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

October 27, 2026

[redacted], EXECUTIVE DIRECTOR
COUNTRY MEADOWS OF ALLENTOWN LLC
[redacted]

RE: COUNTRY MEADOWS OF ALLENTOWN
430 NORTH KROCKS ROAD
BUILDING 1
ALLENTOWN, PA, 18106
LICENSE/COC#: 22693

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/25/2026 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: *COUNTRY MEADOWS OF ALLENTOWN* **License #**: *22693* **License Expiration**: *08/31/2027*

Address: *430 NORTH KROCKS ROAD, BUILDING 1, ALLENTOWN, PA 18106*

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

Administrator

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

Legal Entity

Name: *COUNTRY MEADOWS OF ALLENTOWN LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *05/23/1997* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/25/2026*

Inspection Dates and Department Representative

08/25/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* **Residents Served**: *76*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *60* **Residents Served**: *36*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *76*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *36*

Have Physical Disability: *1*

Inspections / Reviews

08/25/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *09/25/2026*

Inspections / Reviews *(continued)*

10/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/15/2026*

10/27/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2026*

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

29a SOPb5ii - Hospice Care: Fire Drill Simulation

1. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
ii. Reasonably simulate the level of effort required to move the resident and proceed to practice evacuation to the nearest unblocked exit or fire safe area. The simulation will include the number of staff persons that is required during an evacuation to safely move the resident.

Description of Violation

Interviews with staff confirmed that during the fire drill on 8/4/26 at 11:23 a.m., staff did not reasonably simulate the level of effort required to evacuate Resident #1 and did not proceed to practice evacuation to the nearest fire safe area.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

The Executive Director immediately reviewed the hospice fire-drill requirements. Education to coworkers to reasonably simulate the physical effort required to move the resident and proceed to the nearest unblocked exit or designated fire-safe area as required has been scheduled.

For all future fire drills where a resident has met the hospice exempt criteria, staff will reasonably simulate the level of effort required to evacuate the resident to a fire safe area.

The Executive Director or designee will review all fire-drill records for the next three months to verify that hospice simulations, when applicable, contain the required documentation and demonstrate compliance with the regulation. Any identified discrepancy will be corrected immediately and addressed.

Re-training sign in sheets to be provided.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented ([redacted] - 10/20/2026)

103f - Refrigerator/Freezer Temps

2. 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

On 8/25/26 at 9:34 a.m. the temperature in the Secure Dementia care unit kitchenette refrigerator was 50 degrees Fahrenheit and at 3:15 p.m. it was 45 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

The thermometer in the Secure Dementia care unit kitchenette was replaced with a brand-new calibrated thermometer on August 25, 2026. Once in place, the new thermometer read below 40 degrees indicating an issue with the previous thermometer not with the actual refrigerator.

103f - Refrigerator/Freezer Temps (continued)

Re-training regarding proper temperature for refrigerators and freezers to be completed by October 2, 2026.

Photograph of thermometer to be provided.
Sign in sheet for re-training to be provided.
The Director of Dining Services or the Connections Manager will complete daily thermometer checks for a period of 30 days.

The Director of Dining Services and Connections Manager will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented ([redacted] - 10/20/2026)

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 8/4/26 at 11:23 a.m. notes that 68 residents were in the home and that 68 residents were evacuated. As per interviews with staff it was determined that Resident #1 was not evacuated as per the provisions of regulation 29 however the fire drill log lists that all residents in the home were evacuated.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

The Executive Director reviewed the fire-drill documentation requirements and will ensure through training and monitoring that the drills are documented correctly. Accounting for the total number of residents present, number of residents physically evacuated, and number of residents addressed through an approved hospice simulation, when applicable.

Retraining to be provided by October 2, 2026 regarding the need to reasonably simulate the amount of effort needed to evacuate the resident and proceed to evacuate to the nearest fire safe area.

The Director of Maintenance and Executive Director will monitor monthly fire drills for ongoing compliance by will auditing fire-drill records for three months. The audit will verify that all required information is present and accurately reflects the drill conducted.

Sign in sheet for re-training to be provided.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented ([redacted] - 10/27/2026)

132c - Fire Drill Records *(continued)*

132d - Evacuation

4. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill conducted on 2/25/26 at 11:23 a.m. the home recorded an evacuation time of 16 minutes and 1 second. The home exceeded the evacuation time of 15 minutes which was specified by a fire safety expert on 8/20/25.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

During the fire drill conducted on 2/25/26, a resident was observed still in their apartment during the roll call portion of the fire drill. This resulted in the home not meeting the required evacuation time of 15 minutes since the resident was not evacuated to a fire safe area. At the conclusion of this drill, the Campus Executive Director and Maintenance Director immediately retrained the co-workers on 2/25/26 regarding proper evacuation.

This fire drill was re-run on 2/26/2026 with an evacuation time of 4 minutes 50 seconds and all residents were evacuated to a fire safe area.

The Executive Director and Director of Maintenance will monitor each subsequent fire drill for evacuation time and any problems encountered. Results will be reviewed after each drill to ensure compliance.

