

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Phoebe Allentown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1925 Turner Street Allentown, PA 18104	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48578</p> <p>Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to ensure that residents were out of bed in accordance with individual preferences for one of 39 sampled residents. (Resident 40)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 40 had diagnoses that included history of a stroke with residual right-sided weakness and muscle weakness. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was alert and oriented, and was dependent on staff for transfers to and from bed and chair. According to the care plan, the resident was non-ambulatory, needed assistance from staff with transfers, and had a preference to be out of bed by 9:00 a.m. daily.</p> <p>Observations on August 6, 2024, at 10:15 a.m. and 11:15 a.m., and August 7, 2024, at 10:00 a.m. and 11:06 a.m., revealed that Resident 40 was in bed.</p> <p>In an interview on August 8, 2024, at 12:30 p.m., Resident 40 stated it was her preference to be out of bed by 10:00 a.m., at the latest, but she is usually not out of bed until much later.</p> <p>In an interview on August 8, 2024, at 10:24 a.m., the Director of Nursing confirmed that Resident 40 was to be out of bed by 9:00 a.m., based on her preferences.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs identified in the comprehensive assessment for two of 39 sampled residents. (Residents 33, 231)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 33 was admitted to the facility on [DATE], and had diagnoses that included diabetes and chronic kidney disease. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated October 13, 2023, noted that the resident's urinary incontinence was to be addressed in the care plan due to her medical history and prescribed diuretics. The MDS assessment dated [DATE], indicated that Resident 33 was always incontinent of urine and continued her use of prescribed diuretics. There was no documented evidence that interventions to address Resident 33's urinary incontinence were included in the current care plan.</p> <p>In an interview on August 8, 2024, at 10:25 a.m., the Director of Nursing confirmed there was no documented evidence that Resident 33's care plan included interventions for incontinence.</p> <p>Clinical record review revealed that Resident 231 was admitted to the facility on [DATE], and had diagnoses that included anxiety and depression. The MDS CAA summary dated April 14, 2024, noted that the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration record revealed the resident was currently receiving both an antipsychotic and antidepressant. There was no documented evidence that interventions to address Resident 231's psychotropic drug use were included in the current care plan.</p> <p>In an interview on August 8, 2024, at 9:15 a.m., the Administrator confirmed there was no documented evidence that Resident 231's care plan included interventions as identified above.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709</p> <p>Based on clinical record review, observation, resident and staff interview, and review of the activities calendars, revealed that the facility failed to provide an on-going activity program to meet the needs of five of 39 sampled residents. (Residents 20, 21, 107, 144, 193)</p> <p>Findings include:</p> <p>Review of the activities calendar for the week of Monday August 5, through Sunday August 11, 2024, revealed that on Tuesday August 6, 2024, there had been a morning activity scheduled for [NAME] Way nursing unit. On Wednesday August 7, 2024, there was no morning activity scheduled for [NAME] Way nursing unit. There was only one scheduled activity listed for August 7, 2024, for the entire day on the [NAME] Way nursing unit.</p> <p>Clinical record review revealed that Resident 20 had diagnoses that included dementia, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment section F which was preferences for routine activities, dated June 5, 2024, revealed that it was very important for the resident to keep up on the news, do things with groups of people, and do her favorite activities. A review of the care plan revealed that the resident needed cueing and set up to successfully engage in activities offered on the nursing unit.</p> <p>Observation on August 7, 2024, from 10:15 a.m., through 11:30 a.m., the resident was in the lounge area on the [NAME] Way nursing unit. There was no scheduled activity for the residents at that time. Throughout this time period, the resident was asking, What are the morning activities?, and she also stated that she was bored. She was observed frequently calling out for staff. She was also restless during this time period. In addition, she had no interest in what was on the television and she was not able to change the station.</p> <p>Clinical record review revealed that Resident 21 had diagnoses that included chronic kidney disease, congestive heart failure and depression. Review of the MDS assessment section F dated June 24, 2024, revealed that it was somewhat important to keep up on the news, listen to preferred music, do things with groups of people, and do her favorite activities. A review of the care plan revealed that the resident was to allow staff to assist her with activities, social stimulation, and social interaction.</p> <p>Observation on August 7, 2024, from 10:15 a.m., through 11:30 a.m., the resident was in the lounge area on the [NAME] Way nursing unit. There was no scheduled activity for the residents at that time. Throughout this time period, the resident was observed asking, what are the morning activities?, and she was restless. She was also frequently calling out for staff during this time period.</p> <p>Clinical record review revealed that Resident 107 had diagnoses that included anxiety, depression, and Parkinson's disease. Review of the MDS assessment section F dated June 29, 2024, revealed that it was very important for the resident to keep up on the news and that it was somewhat important to listen to preferred music, do things with groups of people, and do her favorite activities. A review of the care plan revealed that the resident was independent with choosing her leisure pursuits.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On August 7, 2024, at 10:00 a.m., the resident was observed in the lounge area on the [NAME] Way nursing unit. There was no scheduled activity at that time. At 11:23 a.m., the resident stated that she was bored, that she was aware there was no scheduled morning activity. She stated that she was aware that the only scheduled activity for the day was in the afternoon which she had planned to attend.