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

June 20, 2024

[redacted] ADMINISTRATOR
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 05/01/2024, 05/02/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *STABON MANOR PERSONAL CARE HOME* **License #**: *20512* **License Expiration**: *04/21/2025*

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

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

Administrator

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

Legal Entity

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

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

Phone: [redacted] **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**: *115* **Waking Staff**: *86*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/02/2024*

Inspection Dates and Department Representative

05/01/2024 - On-Site: [redacted]

05/02/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *160* **Residents Served**: *115*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *93* **Are 60 Years of Age or Older**: *79*

Diagnosed with Mental Illness: *90* **Diagnosed with Intellectual Disability**: *27*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

05/01/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/02/2024*

06/14/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/19/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/19/2024*

Inspections / Reviews *(continued)*

06/20/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/19/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The 55 PA code 2600. Regulations were not posted in the home on the date of inspection.

Plan of Correction ***Accept (- 06/14/2024)***

This issue was corrected while survey was taking place. On a weekly basis, beginning May 3, 2024 and onward, the Administrator shall check that the DHS regulations are posted in a public place, and if found missing, will immediately replace it.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented (- 06/20/2024)

15c - Supervision

2. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

Staff Person A was accused of taking drugs from the home and selling them by Staff Person B on -24. Staff Person A was allowed to continue working without a plan of supervision being approved by the Department. A Plan of supervision was put in place and was approved by the Department on -24 however the employee was not suspended and was working continuously prior to the plan's approval.

Plan of Correction ***Accept (- 06/14/2024)***

After the internal investigation, there was no merit found to the claim made. Person A was a victim of employee retaliation. A phone call was requested to at DHS by the owners to discuss this matter but never made that call. A plan of supervision (POS) was faxed to the department with a telephone call following up asking for approval of the POS. It is still in place for Staff Person A until the DHS investigation is concluded. It has been several weeks and we still haven't heard from DHS if the POS was accepted. As suspending Staff Person A would have been an undue hardship on both staff and residents, Staff Person A continued to work under the guidelines of the POS. Moving forward, should a POS need to be implemented for any staff person, the Administrator shall suspend the staff and contact DHS.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented (- 06/20/2024)

17 - Record Confidentiality

3. Requirements

2600.

17 - Record Confidentiality *(continued)*

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The home's Conference Room was unlocked at time of inspection, and had multiple resident medication administration records unsupervised, unlocked and accessible.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Administrator removed the MARs out of the conference room on Thursday, May 2, 2024 and shall, monthly, check that there are no new records in that room. There were no resident or staff records anywhere else in the conference room. The Administrator will continue to make periodic checks to ensure that any resident paperwork is kept in a secure location.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

18 - Compliance With Laws

4. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The influenza poster located in the home was posted in the home's medication room and was not posted in a public area.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The influenza poster was moved from it's former location in the medication room to a more public location while the survey was taking place. The Administrator shall make it part of the weekly hallway rounds to ensure that the influenza poster remains in a public place.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

57b - 1 Hour/Day

5. Requirements

2600.

57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On the following dates, the home had a census of 105 residents in the building, requiring a total of 105 direct care staffing hours to be provided daily, with 78.75 of those hours provided during waking hours. On 4/27/24 the home had only 102.5 total direct care staffing hours scheduled. On 4/28/24 the home had only103.5 total direct care staffing hours scheduled.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Employee Supervisor and Administrator has been working to hire additional staff so that all staffing hours can

57b - 1 Hour/Day (continued)

be met. Open positions for DCS are on Indeed, word of mouth and telephone calls with active applications to date. Should no new staff be available, the Administrator will ensure that all hours are covered by offering available shifts and hours to staff, including overtime so that staff hours are met. The Administrator shall review the schedules daily to ensure staff hours are met.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On the following dates, the home had 105 residents in the building, requiring 3 staff certified in FA/CPR in the building at all times. On the following dates and timeframes there were not enough CPR/FA trained staff in the building:

4/26/24
From 10p – 6a, only 2 staff present in the building certified in CPR/FA.

4/27/24
From 8p-10p, only 2 staff present in the building certified in CPR/FA.
From 10p-6a, only 1 staff present in the building certified in CPR/FA.

4/28/24
From 6p-10p, only 2 staff present in the building certified in CPR/FA.
From 10p-6a, only 1 staff present in the building certified in CPR/FA.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

On April 26, 2024 there were three CPR trained employees on the night shift. I am attaching copies their CPR cards. Since the inspection, the Facilities Manager has become a certified CPR/First Aide Trainer as of 5/25/2024. This will allow us to train staff in CPR /First Aide in the facility. Classes have been set up for June 3, 2024 and June 4, 2024. All ancillary staff will be CPR/First Aid trained by June 30, 2024. This is put in place so that all staff is CPR/First Aid trained and all CPR/FA hours are covered. The Facilities Manager, and Administrator shall meet together monthly to ensure CPR/FA certificates and training are up-to-date.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics *(continued)*

Description of Violation

Staff person C, date of hire [redacted], did not complete training in Meeting needs of residents using RASP/DME/Prescreen in annual training year 2023.

