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

October 8, 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 09/02/2026 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

Type: *I-1* **Date**: *10/02/2020* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/02/2026*

Inspection Dates and Department Representative

09/02/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *76*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *secured* **Capacity**: *30* **Residents Served**: *21*

Hospice

Current Residents: *4*

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: *32*

Have Physical Disability: *1*

Inspections / Reviews

09/02/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2026*

09/30/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/07/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/07/2026*

Inspections / Reviews *(continued)*

10/08/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/07/2026*

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

183e Storing Medications

1. 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

At 11:30 a.m., Resident [redacted] s[redacted], Resident [redacted] s[redacted] and [redacted] and Resident [redacted] s[redacted] were in the medication cart. None of the pens were dated when they were opened to determine when they would expire.

Plan of Correction ***Accept [redacted] 09/29/2026)***

Immediately following the inspection on 09/02/2026, the Director of Wellness (DOW) reviewed the insulin pens identified during the inspection.

The following insulin pens were discarded and replaced with new pens:
Resident [redacted]
Resident [redacted]
Resident [redacted]

The replacement insulin pens were dated by the DOW on 09/02/2026 to establish the date opened and allow for accurate determination of the expiration/discard date in accordance with applicable medication requirements.

The Executive Director provided education to all Medication Technicians (MedTechs) on 09/02/2026, 09/16/2026, and 09/17/2026 regarding the proper dating of insulin pens when opened.

Education specifically addressed the requirement to:
Date each insulin pen when it is first opened. Ensure the date is clearly identifiable on the pen, Use the opening date to determine the appropriate expiration/discard date, Verify the date before administering insulin to ensure the pen remains within its allowable use period.

Effective 09/02/2026, the DOW or designee will conduct a daily audit of all insulin pens for a period of 30 consecutive days. The daily review will verify that each insulin pen is appropriately dated and that the date supports continued use within the applicable expiration/discard timeframe. This audit will be completed by 10/03/26.

Any insulin pen identified without the required opening date or beyond its allowable use period will be removed from use and addressed immediately.

Following completion of the 30-day daily monitoring period, the DOW or designee will remain responsible for ongoing compliance with insulin pen dating and expiration requirements. Compliance will be incorporated into routine medication monitoring and audits to ensure that all insulin pens are appropriately dated when opened and removed from use when they reach their expiration/discard date.

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

Implemented[redacted] - 10/08/2026)

187d Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] and [redacted] to be administered at 10:00 p.m. On [redacted] resident [redacted] was not administered these medications as prescribed.
Resident [redacted] is prescribed [redacted] at 2;00 p.m. On [redacted], Resident [redacted] was not administered the medication as prescribed.
Resident [redacted] is prescribed [redacted] once a day. On [redacted], the medication was not administered as ordered.

Repeated Violation.[redacted].

Plan of Correction ***Accept ([redacted] - 09/29/2026)***

On 08/23/2026, the Administrator identified medication errors involving Residents [redacted] and [redacted] during an internal medication record audit. The Administrator reported the incidents to the Department within 24 hours of discovery, in accordance with 55 Pa. Code §2600.16(c)(7).

During the Department's partial inspection on 09/02/2026, the inspector reviewed the reported incidents and substantiated the deficiency. Following the inspection, the Administrator reviewed the identified medication errors and confirmed that the required incident reporting had been completed.

On 08/30/2026, Staff Person A and Staff Person B were individually coached and counseled regarding medication administration requirements. Education included: The Five Rights of Medication Administration, the requirement to administer medications exactly as ordered by the prescriber, The importance of ensuring that medications are available and administered as prescribed, the requirement to verify medication orders against the Medication Administration Record (MAR) before dispensing or administering medication and Proper procedures for handling and implementing medication order changes.

On 09/02/2026, 09/16/2026, and 09/17/2026, the Administrator provided re-education to all medication administration staff. Training focused on comparing the current written prescriber order with the MAR before dispensing or administering medication, verifying the Five Rights of Medication Administration, and appropriately implementing changes to medication orders.

Additionally, the Regional Director of Clinical Services is scheduled to provide an additional medication management training on 10/01/2026. This training will reinforce medication administration procedures, order verification, MAR accuracy, order changes, and medication safety.

Effective 09/02/2026, the Director of Wellness (DOW), Administrator, or designee will conduct daily medication cart and MAR audits for 30 consecutive days. The audits will verify that:

Medications available on the medication cart correspond with current prescriber orders, MARs accurately reflect current medication orders., Medications are administered as prescribed, The Five Rights of Medication Administration are being followed, Medication order changes have been appropriately implemented, required medications are available for administration.

187d - Follow Prescriber's Orders (continued)

The initial 30-day monitoring period will conclude on 10/03/2026.

The Executive Director/Administrator will review the completed audits to verify that the audits are complete, accurate, and that any identified discrepancies are addressed promptly.