</p> <p>Clinical record review revealed that Resident 144 had diagnoses that included dementia, depression, anxiety, and Parkinson's disease. Review of the MDS assessment section F dated July 21, 2024, revealed that it was very important for her to listen to preferred music, be around pets, keep up on the news, do things with groups of people, and do her favorite activities. A review of the care plan revealed that the resident was to attend group programs of her assessed interest.</p> <p>Observation on August 7, 2024, from 10:10 a.m., through 11:15 a.m., the resident was in the lounge area on the [NAME] Way nursing unit and there was no scheduled morning activity. In an interview at 11:15 a.m., the resident stated that she was bored because there was no activity going on and it seemed like the activities were repetitious at times.</p> <p>Clinical record review revealed that Resident 193 had diagnoses that included Alzheimer's dementia with agitation, anxiety, and depression. Review of the MDS assessment section F dated July 20, 2024, revealed that it was very important for her to do her favorite activities and somewhat important for her to listen to preferred music and do things with groups of people. A review of the care plan revealed that the resident joined her peers in group programs.</p> <p>Observation on August 7, 2024, from 10:00 a.m. through 11:30 a.m., the resident was in the lounge area on the [NAME] Way nursing unit and there was no scheduled activity. The resident was restless, continually coming back to the area to see if there was an activity, and stated that she was bored.</p> <p>In an interview on August 8, 2024, at 9:15 a.m., the Administrator stated that there had been no scheduled morning activity on the [NAME] Way nursing unit on August 7, 2024.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39422</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 39 sampled residents. (Resident 93)</p> <p>Findings Include:</p> <p>Clinical record review revealed that Resident 93 had diagnoses that included congestive heart failure and hypertension (high blood pressure). A physician's order dated April 19, 2024, directed staff to obtain a daily weight and to notify the provider for a weight gain of three or more pounds (lbs.) in one day. There was no evidence that staff obtained the resident's weight or that the resident refused to be weighed on June 4, 5, 6, 14, 16 through 24, and 27, 2024, July 7, 9, 15, 17, 27, and 30, 2024, and August 1, 2, and 4, 2024.</p> <p>In an interview on August 8, 2024, at 10:25 a.m., the Director of Nursing confirmed that there was no evidence that staff weighed the resident or that the resident refused to be weighed on the above-mentioned dates.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48578</p> <p>Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for one of eight sampled residents with limited range of motion. (Resident 40)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 40 had diagnoses that included history of a stroke with residual right-sided weakness and muscle weakness. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented and dependent on staff for all upper and lower body care. A physician's order dated July 31, 2024, directed staff to apply a splint to Resident 40's right elbow at 10:30 a. m., and remove it at bedtime daily.</p> <p>Observation on August 6, 2024, at 11:58 a. m., 12:47 p.m., and 2:26 p.m., revealed Resident 40 did not have the right elbow splint in place. The elbow splint was observed on the bedside table. On August 7, 2024, at 11:06 a.m., 11:45 a.m., and 1:10 p.m., the resident's right elbow splint was not in place. On August 8, 2024, at 10:55 a.m. and 12:30 p.m., the resident was observed without the right elbow splint in place. The splint was in a dresser drawer.</p> <p>In interviews on August 6, 2024, at 11:58 a.m., and August 8, 2023, at 12:30 p.m., Resident 40 stated she wanted to wear the splint, but she had to wait for staff to help her put it on. She further stated, They don't help me here. They say, ask for help, and I ask two or three times, but nobody helps me. Only one nurse was trained to put (the splint) on me.</p> <p>In an interview on August 8, 2024, at 10:23 a.m., the Director of Nursing confirmed that staff was to apply the right elbow splint as ordered by the physician.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45125</p> <p>Based on facility policy review, observation, and staff interview, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department, on two of six unit kitchens (1 [NAME] and 1 East), and on two of six unit pantries (2 East and 3 East).</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Labeling Food and Beverages, last reviewed February 27, 2024, revealed staff were to date all food items.</p> <p>Review of the facility policy entitled, Use and Storage of Resident Obtained Foods, last reviewed July 13, 2024, revealed that staff were to place the resident's name and date on any food placed in the unit pantry refrigerator and these items were to be discarded after five days.</p> <p>Observations during the main kitchen tour on August 6, 2024, at 9:45 a.m., revealed the following:</p> <p>In the meat cooler, there was an opened container of icing with a use-by date of May 21, 2024. There were four raw pork loins that were not properly labelled.</p> <p>In the produce cooler, there was an open container of coleslaw with a use-by date of July 24, 2024, and an opened bag of croissants that was not dated.</p> <p>In the walk-in freezer, there was ice build-up on three opened boxes of cinnamon rolls and biscuits and one box of ravioli. There was a pan with four dished containers of salmon with ice on top of the lids. The printing on the lids was illegible.</p> <p>In the 1 [NAME] kitchen cooler, there was an opened package of whipped topping that was not dated.</p> <p>In the 1 East kitchen cooler, there was one plated Danish that was not dated.</p> <p>In an interview on August 6, 2024, at 10:30 a.m., the Culinary Services Manager stated that the above mentioned items should have been dated and legible.</p> <p>Observation of the 2 East unit pantry on August 7, 2024, at 12:16 p.m., revealed a note on the refrigerator door that said it was for resident food only. Inside the refrigerator, there was an opened package of dates, an opened bottle of coffee creamer, an opened container of shredded cheese, and an opened jar that was labeled to be sour cherry and honey preserves but had an unidentifiable liquid product in it. These items were not labeled with a resident's name or date on them.</p> <p>Observation on 3 East unit pantry on August 7, 2024, at 9:30 a.m., revealed a note on the refrigerator door that said it was for resident food only. Inside the refrigerator, there were four sandwiches that were not labeled with a resident's name or date on them.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>28 Pa. Code 201.18(e)(2.1) Management.</p>