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

April 9, 2026

[redacted], ADMINISTRATOR
RIVERTON OPERATOR LLC

RE: RIVERTON ENHANCED SENIOR LIVING
803 NORTH WAHNETA STREET
ALLENTOWN, PA, 18109
LICENSE/COC#: 23044

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/12/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *RIVERTON ENHANCED SENIOR LIVING* **License #**: *23044* **License Expiration**: *01/24/2027*

Address: *803 NORTH WAHNETA STREET, ALLENTOWN, PA 18109*

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

Administrator

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

Legal Entity

Name: *RIVERTON OPERATOR LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/25/1983* **Issued By**: *dept L&D*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *41* **Waking Staff**: *31*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/12/2026*

Inspection Dates and Department Representative

02/12/2026 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *8* **Have Physical Disability**: *1*

Inspections / Reviews

02/12/2026 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/20/2026*

04/01/2026 - POC Submission

Submitted By: **Date Submitted**: *04/03/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/03/2026*

Inspections / Reviews *(continued)*

04/09/2026 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/03/2026*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At approximately 9:40 a.m. in the 1st floor laundry room, there was an approximate 1/8-inch accumulation of lint in the lint trap of the full-sized dryer. There were no clothes in the dryer at the time.

Repeat Violation 2/26/25 et al.

Plan of Correction ***Accept (- 04/01/2026)***

1. The lint trap of the 1st floor dryer was cleaned on 02/12/2026 by the maintenance director.
2. On 02/13/2026 the Executive Director educated the Housekeeping Director on 105g Lint Removal and Dust Cleaning.
3. On 02/24/2026 all housekeepers were educated by the Housekeeping Director to ensure that lint traps are free from lint.
4. On 02/16/2026 signs were hung in laundry rooms to remind staff and residents to clean lint traps after each load of laundry.
5. The housekeeping director conducted an audit of all lint traps on 02/16/2026 to ensure that lint traps are free from lint.
6. The housekeeping director or designee will conduct a random audit of 3 lint traps, 2 times per week for 2 months to ensure that lint traps are free from lint and in good repair. To be completed by 04/16/2026.
7. The Housekeeping Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *04/16/2026*

Implemented (- 04/09/2026)

125a - Combustible Storage

2. Requirements

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

Description of Violation

At approximately 9:50 a.m. in the 4th floor laundry room, there was a white plastic All laundry detergent bottle wedged behind the dryer and the wall.

Plan of Correction ***Accept (- 04/01/2026)***

1. The old laundry detergent container was removed on 02/12/2026 by the maintenance director.
2. On 02/13/2026 the Executive Director educated the Housekeeping Director on 125a Flammable and Combustible materials.
3. On 02/24/2026 all housekeepers were educated by the Executive Director to ensure that all laundry cleaning products are stored in resident apartments or moved to trash rooms once empty.
4. The Housekeeping director conducted an audit of all laundry rooms on 02/16/2026 to ensure that laundry rooms are free of cleaning agents.

125a - Combustible Storage (continued)

5. The housekeeping director or designee will conduct a random audit of 3 laundry rooms, 2 times per week for 2 months to ensure that all cleaning agents are stored appropriately. To be completed by 04/16/2026.
6. The Housekeeping Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *04/16/2026*

Implemented (█ - 04/09/2026)

132e - Fire Drill Sleeping Hours

3. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 12/31/25 at 5:01 a.m. The previous sleeping hours fire drill was conducted on 5/29/25 at 5:00 a.m.

Plan of Correction ***Accept (█ - 04/01/2026)***

1. Education was provided to the Maintenance Director on 132e by the Executive Director on 02/13/2026. Maintenance Director was educated to hold fire drills during sleeping hours at varied times throughout the overnight shift
2. An overnight fire drill was conducted on 02/27/2026.
3. Audits will be conducted 1x/month on all fire drills beginning on 03/01/2026 by Executive Director or designee to ensure fire drills are completed each month. To be completed by 05/01/2026.
4. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (█ - 04/09/2026)

183e - Storing Medications

4. 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

A Loose white circle pill was stored in medication cart labeled for room #400's drawer.

Resident #3's expired stool softener capsula 100mg was stored in the home's medication cart.

Plan of Correction ***Accept (█ - 04/01/2026)***

1. Expired Med was removed immediately on 02/12/2026 by staff member.
2. Lose Pill was removed immediately on 02/12/2026 by staff member.

