/7/25 at 8:00 p.m., [redacted], on [redacted] and [redacted], [redacted] tablet on [redacted], [redacted], [redacted], on [redacted] at 8:00 p.m., [redacted] at 8:00 a.m. [redacted] at 8:00 a.m., Elevation of legs on [redacted] at 7:00 p.m. On [redacted] Resident #3's Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident # 4's Medication Administration Record is blank for the following medications: [redacted], on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 a.m. and [redacted] 5 at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] chew tab on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 p.m. On [redacted] Resident #4's Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted] by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident #5's Medication Administration Record is blank for the following medications: [redacted] on [redacted] [redacted] on [redacted] at 8:00 p.m., [redacted] tablet on [redacted] 8:00 p.m., [redacted] on [redacted] at 8:00 p.m. [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m. On [redacted] Resident #5's Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Medication Administration Record is blank for the following medications: [redacted] tablet on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] tablet on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m. and [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted], on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., on [redacted] at 12:00 p.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at

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

8:00 a.m., [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] tablet on [redacted] at 8:00 p.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Administration Record is blank for the following medications: [redacted] tablet on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] tablet, on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 p.m., Furosemide 20 mg tablet on 12/6/25 at 8:00 a.m., 12/7/25 at 8:00 a.m., Losartan Potassium 50mg tablet on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 p.m., [redacted] tablet on 8:00 p.m., [redacted] tablet on 12/1/25 at 8:00p.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Administration Record is blank for the following medications: [redacted] at 8:00 p.m., [redacted] tablet [redacted] at 8:00 p.m., [redacted] tablet, take 1 by mouth daily missed [redacted] at 8:00 p.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows "Refused" was recorded on the Medication Administration record sometime between [redacted] and [redacted], by staff person C, not when the medication was refused.

On [redacted] a printed copy of Resident [redacted] Medication Administration record is blank for the following medications: [redacted], on [redacted] at 8:00 p.m. and [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 p.m., [redacted] at 8:00 a.m., and [redacted] at 2:00 p.m., [redacted] on [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 p.m., and [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] on [redacted] at 9:00 p.m., [redacted] tablet on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m. on [redacted] at 8:00 p.m. On [redacted] Resident [redacted] s Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted] by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Administration record is blank for the following medications: [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., 8:00 p.m. and [redacted] at 8:00 p.m., [redacted] tablet on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m. and [redacted] at 2:00 p.m., [redacted] tablet on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m. On [redacted] Resident [redacted] s Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted] by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Medication Administration record is blank for the following medications: [redacted] on [redacted] at 8:00 a.m., and [redacted] at 8:0 0a.m., [redacted] on [redacted] at 8:00 p.m., [redacted], on [redacted] at 8:00 p.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time

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

between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Medication Administration record is blank for the following medications: [redacted] on [redacted] at 8:00 a.m. and [redacted] at 8:00 a.m., [redacted] on [redacted] at 8:00 a.m., [redacted] at 8:00 a.m., on [redacted] at 8:00 p.m., [redacted] capsule on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] tablet on [redacted], and [redacted] at 8:00 a.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted] by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted]s Medication Administration record is blank for the following medications: [redacted], [redacted] and [redacted] at 8:00 a.m. an [redacted] at 8:00 p.m., [redacted] 1 mg tablet on [redacted] and [redacted] 8:00 a.m. and on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on missed [redacted] at 8:00 p.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

On [redacted] a printed copy of Resident [redacted] Medication Administration Record is blank for the following medications: [redacted], and [redacted], on [redacted] at 9:00 a.m. On [redacted] Resident [redacted] Medication Administration Record was reviewed and shows all the above listed dates and times were initialed as administered at some time between [redacted] and [redacted], by Staff person C, not when the medication was administered.

