STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395080	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoebe Allentown Health Care Center	1925 Turner Street Allentown, PA 18104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to document the rationale for the continued use of as needed (PRN) anti-anxiety medications for one of five sampled residents who were on psychotropic medications. Findings include: Clinical record review revealed that Resident 40 had diagnoses that included Alzheimer's disease, dementia and anxiety disorder. The Minimum Data Set assessment dated [DATE], indicated that the resident had cognitive impairment. A review of the care plan revealed that the resident received anti-anxiety medications (Lorazepam) related to an anxiety disorder. On February 4, 2026, a physician ordered for staff to apply Lorazepam gel topically to the skin every two hours as needed for anxiety and to re-evaluate the need to continue the PRN medication on May 14, 2026. Review of the May 2026 Medication Administration Record revealed that the PRN Lorazepam had been applied as ordered six times in May. There was no documented evidence that the continued use of the PRN medication had been evaluated by the physician. In addition, there was no stop date indicated after 14 days for the PRN medication. In an interview on June 11, 2026, at 10:20 a.m., the Administrator stated that the PRN medication had not been re-evaluated by the physician and there was no stop date after 14 days ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed accurately to reflect the resident's current status for two of 35 sampled residents. (Resident 25 and 40) Findings include: Clinical record review revealed that Resident 25 had a diagnosis of Alzheimer's disease. A review of the care plan revealed a problem area as of May 22, 2026, that the resident had a terminal diagnosis related to Alzheimer's disease with a start of hospice care on May 22, 2026. On that date, a physician had ordered hospice services to start for the resident. Review of the significant change MDS dated [DATE], revealed that Section O for special treatments failed to reflect that the resident was on hospice services. Clinical record review revealed that Resident 40 had a diagnosis of dementia, anxiety and Post Traumatic Stress Disorder (PTSD). A review of the care plan dated June 27, 2024, revealed that the resident had a problem area of PTSD trauma with family growing up as a child and that the resident was able to still recall her years as a child at times as per family. Review of the psychosocial assessment dated [DATE], indicated that the resident had PTSD and that the family had reported she experienced trauma during her early childhood. Review of the annual MDS dated [DATE], revealed that the Section I for active diagnoses failed to reflect that the resident had PTSD. In an interview on June 11, 2026, at 10:20 a.m., the Administrator stated that the MDS assessments had not accurately reflected the resident's current medical status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed each resident's needs as identified in the comprehensive assessment for one of 35 sampled residents. (Resident 18)Findings include:Clinical record review revealed that Resident 18 had diagnoses that included obstructive sleep apnea. Review of Section O (Special Treatments, Procedures, and Programs) of Resident 18's Minimum Data Set assessment, dated May 27, 2026, indicated that the resident received a respiratory treatment from a non-invasive mechanical ventilator. A physician's order dated December 3, 2025, instructed staff to apply the continuous positive airway pressure (CPAP) device (a medical device used to treat sleep apnea by delivering a constant flow of air to keep the airways open during sleep) on Resident 18 every night. Review of the Treatment Administration Record from December 2025 to June 2026, revealed that the resident used the CPAP device every night. There was no documented evidence that use of the CPAP device was included in the resident's current care plan. In an interview on June 11, 2026, at 10:39 a.m., the Assistant Director of Nursing confirmed that there was no documented evidence that the CPAP device was addressed on the current care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for three of 35 sampled residents. (Residents 14, 18, and 204)Findings include: Clinical record review revealed that Resident 14 had a diagnosis of vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain), chronic kidney disease, and dysphagia (difficulty or discomfort when swallowing). A review of the Minimum Data Set Assessment (MDS), dated [DATE], revealed that Resident 14 had an unplanned weight loss. A dietary note dated May 11, 2026, stated that Resident 14 had an additional weight loss of four pounds over the last month, the resident's current intake did not appear to be meet the resident's needs as evidenced by weight loss, and recommended that the resident was to be assessed by a speech therapist related to chewing difficulty. On May 24, 2026, the physician ordered a speech therapy assessment for Resident 14 related to resident's report of chewing difficulties. There was no documented evidence that Resident 14 was assessed by Speech Therapy. In an interview on June 12, 2026, at 11:50 a.m., the Assistant Director of Nursing confirmed that Resident 14 was not assessed by speech therapy as ordered. Clinical record review revealed that Resident 18 had diagnoses that included spinal stenosis and abnormal posture. Review of the MDS assessment, dated May 27, 2026, revealed Resident 18 had cognitive impairment and was dependent on staff for upper body dressing. Review of Resident 18's care plan revealed she was at risk for bruises, skin tears, and skin breakdown with a goal for staff to apply Geri sleeves or encourage long sleeves clothing for prevention. On March 12, 2026, the physician ordered for staff to apply Geri sleeves to Resident 18's arms. Observations on June 9, 2026, at 12:00 p.m., 1:15 p.m., and 1:40 p.m., revealed Resident 18 was in bed wearing a short-sleeved shirt that exposed the skin on both arms from the forearms to above the elbows. The Geri sleeves were not in place. Further observations on June 11, 2026, at 11:55 a.m., and 12:25 p.m., revealed Resident 18 was in the dining room, wearing a short-sleeved shirt that exposed the skin on both arms from the forearms to above the elbows. The Geri sleeves were not in place. Resident 18 was not receiving any care at the time of the observations. In an interview on June 11, 2026, at 2:08 p.m., the Assistant Director of Nursing confirmed there was no documentation that the Geri sleeves were offered and that there were no refusals noted for Resident 18. Clinical record review revealed that Resident 204 had diagnosis that included Alzheimer's Disease, dementia, high blood pressure and ankle swelling. Review of the MDS assessment, dated April 22, 2026, revealed Resident 204 had cognitive impairment and was dependent on staff for both upper and lower body dressing. A physician's order dated August 6, 2025, instructed staff to apply tubigrips (an elastic tubular support bandage used to provide firm and continuous compression) to both lower extremities from base of toes to the knee, in the morning and remove in the evening daily for treatment of ankle swelling. Observations on June 9, 2026, at 10:30 a.m., June 10, 2026, at 12:20 p.m., and June 11, 2026, at 12:30 p.m., revealed the resident without the tubigrips in place. There was no documented evidence of refusals. In an interview on June 11, 2026, at 2:08 p.m., the Assistant Director of Nursing confirmed that staff did not apply the tubigrips to Resident 204 and there were no documented refusals. