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

August 17, 2026

[redacted], DIRECTOR
ABODE CARE OF ALLENTOWN LLC
[redacted]

RE: ABODE CARE OF ALLENTOWN
2232 29TH STREET SW
ALLENTOWN, PA, 18103
LICENSE/COC#: 23039

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/16/2026, 06/25/2026, 07/08/2026, 07/13/2026 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: *ABODE CARE OF ALLENTOWN* **License #**: *23039* **License Expiration**: *09/13/2026*

Address: *2232 29TH STREET SW, ALLENTOWN, PA 18103*

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

Administrator

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

Legal Entity

Name: *ABODE CARE OF ALLENTOWN LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/04/2019* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *103* **Waking Staff**: *77*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *06/25/2026*

Inspection Dates and Department Representative

06/16/2026 - On-Site: [redacted]
06/25/2026 - On-Site: [redacted]
07/08/2026 - Off-Site: [redacted]
07/13/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *117* **Residents Served**: *84*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *19* **Have Physical Disability**: *3*

Inspections / Reviews

06/16/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/30/2026*

Inspections / Reviews *(continued)*

08/04/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/09/2026*

08/17/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

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

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home has provided Financial Management for resident #1 since [redacted] but there is no documentation that the resident or the resident's designated person received an itemized account of financial transactions on a quarterly basis during that period of the time.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On, June 30, 2026 the Executive Director sent out a letter to the affected residents along with a statement of itemized financial transactions in accordance with 2600.20b. Additionally, at that time in the letter the home provided a 30 day notice to the affected residents and to all residents that the home will no longer manage finances after the 30 day notice period. Included in the notification were instructions to make arrangements to from the resident or designated person to collect the balance and make arrangements to assist with managing residents finances. In this letter the home also offered means to safegard residents money and offered a lockbox to residents. After the 30 days the home will no longer manage finances and the resident's lease agreements will reflect this. In order to allow for mailing time the new policy will be effective On August 15th 2026, 45 days after notification to resident and designated persons. The Executive Director will be responsible to follow the new policy.

Licensee's Proposed Overall Completion Date: *08/15/2026*

Implemented ([redacted] - 08/17/2026)

20b9 - Record Keeping

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
9. A copy of the itemized account shall be kept in the resident's record.

Description of Violation

On 6/16/26 at approximately 11:30 a.m., resident #1 who receives financial management by the home. The home did not include a copy of a quarterly itemized account of financial transactions during the period of [redacted] through 3/31/26.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On, June 30, 2026 the Executive Director sent out a letter to the affected residents along with a statement of itemized financial transactions in accordance with 2600.20b. Additionally, at that time in the letter the home provided a 30 day notice to the affected residents and to all residents that the home will no longer manage finances after the 30 day notice period. Included in the notification were instructions to make arrangements to from the resident or designated person to collect the balance and make arrangements to assist with managing residents finances. In this letter the home also offered means to safegard residents money and offered a lockbox to residents. After the 30 days the home will no longer manage finances and the resident's lease agreements will reflect this. In order to allow for mailing time the new policy will be effective On August 15th 2026, 45 days after notification to resident and designated persons. The Executive Director will be responsible to follow the new policy.

20b9 Record Keeping *(continued)*

Licensee's Proposed Overall Completion Date: *08/15/2026*

Implemented ([redacted] - 08/17/2026)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person B hired on [redacted] did not have PA State Police Request for Criminal Record Check completed in accordance with Older Adult Protective Services Act (35 P. S. § § 10225.101 10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
Repeated Violation 12/10/2025, et al."

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On 06/26/26 the Office Manager ran the PA state Police Request for Criminal Record Check for staff person B. The record is kept in staff person b's file. On 06/30/26 the Office Manager completed an audit of all employee files to ensure compliance with the 2600.51. Any areas of deficiencies were corrected by the Office Manager and all employee records are now in compliance with 2600.51. Additionally, on 06/26/26 the Regional Director of Operations educated the Office Manager and Executive Director on 2600.51 to ensure understanding of the background check requirement. Moving foward the Executive Director will check all new employee files will be checked prior to orientation/first date of employment to ensure the Criminal History checks are being completed in accordance with 2600.51. A new checklist was created and will be used on all employee files as of August 1, 2026 by the Execuitve Director to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/17/2026)