Following completion of the initial 30-day daily monitoring period, the DOW, Administrator, or designee will conduct weekly medication cart and MAR audits to maintain ongoing compliance with medication administration and documentation requirements.

The Executive Director/Administrator will continue to review the audits for completeness and accuracy and will ensure that any identified discrepancies are immediately investigated, corrected, and addressed through additional staff education or corrective action when indicated.

The DOW and Administrator will be responsible for maintaining ongoing compliance with 55 Pa. Code §2600.16(c)(7) and applicable medication administration requirements.

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

Implemented [redacted] - 10/08/2026)

234a - Admission Support Plan

3. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [redacted] was admitted to the secured dementia unit on [redacted] The assessment and support plan was not completed until [redacted].

Plan of Correction ***Accept [redacted] - 09/29/2026)***

Immediately following the partial inspection, the Administrator reviewed Resident [redacted]s record and documented the identified deficiency in the resident's file. Prior to the partial inspection, on 08/31/2026, the Administrator had completed an audit of all SCDU resident records for compliance with 55 Pa. Code §2600.234(a). This audit was initiated as part of the facility's corrective action in response to a previously identified deficiency and the associated Plan of Correction due to the Department on 08/28/2026. During the audit, the Administrator identified records requiring correction; however, the Administrator had not understood that, when an identified deficiency could not be corrected retrospectively without compromising the integrity of the record, the deficiency itself was required to be documented in the resident's record.

On 09/02/2026, the Regional Director of Operations provided direct education and counseling to the Administrator regarding the required process for documenting deficiencies identified during record audits. The Administrator was instructed that:
When an audit identifies a deficiency that can appropriately be corrected prospectively, the correction must be completed.

234a - Admission Support Plan (continued)

When a deficiency involves documentation that was completed late or was otherwise not completed within the required timeframe, the original document/date must not be altered or backdated. When the deficiency cannot be corrected retrospectively because doing so would compromise the integrity of the resident record, the Administrator or designee must place a dated notation in the resident's record identifying the deficiency and documenting the corrective action taken going forward.
This process applies to deficiencies identified during routine audits as well as deficiencies identified through regulatory inspections.
The Administrator was specifically educated that an initial Support Plan that was completed late cannot be backdated to reflect compliance with the original required timeframe. Instead, the record must accurately reflect when the document was actually completed, and the identified deficiency must be documented appropriately in the resident's record.

Effective 07/29/2026, an Admission Record Checklist was implemented for all new admissions. The Executive Director/Administrator is responsible for completing the checklist for each new resident admission to verify that all required admission documentation, including the Assessment and Support Plan, is completed accurately and within the required timeframe.
The completed Admission Record Checklist will be maintained in the resident's record as evidence that the admission documentation was reviewed for completeness, accuracy, and timeliness.

Moving forward, the Executive Director/Administrator will be responsible for ongoing compliance with §2600.234(a), including timely completion and review of required resident documentation. During subsequent record audits, any deficiencies identified will be corrected when correction is appropriate and possible. When a deficiency cannot be corrected retrospectively without altering the integrity of the original record, the Administrator or designee will document the deficiency and the corrective action taken in the resident's record.

Licensee's Proposed Overall Completion Date: *09/28/2026*

Implemented [redacted] - 10/08/2026)

251c - Standardized Forms

4. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [redacted] Documentation of Medical Evaluation, dated [redacted] was not completed on the Department's current standardized form.

Plan of Correction ***Accept ([redacted] - 09/29/2026)***

On 09/02/2026, the Director of Wellness (DOW) immediately contacted the resident's physician after the inspection identified that the resident's Department-standardized Medical Evaluation form had not been used. The DOW requested that the physician complete the Medical Evaluation on the correct Department-standardized form. The corrected Medical Evaluation was obtained and placed in the resident's record on 09/02/2026, bringing the resident's documentation into compliance with 55 Pa. Code §2600.251(c).

251c - Standardized Forms (continued)

On 09/02/2026, the Executive Director re-educated the DOW regarding the requirements of 55 Pa. Code §2600.251(c). The education specifically addressed the requirement to use the Department-standardized Medical Evaluation form and to verify that the required form is used before the documentation is accepted into the resident's record. The DOW was instructed that a Medical Evaluation completed on a non-standard form does not meet the documentation requirement and that the correct Department-standardized form must be obtained and maintained in the resident's record.

To determine whether the issue was isolated or existed in other resident records, the DOW, Executive Director, or designee completed an audit of all resident Medical Evaluations to verify that the Department-standardized form was being used as required.
The audit was completed on 09/23/2026. Any discrepancies identified through the audit were addressed in accordance with regulatory requirements.

Moving forward, the DOW, under the oversight of the Executive Director, will be responsible for ensuring that all required Medical Evaluations are completed on the current Department-standardized form before being accepted into the resident record.

Licensee's Proposed Overall Completion Date: *09/28/2026*

Implemented ([redacted] - 10/08/2026)