Training sign in sheet from 2/25/2026 re training to be provided as well as a copy of the fire drill log showing the repeat drill information from 2/26/2026.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented ([redacted] - 10/27/2026)

162c - Menus Posted

5. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week ending 8/29/26 was posted. However, the menus were not posted a week in advance from 8/25/26.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

The menu for the week of 8/25/26 was posted at the time it was discovered that the appropriate menu was not originally posted on the day of inspection.

162c Menus Posted (continued)

Retraining to be completed by October 2, 2026 regarding menu posting requirements.

The Director of Dining Services and the Dining Room Manager are to complete weekly audits for the next 90 days in order to ensure ongoing compliance.

Photograph of 2 weeks of menus posted to be provided.
Sign in sheet for re training to be provided.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented (- 10/20/2026)

187a - Medication Record

6. 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 #1 is prescribed Insulin Glargine on a sliding scale once daily at 8:00 a.m. However, Resident #1's August 2026 medication administration record does not indicate the number of units administered.

Repeated Violation 6/11/25

Plan of Correction ***Accept (- 10/13/2026)***

A review of Resident #1's medication order and medication administration record to ensure that the insulin order and MAR accurately identify the required dose and administration information was completed.

The residents EMAR has been updated beginning September 1, 2026 to display the number of units of insulin administered as well as the residents blood sugar reading.

Retraining regarding appropriate documentation in the residents MAR to be completed by October 2, 2026.

The DON and ADON will monitor for ongoing compliance through weekly audits over the next 90 days. The audit will verify that the prescribed dose, actual dose administered, and required documentation are accurately recorded.

Copy of residents MAR beginning 9/1/2026 to be provided.
Re training sign in sheet to be provided.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented (- 10/27/2026)

225c - Additional Assessment

7. Requirements

225c - Additional Assessment *(continued)*

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #4 utilizes an enabler bar, the resident's assessment dated [redacted] does not include the specific need for the device

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

Resident # 4's RASP was updated on 9/21/2026 to include the specific need for the enabler bar device.

An audit is to be completed on all support plans by October 2, 2026 for all residents who have a bed enabler to ensure that the correct information regarding the bed enabler is in each RASP.

Retraining to be completed by October 2, 2026, for all coworkers responsible for completing RASPs regarding the need for any resident with a bed enabler to ensure the reason for use is identified in each RASP.

The Director of Nursing and Assistant Director of Nursing will conduct a monthly audit of at least three residents RASP who have a bed enabler to review RASP documentation. This will be completed for 90 days.

A copy of resident # 4's RASP to be provided to show updated information.
Re-training sign in sheets to be provided.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented ([redacted] - 10/20/2026)

227e - Self Administer Medication

8. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #5's support plan dated [redacted] indicates the resident chooses the home to manage their medications; however Resident #5 self-administers their medications.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

Resident # 5's support plan has been updated on 9/21/2026 to reflect that resident self administers their medications.

The Director of Nursing or designee will review the medication-management status of all residents who self-administer medications to ensure that each resident's support plan accurately documents the resident's ability to self-administer medications or the need for medication administration.

227e - Self Administer Medication (continued)

Coworkers responsible for support-plan development will receive re-education regarding the requirement that support plans accurately reflect the resident's current medication-management status.

The Director of Nursing and Assistant Director of Nursing will audit the support plans of residents who self-administer medications monthly for three months to verify that the support plan agrees with the resident's actual medication-management practice.

A copy of resident # 5's RASP to be provided to show updated information.
Re-training sign in sheets to be provided.

Licensee's Proposed Overall Completion Date: *09/25/2026*

Implemented (- 10/20/2026)

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 for operating the home's locking mechanism are not conspicuously posted near the gate used to exit the Secure Dementia Care Unit (SDCU) courtyard.

Plan of Correction ***Accept (- 10/13/2026)***

The community immediately posted clear, legible operating instructions adjacent to the SDCU courtyard exit gate in a location readily visible to staff and other persons who may need to operate the locking mechanism.

Retraining to be completed by October 2, 2026 regarding conspicuously posting the directions for operating the home's locking mechanism.

The Connections Manager and Executive Director to complete an audit for a period of three months to make sure the information remains posted near the gate.

Photograph of the code posted in both locations to be included.
Re-training sign in sheet to be included.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented (- 10/20/2026)

234d - Support Plan Revision

10. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

234d Support Plan Revision *(continued)*

Description of Violation

Resident #2's support plan dated [redacted] does not include the services that hospice care provides to the resident.

Resident #3's support plan dated [redacted] does not include identification of the specific type of enabler bar attached to their bed or whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 10/13/2026)***

Resident # 2 deceased on [redacted] prior to the support plan being updated to add the services that hospice care was providing to the resident.

Resident # 3s support plan was updated on 9/21/2026 to identify the specific type of bed enabler and whether a cover is required to meet FDA guidelines.

The Director of Nursing and Assistant Director of Nursing will conduct a review of all residents receiving hospice services and all residents utilizing enabler bars or similar devices to ensure that their support plans accurately reflect the services, devices and resident specific needs.

Staff responsible for assessment and support plan development will receive re education regarding the requirement to revise support plans when a resident's condition, services, equipment, or needs change. Retraining to be completed by October 2, 2026.

A copy of resident # 3's RASP with updated information to be provided.
Re training sign in sheets to be provided.

Licensee's Proposed Overall Completion Date: *10/02/2026*

Implemented ([redacted] - 10/20/2026)