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

August 19, 2026

[redacted], ADMINISTRATOR
1680 SPRING CREEK ROAD OPERATIONS LLC
1680 SPRING CREEK ROAD
MACUNGIE, PA, 18062

RE: LEHIGH COMMONS
1680 SPRING CREEK ROAD
MACUNGIE, PA, 18062
LICENSE/COC#: 22205

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/20/2026 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEHIGH COMMONS* **License #**: *22205* **License Expiration**: *03/16/2027*

Address: *1680 SPRING CREEK ROAD, MACUNGIE, PA 18062*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *1680 SPRING CREEK ROAD OPERATIONS LLC*

Address: *1680 SPRING CREEK ROAD, MACUNGIE, PA, 18062*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/19/1997* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *91* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/20/2026*

Inspection Dates and Department Representative

05/20/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *14* **Residents Served**: *14*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *72*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *19*

Have Physical Disability: *0*

Inspections / Reviews

05/20/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2026*

07/07/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/17/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/20/2026*

Inspections / Reviews *(continued)*

08/19/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/17/2026*

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

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At approximately 2:04 p.m. there was no thermometer in the ice cream chest freezer in the kitchen.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

Administrator corrected the deficiency immediately. A thermometer was obtained and placed in the ice cream chest freezer.

On 6/16/26, All refrigerators and freezers throughout the facility were audited by Food Service Director to verify that each unit contains a functioning thermometer. Any missing thermometers were replaced immediately.

On 6/24/2026, Administrator will educate all staff on food storage requirements, including the requirement that all refrigerators and freezers have an easily visible thermometer and that temperatures are monitored in accordance with facility policy and applicable regulations.

Administrator updated Temperature monitoring logs to include the thermometer in place and temps are correct. The new log will start 6/25/26.

The Dietary Manager will verify weekly for four weeks that thermometers remain in place and that temperature documentation is being completed accurately starting Week 7/1/2026, will initial the log and report any identified concerns to the Administrator.

To ensure ongoing compliance, ongoing audit will be completed Quarterly by Dietary Manager.
This requirement will be added as a standing agenda item for monthly Quality Assurance meetings for the remainder of 2026 to monitor compliance, review audit findings, and reinforce adherence to regulation starting at the June 2026 meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

121a - Unobstructed Egress

2. 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

At approximately 9:20 a.m. the dining room exit door was blocked by a chair and a laundry cart on wheels, preventing immediate egress in the event of an emergency.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

Administrator immediately inspected the area of violation to confirm all exit routes are free of furniture, equipment, or any items that could impede evacuation. Administrator had Dietary Staff move tables further away from doors.

121a - Unobstructed Egress (continued)

Administrator purchased do not block door signs to be placed on doors.

On 6/24/26, Administrator will educate all staff on 2600.121.a, Unobstructed egress.

To ensure ongoing compliance, The Administrator/Designee and Maintenance Director will conduct daily environmental rounds for two weeks, then weekly thereafter for one month, to ensure all exit routes remain unobstructed.

This issue will be added as a standing agenda item for monthly Quality Assurance meetings for the remainder of 2026 to monitor compliance, review audit findings, and reinforce adherence to life safety regulations.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

123b - Emergency Procedures Posted

3. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The local municipality's emergency procedures were not posted in a public conspicuous area of the home.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

Administrator corrected the deficiency immediately and ensured the local municipality's emergency procedures were properly posted in a visible and conspicuous public area of the facility.

On 6/24/26, Administrator will educate all staff on 123b-Emergency Procedures posted.

To ensure ongoing compliance, Administrator will audit The Emergency Procedures Manual annually each January to verify compliance with posting requirements and to ensure all updates from the municipality are incorporated promptly.

Licensee's Proposed Overall Completion Date: *06/24/2026*

Implemented ([redacted] - 08/19/2026)

124 - Notice to Fire Department

4. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

124 Notice to Fire Department *(continued)*

Description of Violation

The homes notice to the fire department dated 5/11/26 notes 21 residents need assistance to evacuate; the home currently serves 19 residents who need assistance to evacuate in the event of an emergency.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

Administrator rewrote the notice to the Fire Department to include the requirements of 2600.124 and added a general description of the mobility needs of the residents served at the home.
By 7/20/2026, The administrator will get confirmation from the local fire department and ask whether additional information is required.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

132g - Fire Drills Days/Times

5. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely staffs the 11:00 p.m. to 7:00 a.m. shift with 4 5 staff persons. The overnight sleeping hour fire drills conducted on 1/23/26 at 6:17 a.m. 11 staff participated and on 8/28/25 at 11:35 p.m. 6 staff participated.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

Administrator requested a Fire Drill to be held during 11 pm 7 am when 4 5 staff members are routinely scheduled. Fire Drill was conducted successfully on 6/16/2026 at 4:32 am, 4 staff members participated.

On 6/24/26, Administrator will in service all staff on 2600.132g.

To ensure ongoing compliance, Administrator will review fire drill attendance to be sure only staff scheduled participated in the drill.

This requirement will be added as a standing agenda item for monthly Quality Assurance meetings to monitor compliance, review audit findings, and reinforce adherence to life safety regulations starting at the June 2026 meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

182c - Medication Administration

6. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

182c - Medication Administration *(continued)*

Description of Violation

At approximately 1:55 p.m. staff person A administered Resident #4's 2:00 p.m carbido/levo 25/100 mg without looking at the medication administration record. The staff removed the medication from the blister pack, administered the medication and then came back to initial the medication administration record.