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement appropriate measures for the care and management of a peripherally inserted central catheter (a vascular access tool inserted into an upper arm vein to serve as an alternative to a shorter IV for treatment) in accordance with facility policy and professional standards of practice for one of 35 residents reviewed. (Resident 241) Findings include: Review of Pennsylvania Code Title 49, Chapter 21, Subchapter B. Practical Nurses, revealed guidelines which included that an LPN shall follow the written, established policies and procedures of the facility. A licensed practical nurse shall document and maintain accurate records. A licensed practical nurse may not falsify or knowingly make incorrect entries into the patient's record or other related documents. Review of the facility policy, titled Peripherally Inserted Central Catheter (PICC) Valved and Non-Valved, last reviewed December 17, 2024, revealed that upon insertion or admission of a resident with a PICC line, the type, catheter length, lot number and arm circumference must be determined and documented in the medical record. The initial insertion dressing was to be changed in 24 hours and then every seven days thereafter or more frequently as needed. The following information was to be recorded in the resident's medical record: Date of dressing change, length of the catheter as measured from the insertion site to the end of the hub, and upper arm circumference was to be documented every seven days. Clinical record review revealed that Resident 241 had diagnoses that included diabetes mellitus, high blood pressure and sepsis (bacteria infection) of the right foot wound. Resident 241 was admitted to the facility on [DATE], with a PICC line in place for administration of antibiotics. A physician order dated June 3, 2026, directed staff to change the central venous catheter dressing every five days and as needed. Observations of Resident 241 on June 9, 2026, at 10:27 a.m., June 10, 2026, at 12:42 p.m., and June 11, 2026, at 9:38 a.m., revealed that a PICC line was in place to the right upper arm and covered with a dressing. The dressing was dated June 3, 2026. In an interview on June 11, 2026, at 10:04 a.m., Resident 241 stated that the PICC line dressing had not been changed since she was in the hospital, prior to her admission to the facility on June 3, 2026. Review of Resident 241's Medication Administration Record (MAR) for June 2026 revealed that licensed practical nurse (LPN) 1 indicated that the dressing change was completed on June 8, 2026. There was no evidence that the resident refused a dressing change. In an interview on June 11, 2026, at 10:04 a.m., licensed practical nurse (LPN) 2 confirmed the resident's dressing was dated June 3, 2026, and it had not been changed. In an interview on June 11, 2026, at 2:08 p.m., the Assistant Director of Nursing confirmed that the nurse falsely documented that the dressing change was completed on June 8, 2026, and that the resident's actual dressing remained dated June 3, 2026. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one sampled resident receiving dialysis (process of removing excess toxins and water from the blood). (Resident 18)Findings include:Clinical record review revealed that Resident 18 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis. On January 2, 2026, the physician ordered for staff to send Resident 18 to dialysis every Monday, Wednesday, and Friday. On November 25, 2025, the physician ordered for staff to ensure the post dialysis summary was returned with Resident 18 after each dialysis session. If not returned, then the licensed staff were to contact the dialysis center to obtain the information every day shift on Monday, Wednesday, and Friday. There was a lack of evidence to support that staff obtained the post dialysis summary information for Resident 18 on 35 of 56 occasions between February 1, 2026, through June 10, 2026. During an interview on June 12, 2026, at 8:54 a.m., the Administrator confirmed that there was no documented evidence that staff ensured the completed post dialysis summary was returned or that staff contacted the dialysis center if the form was not returned after each dialysis session. 28 Pa. Code 211.12(1)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 35 sampled residents. (Resident 111)Findings include: Review of the facility policy entitled, Transmission Based Precautions - Infection Control, last reviewed August 19, 2025, revealed that a gown and gloves were to be used when providing any high contact resident care activity which included wound care. Clinical record review revealed that Resident 111 had diagnoses that include high blood pressure, vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain), and peripheral vascular disease (a circulation disorder characterized caused by plaque buildup in blood vessels outside the heart and brain). A wound assessment report dated June 2, 2026, revealed that Resident 111 had a stage four pressure injury (a severe, full thickness wound that penetrates through all skin layers, exposing deep structures like muscle, tendon, ligament, cartilage, or bone) on the sacrum (the large bone at the base of the spine and the center of the pelvis). A physician's order dated June 8, 2026, directed staff to apply gauze soaked with Vashe wound solution (a solution that gently cleanses wounds for optimal healing) to the wound base, lightly pack the wound bed with Kerlix (a 100% cotton fluff bandage), and cover with a dry dressing twice a day. During an observation of wound care to Resident 111's sacral pressure injury, on June 10, 2026, at 10:30 a.m., the registered nurse (RN 1) did not wear a gown during the dressing change. On June 10, 2026, at 11:45 a.m., the Assistant Director of Nursing confirmed that staff did not use appropriate personal protective equipment (PPE) during Resident 111's dressing change. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.