102i - Soap Dispenser

4. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 6/16/26 at approximately 10:32 a.m., a used, unlabeled bar of soap was observed in the shower stall, in the 200 hallway shared shower room.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On 6/16/26 while the inspector was on site this was corrected by the Housekeeping supervisor the soap was thrown away. On 7/14 The Executive Director did a education with all staff on regulation 2600.102.i. Moving forward all residents choosing to use bar soap will be provided with a labled soap holder with their name on it. PCA and MT will be responsible to ensure that any bar soap used is transported in its case and returned to the case after each use. On July 30th The Executive Director will send out a memo to all resident that if that want to use bar soap they will be issued a holder with their name on it

102i Soap Dispenser *(continued)*

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/17/2026)

102j - Towels/Wash Cloths Access

5. Requirements

2600.
102.j. Towels and washcloths shall be in the possession of the resident in the resident's living space unless the resident has access to the home's linen supply.

Description of Violation

On 6/16/26 at approximately 10:20 a.m., a used, unlabeled loofah sponge was observed in the shower stall, in the 400 hallway shared shower room.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On 6/16/26 while the inspector was on site this was corrected by the Housekeeping supervisor the loofah was thrown away. On 7/14/26 The Executive Director did a education with all staff on regulation 2600.102.j. On July 30th The Executive Director will send out a memo to all resident that if that want to use a loofah that they need to ensure all personal items will not be left in the shared shower area. Moving Forward PCA and MT will ensure that all residents personal belongings will be removed from the shared shower room after each shower.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/17/2026)

183d - Prescription Current

6. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 6/25/26 at 11:15a.m., resident #4 prescription for Trimcinolone Acetonide 0.1 was found in the home's medication cart. However, the medication was d/c on 6/4/26.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On 6/25/2026 Immediately following the inspection the DOW removed the medication off the cart. On 7/14/26 The executive director facilitated an education with med techs at the all staff meeting on regulation 2600.183D. As of 7/31/2026 a new process was implemented for the DOW or ADOW to ensure all discontinued orders are signed off after the medication has been removed off the cart. The DOW and ADOW will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/17/2026)

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #6 has a prescription for Albuterol Sulfate HFA 90MCG/actuation, 2 puffs every 6 hours as needed. However, on 6/25/26 at 11:47a.m., the medication was not available in the home.
"Repeated Violation – 12/10/2025, et al."

Plan of Correction ***Accept (- 08/04/2026)***

On 06/25/26, upon requesting and verifying the order immediately and the Director of Wellness consulted with the physician and pharmacy the physician discontinued the PRN medication. On 07/14/26 a training was done with all medication associates, director of wellness and wellness director by the Executive Director to ensure understanding of regulation 2600.185a. Additionally, as of 07/30/26 the New Administrator implemented a daily cart audit to be facilitated by the Director of Wellness or designee to ensure The physician's orders (or current MAR/eMAR orders) – what the resident is prescribed., the medication administration record (MAR/eMAR) – what staff are expected to administer and the medications physically on the cart – what is actually available. This three-way reconciliation process will be followed daily by the Director of Wellness for one month starting on 07/30/26 and then will continue weekly thereafter to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2026*

Implemented (- 08/17/2026)

187a - Medication Record

8. 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

Resident #2 is prescribed Cyanobalamin 1000 mcg one tablet daily: however, on 6/16/25 the resident's Medication Administration Record lists the medication as Vit B12 1000 mcg one tablet daily.

Resident #2 is prescribed Lisinopril 20 mg with instructions to take one tablet at 1:00 p.m. daily. The resident's Medication Administration Record documents the prescription was changed on 2/05/26 to add a parameter to hold the medication for systolic blood pressure less than 100. As per staff person A, there have been no Doctor order's received adding the parameters until 6/11/26.

