Department of Human Services
Bureau of Human Service Licensing

February 6, 2022

[redacted]
STABON MANOR PERSONAL CARE HOME, INC.
1555 HAAK STREET
READING, PA, 19602

RE: STABON MANOR PERSONAL CARE HOME
1555 HAAK STREET
READING, PA, 19602
LICENSE/COC#: 20512

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/23/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *STABON MANOR PERSONAL CARE HOME* **License #**: *20512* **License Expiration**: *04/21/2022*

Address: *1555 HAAK STREET, READING, PA 19602*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: *6103732272* **Email**: [redacted]

Legal Entity

Name: *STABON MANOR PERSONAL CARE HOME, INC.*

Address: *1555 HAAK STREET, READING, PA, 19602*

Phone: *6103732272* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/18/1991* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *89* **Waking Staff**: *67*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *09/23/2021*

Inspection Dates and Department Representative

09/23/2021 - On-Site: Pamela Harris

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *160* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *71* **Are 60 Years of Age or Older**: *47*

Diagnosed with Mental Illness: *39* **Diagnosed with Intellectual Disability**: *16*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

09/23/2021 - Partial

Lead Inspector: *Pamela Harris* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/27/2022*

Inspections / Reviews *(continued)*

01/25/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/28/2022*

02/06/2022 - Document Submission

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

The home did not immediately notify the local area agency on aging of the alleged emotional abuse of residents by Staff A and Staff B.

Plan of Correction ***Accept***

Staff A was terminated on 9/12/2021 report was sent to DHS request AAA was sent a report on 9/23/2021, a verbal report to AAA was done on 9/13/2021.
Staff B abuse was brought to the owner's attention on 9/21/2021. Reports to DHS and AAA were completed and sent on 9/23/2021, it was within 24 hours as required. In the future, all abuses will be reported by the Administrator, as required.

Deysi Ynoa, Adm

Document Submission ***Implemented***

completed

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 9/14/21 Allegations of emotional abuse were made against staff B. A report was not made to the Department.

Plan of Correction ***Accept***

This is not correct as stated in the description.
Staff A was reported during the Resident Council Meeting on 9/14/21, after that Staff A was terminated.
Staff B was not reported at this meeting. Reports came to the owner on 9/21/21. In the future, if any type of abuse occurs, the new Administrator will report it immediately, as soon as if is reported.

[redacted], *Adm*

Document Submission ***Implemented***

completed

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

42s - Privacy *(continued)*

Description of Violation

Through interviews with Staff C, Staff D, Staff E, and Staff F it was confirmed that when the smoking policy changed to no smoking on premise staff A ordered all direct care staff to confiscate all residents cigarettes and lighters.

Plan of Correction ***Accept***

Privacy coding document only lists staff C, D, and E. No F, Staff A, the Administrator terminated for abuse, made [redacted] decision on [redacted] own, and instructed staff to perform this task. Staff A should have known this was a violation since the termination of staff A no items from residents have been removed. The new administrator has educated the staff on the importance of following this regulation, so we are in compliance. in the future, the Administrator will be responsible to keep staff educated on this matter.
[redacted], Adm

[redacted], Adm

Update: *01/25/2022*

please send/Attach proof of staff training. 1-25-2022 MM

Document Submission ***Implemented***

Please see attached

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff A was treating residents #1 through #4, in disrespectful manner by yelling at residents, slamming office door in their faces, reporting in the social room that they do not have money in their account., and threating residents with a 30-day notice if they come to the office to ask questions.

Staff B was treating resident #1, resident #2, resident #3, and Resident #4 disrespectful when Staff B would yell at residents, threaten residents with bodily harm, and throw ice at them.

repeat violation - 12/21/20, 9/29/20

Plan of Correction ***Accept***

Staff A and Staff B were terminated upon completion of an internal investigation.
Staff A was terminated on [redacted]
Staff B was terminated on [redacted]
All staff was told that abuse of any kind will not be tolerated and any staff member that witnesses an abuse must report it immediately.
In the future, the Administrator will make sure that any staff member is terminated if they are found guilty in any abuse case.

Deysi Ynoa, Adm

42c - Treatment of Residents *(continued)*

Document Submission ***Implemented***

Please see attached