Resident [redacted] is prescribed; [redacted], tablet, take 1 by mouth daily at 9:00a.m., [redacted] tablet, take 1 by mouth daily at 9:00a.m., [redacted] tablet take 1 twice daily 9:00 a.m. and 8:00 p.m., [redacted], take 1 by mouth at 9:00 a.m., [redacted], take 1 by mouth daily at 9:00 a.m., Ft [redacted], take 1 by mouth daily at 9:00 a.m., [redacted] tablet, take 2 by mouth twice daily 9:00 a.m. and 4:00 p.m., [redacted], apply topically twice daily 9:00 a.m. and 8:00 p.m., [redacted], take 1 by mouth at 9:00 a.m., [redacted] tablet, take 1 and ½ by mouth at 9:00 a.m., [redacted], take 1 by mouth daily at 9:00 a.m. However, on [redacted], all the above listed 9:00 a.m. medications were not initialed as administered on the medication administration record.

Resident [redacted] has an order for [redacted] tablet, take 3 tabs of 2.5 to equal 7.5 mg daily at 8:00 a.m. On [redacted] at 8:00 a.m. the medications were not initialed as administered on the medication administration record.

Resident [redacted] has an order for blood sugar readings to be taken daily, before each meal, 3 times a day, with [redacted] to be administered based on a sliding scale. On [redacted], the resident's blood glucose readings and the [redacted] were not initialed as administered on the medication administration record.

Resident [redacted] has an order for [redacted] at 8:00 p.m., [redacted] at 8:00 p.m., [redacted], take ½ tab ([redacted]) at 8:00 p.m. [redacted] 1 tab at 8:00 p.m.and [redacted], take 1 tablet at 8:00 p.m. On [redacted] these medications were not initialed as administered on the medication administration record. On [redacted] at 8:00 p.m. the residents' [redacted], inject 10 units

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

at 8:00 p.m. were not initialed as administered on the medication administration record.

Repeat Violation [redacted] et al

Plan of Correction ***Accept [redacted] - 03/12/2026)***

On 12/29/2025 immediately following the inspection the executive Director did a coaching with DOW and ADOW on regulation 187.B to ensure they understands that only the person administering the medication can document the mar including refusals and late entry. On 1/16 The Executive Director did a education with the med- techs on regulation 2600.187b. on documentation to ensure they understand documentation procedure in accordance with regulation 2600.187b. As of 1/30 The DOW or ADOW will conduct daily review of the emar system that may have indicated any missed medications. If any missed medications are noted the DOW or ADOW will be responsible to notify the Excutive Director immediatley. The Executive Director along with the DOW will be responsible to follow up with the medication associate to verify if medication was administered, missed refused or not available. Upon determining the reason for the missing documentation in the MAR the med tech will be required to document a late entry of reason for the miss medication. If it determined the medication was in fact missed the community will follow the procedures for reporting medication errors. The DOW and ADOW will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented ([redacted] 03/20/2026)

187c - Refusal of Medication

6. 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

On [redacted] and on [redacted] at 8:00 p.m. Resident [redacted] refused the following medications: [redacted], [redacted], and [redacted]. The home did not notify the prescriber of the refusals.

On [redacted] at 9:00 p.m., [redacted] at 10:00 p.m. Resident [redacted] refused [redacted] tablet. The home did not notify the prescriber of the refusals.

On [redacted] at 9:00 a.m., Resident [redacted] refused the following medications: [redacted]

187c - Refusal of Medication (continued)

[redacted]. The home did not notify the prescriber of the refusals.

On [redacted] and [redacted] at 8:00 a.m., Resident [redacted] refused [redacted]. On [redacted] and [redacted] at 8:00 p.m. Resident [redacted] refused [redacted] and [redacted]. The facility did not notify the prescriber of the refusals.

On [redacted] and [redacted] at 8:00 p.m., Resident [redacted] refused [redacted], [redacted], and [redacted]. The facility did not notify the prescriber of the refusals.