Interviews with staff also indicated that while administering medications the staff will take the medication out of the blister pack, initial the medication administration records and then go administer the medication to the residents.

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

On May 27, 2026, the Administrator held an in-service for all Licensed Practical Nurses (LPNs) and Medication Assistants regarding the requirements of 2600.182c.

On June 24, 2026, the Administrator and Director of Health and Wellness (DHW) will provide an additional in-service to staff qualified to administer medications on this requirement and additional education and or corrective action will occur if not compliant.

To ensure ongoing compliance, Starting, 6/25/26, Director of Health and Wellness or Designee will conduct random weekly medication administration observations for four weeks and then monthly to be sure all employees are in compliance with the requirement. Any identified concerns will be addressed promptly through additional education and corrective action as indicated and logged on the facility's weekly medication audit form for the administrator to review.

This requirement will be added as a standing agenda item for monthly Quality Assurance meetings to monitor compliance, review audit findings, and reinforce adherence, starting at the June 2026 meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

185a - Implement Storage Procedures

7. 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

On 5/15/26 at 7:56 a.m., Resident #1's glucometer indicated the blood glucose was 120. 107 was incorrectly recorded on the medication administration record.

Resident#1's PRN Milk of Magnesia and sildenafil 100mg were not available at the time of the inspection.

Repeated Violation 6/17/25

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept ([redacted] - 07/07/2026)***

On 6/16/26, the documentation discrepancy for Resident #1's blood glucose result was reviewed by the Director of Health and Wellness. The documentation was corrected in accordance with facility policy.
Resident #1's PRN Milk of Magnesia was discontinued by the PCP, and sildenafil 100 mg was obtained and made available in accordance with the physician's orders.

During the week of 5/25/26 through 5/31/26, an audit of all resident PRN medications was completed to ensure medications ordered for use were present, available, and stored appropriately.

The facility had a current Medication Availability Audit and Blood Sugar Reading Log Audit processes in place. The Medication Availability Audit requires staff to complete medication audits each shift to ensure all resident medications, including PRN medications, are reviewed weekly for availability and accuracy. The Blood Sugar Reading Log Audit requires weekly review of blood glucose documentation. The deficiency occurred because the assigned staff member failed to complete the required audits as directed, resulting in missing medications and documentation concerns not being identified through the existing processes. The employee received corrective action in accordance with the facility's disciplinary policy.

On 6/24/26, the Administrator and Director of Health and Wellness will provide re-education to all Medication Administration staff regarding the survey findings, corrective actions implemented, expectations for medication management practices, proper medication documentation, blood glucose documentation requirements, and the importance of completing and utilizing all required audit tools.

To ensure ongoing compliance, Beginning 6/29/26, the Director of Health and Wellness will review completed Medication Availability Audit logs and Blood Sugar Reading Log audits weekly for four (4) weeks and monthly thereafter to ensure compliance with established facility processes.
The Director of Health and Wellness will verify that required audits were completed and signed by the responsible staff member. In addition, the Director of Health and Wellness or designee will conduct one random medication cart audit and one random resident blood glucose records weekly for four (4) weeks and monthly thereafter. This review will determine staff compliance to the assigned audit.
Any identified concerns will be addressed immediately through re-education and corrective action as appropriate. Results of all audits will be reviewed weekly and then monthly by the Administrator to ensure ongoing compliance.

This requirement will be added as a standing agenda item for monthly Quality Assurance meetings to monitor compliance, review audit findings, and reinforce adherence to life safety regulations starting at the June 2026 meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)

187b - Date/Time of Medication Admin.

8. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

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

Description of Violation

At approximately 9:29 a.m. staff person A administered medication to Resident #3 after initialing the medication administration record and prior to the medication being administered.

Repeated Violation 6/17/25

Plan of Correction ***Accept (- 07/07/2026)***

Staff Member A was immediately educated on 2600.187 b.
On 5/27/26, Facility's Market President, , RN, in-serviced all staff authorized to administer medications on 2600.187b.

On 6/24/26, Administer will review 2600.187b and facility corrective action at the all staff meeting.

To ensure ongoing compliance, The Director of Health and Wellness, or Designee will complete random Medication Administration observations and MAR audits to monitor compliance for 4 weeks and then monthly. Any identified concerns will be addressed promptly through additional education and/or corrective action as indicated by Administrator. Observations will be documented on the current Medication Audit tool.

This requirement will be added as a standing agenda item for monthly Quality Assurance meetings to monitor compliance, review audit findings starting at the June 2026 meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented (- 08/19/2026)

233c - Key-Locking Devices

9. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions to operate the key locking devices were not posted in the tv room to go into the secured dementia courtyard and to come back in from the courtyard into the tv room in the secured dementia care unit.

Plan of Correction ***Accept (- 07/07/2026)***

Administrator had the required operating instructions for the delayed egress/key locking devices posted at both the exit from the TV room to the secured dementia courtyard and the entrance from the courtyard back into the TV room. Photographs of the posted instructions will be maintained as evidence of correction.

On 6/24/2026, Administrator will in-service all staff on 2600.233.c Key-Locking Devices requirements.

To ensure ongoing compliance, the Administrator or designee will conduct a weekly environmental audit of the secured dementia care unit for four weeks and then monthly after to verify that the operating instructions remain posted, visible, and legible at all required locations.

233c Key Locking Devices (continued)

This requirement will be discussed at the Facility's monthly Quality Assurance meeting for the remainder of 2026 starting at July 2026's meeting.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/19/2026)