Plan of Correction ***Accept (- 08/04/2026)***

On 06/16/26 a new label was placed on the the bottle of the Vitamin b12 1000 mcg one tablet daily to match the prescribers orders and the MAR and the order was verified for resident #2. As of 06/11/2026 the order for the Lisiniprol 20 mg matched the MAr. The Regional Clinical Director is currently invesitigating the root cause of this error. Moving foward as of August 5, 2026 a new process will be in place that community Director of Wellness or Designee will follow up with all providers e-scripts to phamarcy to also send the community a hard copy of the order to be verified and to ensure accuracy. The Executive DIrector will educate the Director of Wellness and Assistant Director of Wellness on this new process on or before 08/05/26.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented (- 08/17/2026)

187d Follow Prescriber's Orders

9. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Pantoprazole 20 mg tablet twice daily and Prevagen 10 mg tablet once daily. The medications were not administered by the home during the period of 12/04/25 through 12/07/25.

Resident #3 has an order for blood glucose testing and administration of a sliding scale for the medication Novolog Flexpen 100u/ml from 6-9a.m., 11a.m.-1:00p.m., and 4-7p.m..The sliding scale order states administer the following if blood sugar is 150 to 199=2 units, 200 to 249 = 4 units, 250 to 299 = 6 units, 300 to 349 = 8 units, 350 to 399 = 10 units, and above 400 to contact physician. The resident's medication administration record documents the following:
6/2/26 at 6:35a.m., blood glucose was 130 and 2 units were administered.
6/12/26 at 11:44a.m., blood glucose was 107 and 2 units were administered.
6/13/26 at 11:08a.m., blood glucose was 102 and 2 units were administered.
6/22/26 at 11:04a.m., blood glucose was 117 and 2 units were administered.

Resident #4 has an order for Menthol Cold and Hot 5% patch apply one patch to lower back daily, on for 12 hours and off for 12 hours. The resident's medication administration record documents the patch was applied and removed in less than 12 hours on the following dates:
On 6/1/26 the medication patch was applied at 8:05a.m. and removed at 5:09p.m..
On 6/3/26 the medication patch was applied at 8:38a.m. and removed at 5:37p.m..
On 6/4/26 the medication patch was applied at 8:08a.m. and removed at 5:45p.m..
On 6/6/26 the medication patch was applied at 8:00a.m. and removed at 5:29p.m..
On 6/9/26 the medication patch was applied at 8:25a.m. and removed at 4:32p.m..
On 6/10/26 the medication patch was applied at 8:25a.m. and removed at 4:44p.m..
On 6/24/26 the medication patch was applied at 8:43a.m. and removed at 4:55p.m..

Resident #5 has an order for blood pressure testing at 8:00a.m. and 8:00p.m., and the administration of Metoprolol Tartrate 100mg every 12 hours with administration based on a parameter. The parameter order states to hold the medication if SBP is less than 110 or HR is less than 55. The resident's medication administration record documents the medication was administered on the following dates when the resident's heart rate was below 55:
6/14/26 resident's heart rate at 4:03p.m., was 50.
6/16/26 resident's heart rate at 5:12p.m., was 52.
6/18/26 resident's heart rate at 8:41a.m., was 54.
6/22/26 resident's heart rate at 5:02p.m., was 54.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

On 06/24/26 the Regional Clinical Director sent a reportable incident on the emdication errors and notified all apprropriate parties at the direction of the state inspector. On 07/14/26 the Executive Director did a training with all medication associates to re educated on proper medication procedures to include 2600.187d. As of 06/24/26 the Regional Clinical Director did a daily check to verify that medtechs were admnistering according to prescribers orders. Moving foward the community added a quality assurance process that includes our Clinical Regional Director checking at least 10 resident MARS weekly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *07/30/2026*

187d - Follow Prescriber's Orders *(continued)*

Implemented ([redacted] - 08/17/2026)

233c - Key-Locking Devices

10. 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 for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

The home currently does not have a Secured Dementia Unit License although the home did submit for licensure to BHSL. The area that was cited has a key locking device in preparaton for the approval of the SCDU licensing. Therefore, the current egress can be entered or exited without a code and any persons can come and go freely at this time. An audilble alarm does sound and a code is only used to suspend the sound. However, upon receiving this violation on 07/30/26 the new Executive Director will place a notice on the door that of how to reset the audible alarm that goes off whenever entering or exting the that section of the building. This notice will be updated with any new instructions should the home receive a license for the SCDU at the time of receipt by the Executive Director or designee. This regulation was reviewed by the Regional Director on 07/30/26 with the new Executive DIrector and the former Executive Director immediately following the inspection on 06/26/26.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/17/2026)