183e - Storing Medications (continued)

3. Education was provided to all CMA's on 183e by the Wellness Director on 02/20/2026.
4. An audit was conducted on 02/26/2026 by the Wellness Director to ensure all medications were within date and in appropriate containers.
5. Audits will be conducted 2x/week on all medication carts beginning on 03/01/2026 by Wellness Director or designee to ensure all medications in carts are in assigned containers and within date. To be completed by 05/01/2026.
6. Wellness Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 04/09/2026)

185a - Implement Storage Procedures

5. 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 #4 is prescribed calcium antacid chew 500mg and Acetaminophen 325mg as needed. On 2/12/26 at 2:03 p.m. medications were not available in the home.

Resident #5 is prescribed Lactulose oral solution 10mg/5ml and Prochlorperazine Maleate oral tab 5mg as needed. On 2/12/26 at 2:08 p.m. medications were not available in the home.

Resident #6 is prescribed melatonin 3mg tab as needed. On 2:22 p.m. medication was not available in the home.

Resident #4 is prescribed blood sugar checks four times daily. On 2/11/26 at 8:36 p.m. the blood sugar reading 227 was recorded in the glucometer; however, the home did not note the reading on the resident's medication administration record. Resident #4 had a blood sugar reading of 420 on 2/7/26 at 7:32pm and the home did not note the blood sugar reading on the medication administration record.

Repeat Violation 4/29/25 et al.

Plan of Correction ***Accept (- 04/01/2026)***

1. Wellness Director reached out to doctor to discontinue or reorder/get new scripts for PRN orders without medications in cart on 02/13/2026.
2. Education was provided to Wellness Director on 185a by Executive Director on 02/13/2026.
3. On 02/13/2026 a PRN order was added to all resident charts with glucose monitoring orders to ensure any additional blood sugars were documented appropriately in the EMAR.
4. Education was provided to the CMA's on 185a by the Wellness Director on 02/20/2026.
5. An audit was conducted on 02/26/2026 by the Wellness Director to ensure all active orders had a medication supply in the cart.
6. Beginning on 03/01/2026 an audit will be conducted 1/week by Wellness Director or designee on all

185a - Implement Storage Procedures (continued)

glucometers to ensure all glucose readings are documented appropriately in the EMAR. To be completed by 05/01/2026.
7. Audits will be conducted 2x/week on all medication carts beginning on 03/01/2026 by Wellness Director or designee to ensure all orders in EMAR have corresponding medications in carts. To be completed by 05/01/2026.
8. The Wellness Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (█ - 04/09/2026)

190c - Record of Training

6. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff persons A, B, C, D, and F does not include whether the staff person had requalified or failed to requalify, student signature, student signature date, or trainer signature date. The annual practicums also note only one observation, and one medication record review was completed. Two were completed during the required timeframe however the documentation is incorrect.

Plan of Correction ***Accept (█ - 04/01/2026)***

1. On 02/13/2026 the Executive Director educated the Wellness Director on 190c Medication Administration Training to ensure all records are completed accurately and appropriately
2. On 02/16/2026 the Wellness Director conducted an audit on all CMA training documents to identify which employees are not in compliance with 190c and ensure they are corrected.
3. Beginning on 03/01/2026 an audit will be conducted 1/week by the Wellness Director on all CMA staff member trainings records to ensure all forms are completed appropriately per state requirements. To be completed by 05/01/2026.
4. The Wellness Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (█ - 04/09/2026)

225c - Additional Assessment

7. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

225c - Additional Assessment *(continued)*

Description of Violation

Resident #1's current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted]

Resident #2's annual assessment dated [redacted] notes the resident requires physical assistance transferring from their bed and chair. The resident also utilizes an enabler bar for transferring which is not noted in the assessment.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

1. On 02/13/2026 the Executive Director educated the Wellness Director on 225c initial and annual assessments.
2. On 02/16/2026 Resident #2 RASP was updated to include addendum for enabler bars.
3. On 02/16/2026 the Wellness Director conducted an audit on all resident RASPs to ensure they were completed within appropriate timeframe, and to ensure all residents utilizing enabler bars are indicated in assessments.
4. Beginning on 03/01/2026 an audit will be conducted 1/week by the Wellness Director or designee on all resident records to ensure all assessments are completed appropriately per state requirements. To be completed by 05/01/2026.
5. The Wellness Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 04/09/2026)