Repeat Violation [redacted] et al

Plan of Correction ***Accept [redacted] - 03/03/2026)***

On 12/29/2025 The DOW contacted Resident #8, #9, #10, #11 & 13 the PCP and POA on residents refusal of medications A coaching was done by the Executive director with the med tech on medication refusal procedure as of 1/30/2025 the med tech involved were terminated. on 12/30/2025 The DOW and ADOW do weekly audits on carts and medication refusal. The DOW and ADOW will be responsible for ongoing compliance

Licensee's Proposed Overall Completion Date: *02/08/2026*

Implemented [redacted] - 04/06/2026)

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] by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted] ake 1 tablet by mouth once daily at 9:00 p.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted] take 1 tablet by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted], take 1 tablet by mouth once daily at 9:00 p.m. On [redacted] the resident did not receive this medication, because it was not available on site.

Resident [redacted] has an order for [redacted] take 2 tablets by mouth once daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted], take 1 tablet by mouth daily at 9:00 a.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted] tablet, take 1 tablet by mouth at 9:00 a.m. On [redacted], the resident

187d Follow Prescriber's Orders (continued)

did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted] capsule, take 2 caps by mouth 3 times a day at 9:00a.m. and 3:00p.m. On [redacted] the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted], take 1 tablet by mouth daily at 9:00a.m.. On [redacted], the resident did not receive this medication because it was not available on site.

Resident [redacted] has an order for [redacted] take 1 by mouth on the 8th of the month. This medication was not administered on [redacted].

Repeat Violation [redacted] et al, [redacted]

Plan of Correction ***Accept [redacted] - 03/12/2026)***

On 12/16/2025, the Executive Director provided education to the Director of Wellness (DOW) and Assistant Director of Wellness (ADOW) regarding the requirements of Pennsylvania Assisted Living Residence Regulation 2600.187(d), which requires the home to follow the directions of the prescriber. On 12/30/2025, the Executive Director conducted a training session with all medication associates to review medication administration requirements and reinforce the expectation that all medications must be administered according to the prescriber's orders. During this training, staff were instructed that any instance in which a medication is not available on site must be immediately reported to the Director of Wellness, Assistant Director of Wellness, Executive Director, and the pharmacy so that appropriate action can be taken to obtain the medication without delay.

Effective 12/17/2025, the community implemented a process for two daily pharmacy deliveries to ensure the timely receipt of medications for new orders or refills and to reduce the likelihood that medications will not be available at the time of administration. Additionally, a new medication management policy was implemented on 01/15/2026 and reviewed with the Director of Wellness, Assistant Director of Wellness, and Marketing Director to ensure understanding and consistent implementation of the new procedures.

Under this policy, all medication orders for new admissions must be sent to the pharmacy prior to the resident's admission, and medications must be delivered to and available in the community before the resident is admitted. This requirement also applies to residents returning from a leave of absence, including hospitalizations or rehabilitation stays, to ensure that medications are available upon their return to the community.

187d - Follow Prescriber's Orders (continued)

The Director of Wellness, or designee, is responsible for ensuring that all new medication orders are promptly processed with the pharmacy and that medications are received and available on site prior to the scheduled administration time. As of 12/17/26, the Director of Wellness and Assistant Director of Wellness will conduct weekly medication cart audits to verify that ordered medications are present and available for administration as prescribed. Any discrepancies identified will be addressed immediately with the pharmacy and appropriate staff.

The Director of Wellness and Assistant Director of Wellness are responsible for ongoing monitoring and compliance with these procedures to ensure that medications are available and administered in accordance with prescriber orders.

Licensee's Proposed Overall Completion Date: *03/10/2026*

Implemented [redacted] - 04/06/2026)

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.

Description of Violation

Resident [redacted] has an order for [redacted] take ½ tablet by mouth once daily at 9:00a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was not reported to the prescriber until [redacted].

