

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  07/17/2025
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and observation, it was determined that the facility failed to provide care and services to one of two sampled residents in a manner that maintained each resident's dignity. (Resident 220) Findings include: Clinical record review revealed that Resident 220 had diagnoses that included dementia with mood disturbance and feeding difficulties. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and required assistance with self-care including eating. A review of the care plan identified that the resident was at nutritional risk due to weight loss and receiving a mechanically altered diet. There was an intervention for staff to provide him with a physician's ordered diet of puree textured food and double portions. Observation on July 15, 2025, at 12:32 p.m., revealed that staff had delivered his lunch meal to him in his room while he was in bed. There were no utensils on the tray for him to use to eat his food. The resident proceeded to attempt to eat his pureed meal, which included mashed potatoes, with his fingers from the time the meal was served until 1:05 p.m. Resident 220 was observed having difficulty eating his food with his fingers and it was difficult for him to complete his meal in a dignified manner. 28 Pa. Code 201.29(j) Resident rights.</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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide services and treatment to prevent further limitations in range of motion for two of seven sampled residents who had limitations in range of motion. (Residents 11 and 183) Findings include: Clinical record review revealed that Resident 11 had diagnoses that included a stroke with hemiplegia (paralysis) affecting the non-dominant left side and contractures. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had limitations in range of motion on one side of both upper and lower extremities. A review of the care plan revealed that the resident required assistance with Activities of Daily Living (ADLs), and there was an intervention for staff to provide assistance as required for completion of ADL tasks. Review of the occupational therapy Discharge summary dated [DATE], revealed that the resident had a resting hand splint for the left hand/forearm. Current physician's orders revealed that staff was to apply a splint to the left forearm to be worn continuously and to check skin integrity every two hours. Observations on July 15, 2025, at 11:40 a.m., 1:00 p.m., and 2:00 p.m., revealed the resident was resting in bed without the splint in place on her left hand/forearm. Observation on July 16, 2025, at 12:16 p.m., revealed the resident was dressed and seated in her wheelchair in the dining room without the splint in place. Clinical record review revealed that Resident 183 had diagnoses that included a stroke with hemiplegia (paralysis) affecting the non-dominant left side and abnormal posture. The MDS assessment dated [DATE], indicated that the resident was alert and oriented and had limitations in range of motion on one side of both upper and lower extremities. A review of the care plan revealed that the resident required assistance with ADL's and there was an intervention for staff to provide assistance as required for completion of ADL tasks. Review of the occupational therapy Discharge summary dated [DATE], revealed that there was a recommendation for the resident to use a left upper extremity hand splint when she was in her wheelchair during the day. On May 4, 2025, a physician ordered for staff to apply a left hand splint every day. Observations on July 15, 2025, at 12:15 p.m., 1:00 p.m., and 2:00 p.m., revealed that the resident was dressed and seated in her wheelchair in her room. She did not have the left hand splint in place. Observation on July 16, 2025, at 12:15 p.m., revealed that the resident was seated in her wheelchair in her room without the left hand splint in place. During all observations, the left wrist/hand splint was laying on top of her nightstand. In an interview on July 17, 2025, at 1:00 p.m., the Director of Nursing stated that the splints were to be on as ordered by the physician for the two residents listed above. CFR 483.25 (c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Previously cited August 8, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, it was determined that the facility failed to ensure that staff provided adequate supervision in order to prevent falls for one of eight residents at risk for falls. (Resident 220) Findings include: Clinical record review revealed that Resident 220 had diagnoses that included dementia with mood disorder, anxiety, and a history of falling. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and had falls. A review of the care plan identified that the resident was at risk for falls. Review of a fall risk assessment dated [DATE], identified that the resident had a history of falls. Review of nursing documentation revealed that on January 5, 2025, at 4:30 a.m., the resident had fallen out of bed. On March 30, 2025, at 2:00 p.m., a nurse noted that the resident had again fallen out of bed. Review of facility documentation revealed that the resident had impulsive behaviors. On April 15, 2025, at 3:30 a.m., the resident had again fallen out of bed. On May 1, 2025, at 2:15 p.m., the resident was in the dining room and had fallen out of his chair. He sustained a lump on the right side of his forehead. On May 2, 2025, at 8:14 p.m., the resident was in the common living area on the nursing unit and had again fallen out of his chair and hit his head on the floor. He was then transferred out to the hospital for an evaluation. On May 15, 2025, at 8:30 p.m., a nurse noted that he had again fallen out of bed. The facility failed to provide adequate supervision to prevent falls for a resident who had impulsive behavior and had fallen six times in five months. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>