Repeat violation 5/9/24, et al.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Administrator shall offer 'catch-up' trainings in the month of December to ensure that all staff completes required annual training. Though Staff Person C had more than 12 training hours, the Administrator shall audit all training so that required training is completed by end of training year (Training year January - December)

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

87 - Lighting

8. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The light located in the social room on the 3rd floor of the home was inoperable.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The light in the 3rd floor social room was replaced while the survey was taking place. The Administrator and Maintenance shall check all light sources weekly and replace any/all bulbs that do not work properly.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

101j7 - Lighting/Operable Lamp

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On the date of inspection, bedrooms #1 and #103 did not have a bedside light source available within the resident's reach.

Repeat violation: 5/9/23, et al

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

In both room #1 and #103, the light was present and in good working order. In room #1, the resident expressed to the surveyor that the light was not welcomed at bedside; however, the surveyor was able to place the lamp bedside and within the resident's reach by explaining the regulations. In bedroom #103, the resident had unplugged and moved the bedside lamp to charge the resident's phone. The Facilities Manager was able to put the bedside lamp back to where it was within resident's reach, plug it in and turn it on for the surveyor. The resident was asked to

101j7 - Lighting/Operable Lamp (continued)

keep the lamp there to meet the regulations. Moving forward, the Administrator shall re-educate all residents as to the importance of bedside lamps and will document any needs plans for the residents in the RASP as well as checking for operable and correctly placed lamps by the housekeeping staff and during the Administrators weekly room inspections.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

125a - Combustible Storage

10. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Cigarette butts were found outside the home in the shrubbery near the exit leading outside to the home's designated smoking area.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The cigarette butts were removed from the shrubbery near the exit leading to the home's designated smoking area. The Administrator, Housekeeper, Facilities Manager and Maintenance will survey the grounds on a daily basis to ensure that cigarette butts are placed in the proper receptacles in the designated smoking area.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 6/30/23 does not include Exit Routes used to evacuate.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Administrator shall ensure that all parts of the paperwork/reporting of all fire drills are completed properly. The Administrator shall also remind all participants, including a fire safely expert, the importance of reporting proper exits routes for evacuation during monthly fire drills so that there is proper documentation.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

132e - Fire Drill Sleeping Hours

12. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

The home last conducted an overnight fire drill on 8/22/23 at 10:00pm, which exceeds the 6-month timeframe required by this regulation.

Plan of Correction ***Accept (- 06/14/2024)***

The Facilities Manager and Administrator shall coordinate and plan, as well as hold, overnight fire drills that are no more than six-months apart. A successful overnight fire drill was held on Tuesday, May 21, 2024 at 0545. The next overnight fire drill will be held no later than November 21, 2024.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented (- 06/20/2024)

132h - Designated Meeting Place

13. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the following fire drills, not all residents were evacuated. The home's administrator stated that these residents were receiving hospice services and were not evacuated.

8/22/23 – 108 of 109 residents in the building were evacuated;
9/11/23 – 100 of 102 residents in the building were evacuated;
10/11/23 – 102 of 104 residents in the building were evacuated;
12/15/23 – 97 of 99 residents in the building were evacuated;
1/26/24 – 104 of 106 residents in the building were evacuated;
2/27/24 – 87 of 88 residents in the building were evacuated;
3/15/24 – 99 of 100 residents in the building were evacuated;
4/30/24 – 95 of 96 residents in the building were evacuated.

The home did not implement the Hospice Care and Services Statement of Policy § 2600. 29ab1-29a-b11

Plan of Correction ***Accept (- 06/14/2024)***

All staff will be retrained on the proper procedure of evacuation of any hospice residents during a fire drill by Friday, May 31, 2024. Until this resident is actively dying, this resident will be evacuated during every fire drill.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented (- 06/20/2024)

141b1 - Annual Medical Evaluation

14. Requirements

2600.

141b1 - Annual Medical Evaluation *(continued)*

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1 had a Documentation of Medical Evaluation completed on [redacted]. The resident's previous Documentation of Medical Evaluation was completed on [redacted].

Resident #2 was evaluated for a Documentation of Medical Evaluation on 9-19-22. There is no documentation the resident was evaluated for a new Documentation of Medical evaluation after this date.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Administrator shall audit all DME's to ensure that each resident is evaluated at least one time annually and that the DME for is completed properly. As Resident #1 has a DME that is current, it will be also completed by 02/28/2025. Resident #2 DME was completed incorrectly indicating that no annual evaluation was done since [redacted] but actually was evaluated and form completed on [redacted], as indicated on page 2 of DME; however, since the paperwork was unclear, Resident #2 will be evaluated and a new DME completed by May 31, 2024.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)

227d - Support Plan Medical/Dental

15. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3 uses a bed shaker and has a signal light to notify the resident if the fire alarm has been activated in the home. The resident's Resident Assessment Support Plan dated [redacted] does not note the resident's use of the bed shaker or signal light.

Repeat violation: 4/9/24, 12/2/23, 5/9/23, et al.

Plan of Correction ***Accept ([redacted] - 06/14/2024)***

The Administrator corrected Resident #3 RASP on Thursday, May 2, 2024 to reflect the adaptive equipment used by the resident. The Administrator shall indicate on the RASP when/if any resident requires a bed shaker and/or light-up-door bell so that the care plan reflects the actual needs of the residents. This shall be completed at the time of the initial or new need for each resident annually or sooner, as well as each new resident admitted to Stabon Manor.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented ([redacted] - 06/20/2024)