Resident [redacted] has an order for [redacted] take 1 tablet by mouth once daily at 9:00a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was not reported to the prescriber until [redacted]

Resident [redacted] has an order for [redacted], take 1 tablet by mouth once daily at 9:00a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was not reported to the prescriber until [redacted]

Resident [redacted] has an order for [redacted] take 1 tablet by mouth once daily at 9:00p.m. On [redacted] the resident did not receive this medication, because it was not available on site. This was not reported to the prescriber until [redacted]

Resident [redacted] has an order for [redacted] take 2 tablets by mouth once daily at 9:00a.m. On [redacted] the resident did not receive this medication because it was not available on site. This was not reported to the prescriber until [redacted]

Resident [redacted] has an order for [redacted], take 1 tablet by mouth daily at 9:00a.m. On [redacted] the administration record inaccurately indicates the resident refused the medication when according to the pharmacy receipt, it was unavailable on site. This medication error has not been reported to the prescriber.

Resident [redacted] has an order for [redacted] tablet, take 1 tablet by mouth at 9:00a.m. On [redacted] the administration record inaccurately indicates the resident refused the medication when according to the pharmacy

188b - Medication Error Reporting (continued)

receipt, it was unavailable on site. This medication error has not been reported to the prescriber or designated person.

Resident [redacted] has an order for [redacted], take 2 caps by mouth 3 times a day at 9:00a.m. and 3:00p.m. the administration record inaccurately indicates the resident refused the medication when according to the pharmacy receipt, it was unavailable on site. This medication error has not been reported to the prescriber or designated person.

Resident [redacted] has an order for [redacted] take 1 tablet by mouth daily at 9:00a.m., the administration record inaccurately indicates the resident refused the medication when according to the pharmacy receipt, it was unavailable on site. This medication error has not been reported to the prescriber or designated person.

Resident [redacted] has an order for [redacted], take 1 by mouth on the 8th of the month. This medication was not administered on [redacted]. The medication error was not reported to the prescriber.

Repeat Violation [redacted] et al

Plan of Correction ***Accept [redacted] - 03/12/2026)***

Immediately following the inspection, on 12/16/2025 and 12/29/2025, the Director of Wellness (DOW), who is responsible for correcting this issue, notified Resident #1's and Resident #12's responsible parties (POA), primary care providers (PCP), and the residents as appropriate regarding the identified medication errors. The Department was also notified in accordance with Pennsylvania Assisted Living Residence Regulation 2600.16(c).

On 01/16/2026, the Executive Director and Director of Wellness conducted training with all Medication Technicians regarding medication error procedures and reporting requirements under Pennsylvania Assisted Living Residence Regulation 2600.188(b) and Pennsylvania Assisted Living Residence Regulation 2600.16(c). The training emphasized the requirement that all medication errors must be reported and documented and that the resident's primary care provider and responsible party must be notified when a medication error occurs.

Effective 01/01/2026, a new Medication Error/Incident Reporting Form was implemented to ensure consistent documentation and reporting. This form requires staff to document the medication error, the individuals notified (including PCP and POA), as well as the date, time, and other pertinent information related to the incident. The form must be completed immediately following the incident and placed in the designated location for review by the Director of Wellness no later than the end of the staff member's shift.

In addition to completing the form, staff are required to provide an immediate verbal report to the Director of Wellness, Executive Director, or designee. The Director of Wellness or Executive Director will review incident reports daily to ensure that all medication errors are properly documented and that required notifications have occurred. If neither the Director of Wellness nor the Executive Director is present in the building, the report must be provided to the Manager on Duty, and the completed form must also be scanned and emailed to both the Director of Wellness and Executive Director with the subject line "Incident Reporting Form." Staff are also required to notify both the Director of Wellness and Executive Director by phone to confirm that the report has been submitted.

The Director of Wellness and Assistant Director of Wellness are responsible for monitoring this process and ensuring ongoing compliance with medication error reporting and notification requirements.

Licensee's Proposed Overall Completion Date: *03/10/2026*

188b - Medication Error Reporting *(continued)*

Implemented [redacted] - 04/06/2026)