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

September 5, 2025

OWNER
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

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *STABON MANOR PERSONAL CARE HOME* **License #**: *20512* **License Expiration**: *04/21/2026*

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

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

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

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

Phone: **Email**:

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**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/21/2025*

Inspection Dates and Department Representative

05/21/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *160* **Residents Served**: *100*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *84* **Are 60 Years of Age or Older**: *75*

Diagnosed with Mental Illness: *73* **Diagnosed with Intellectual Disability**: *24*

Have Mobility Need: *0* **Have Physical Disability**: *5*

Inspections / Reviews

05/21/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/05/2025*

07/16/2025 - POC Submission

Submitted By: **Date Submitted**: *07/21/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/21/2025*

Inspections / Reviews *(continued)*

09/05/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *07/21/2025*

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 License Inspection Summary (LIS) dated 5/1/24 and 1/7/25 were posted in a glass enclosed bulletin board. The LIS's enclosed in the bulletin board were not accessible due to a water cooler blocking access to the bulletin board. The home also did not have the additional required LIS's dated 8/22/24, 9/10/24, and 2/19/25 posted.
Repeat violation 5/1/24, et al.

Plan of Correction ***Accept (- 07/09/2025)***

Immediate Action
Corrected on the day of inspection. The LIS for LIS for 2/19/25; 9/10/24; 8/22/24 were posted in the glass cabinet in the main 1st floor hallway.
Ongoing Compliance and responsibility
The Executive Director or designee will be responsible to post the VR that was issued with the most current license, and any additional VRs issued between the most current license and the receipt of the next license.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)

18 - Compliance With Laws

2. 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 batteries for the carbon monoxide detector in the kitchen were last changed on 5/9/23.

Plan of Correction ***Accept (- 07/09/2025)***

Immediate Action
Corrected on the day of inspection. The batteries were changed immediately and dated. The batteries will be changed when clocks are changed for Daylight Saving Time. A reminder tickler has been placed on the calendar in TabulaPro as a reminder. The maintenance team will be responsible to change the batteries. The Administrator or designee will be responsible to ensure that the batteries are changed, at a minimum on a yearly basis or per manufacturer recommendation.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)

20b1 - Financial Records

3. Requirements

20b1 - Financial Records *(continued)*

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident #1. However, the resident's record of financial transactions has no transactional description for the account withdrawals made on 4/10/25 for $45, 4/14/25 for $40, 5/9/25 for $50, and 5/12/25 for $25.

Plan of Correction ***Accept (- 07/15/2025)***

Immediate Action
Stabon Manor uses tabulapro to track financial records.
This regulation requires the home to:
1. Keep a record of financial transactions with the resident including the dates, amounts of deposits, amounts of withdrawals and the current balance. This includes deposits and withdrawals of any amount and purchases made by the provider on behalf of the resident. Receipts must be kept for the purchases.
2. Obtain a written receipt from the resident for cash disbursements at the time of disbursement. The resident should initial or sign a completed receipt including the name of the resident, the amount of the disbursement and the date of the disbursement.
Resident #1's financial record for the dates cited did have a transactional description of "withdrawal" as required by the regulation. The home did obtain a written receipt from the resident for each cash disbursement at the time of the disbursement including the resident's signature. The regulation does not require that the resident provide a description of what they intend to use their cash disbursement for. A notation of 'Deposit' and 'Withdrawal' is documented for each financial transaction similar to a bank. This is the "transactional description". Resident #1's financial record was corrected to add a description of "cash disbursement Personal Spending Money". Resident #1 was informed of the change to the financial record and a written acknowledgement from the resident was obtained.
Ongoing Compliance
Beginning the week of 7.7.25 the home will add "Cash Disbursement Resident Personal Spending Money" to resident cash withdrawals from their PNA funds. The Activity Director or designee is responsible for disbursement of resident PNA funds. Beginning the week of 7.7.25 the Administrator will complete a weekly random audit for 4 weeks of 5 resident financial records to ensure that a transactional description has been included for all cash disbursements. Thereafter the Administrative Assistant will ensure transactional descriptions are complete when preparing each resident's Quarterly Statement.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 09/05/2025)

28a - Refunds

4. Requirements

2600.
28.a. If, after the home gives notice of discharge or transfer in accordance with § 2600.228(b) (relating to notification of termination), and the resident moves out of the home before the 30 days are over, the home shall give the resident a refund equal to the previously paid charges for rent and personal care services for the remainder of the 30-day time period. The refund shall be issued within 30-days of discharge or transfer. The resident's personal needs allowance shall be refunded within 2 business days of discharge or transfer.

28a - Refunds *(continued)*

Description of Violation

Resident #2 was discharged on [redacted] to [redacted]; the resident did not receive a refund until [redacted] The refunded amount of $3252.56 included 2 months of Personal Needs Allowance.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

Immediate Action

Resident #2 has been discharged from the home; therefore no immediate action can be taken to correct the PNA that were not refunded within 2 days.

Ongoing compliance

The Business Office Manager or designee is responsible to ensure that the resident's funds being managed or stored by the home will be returned to the resident within 2 business days from the date the room is cleared of the resident's personal property. Beginning in the month of July 2025 the Administrator will review discharged resident financial records monthly to ensure that the resident's PNA is refunded within 2 days of the discharge date defined as when the resident's belongings are removed from the home.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 09/05/2025)

28f - Resident's Funds and 30-day Refund

5. Requirements

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 was discharged [redacted] to [redacted]. There was no itemized account regarding the refund sent on [redacted]. The home continued charging the resident for a bed hold.

Plan of Correction ***Accept ([redacted] - 07/15/2025)***

Immediate Action

Resident #2 has been discharged from the home; therefore no immediate action can be taken to correct the refund that was not refunded within 30 days.

Ongoing compliance

The Business Office Manager or designee is responsible to ensure that the resident's funds being managed or stored by the home will be returned to the resident within 2 business days from the date the room is cleared of the resident's personal property. The Administrator will review discharged resident financial records to ensure that the resident's PNA is refunded within 30 days of the discharge date defined as when the resident's belongings are removed from the home.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 09/05/2025)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At approximately 9:45 a.m. the following was observed:
In the ground floor hallway, four ceiling tiles were water damaged and observed to be wavy and did not fit in the required track for ceiling tiles.

Plan of Correction ***Accept (█ - 07/15/2025)***

Immediate Action
On 5.22.25 the 2 ceiling tiles and smoke detector by room 01 were replaced.
Ongoing Compliance
The maintenance team is responsible for building maintenance. There is a 'maintenance repair' form in each med room for care staff to request building maintenance repairs. The Executive Director completes weekly room and floor rounds to ensure furniture and equipment is in good repair. Documentation of room audits is maintained.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

There were 2 ceiling tiles in the hall on the ground floor that had holes in them, exposing the electrical wiring in the ceiling.
The smoke detector located on ground floor near bedroom #1 was hanging by two wires from the ceiling tile.

Plan of Correction ***Accept (█ - 07/16/2025)***

Immediate Action
On 5.22.25 the 4 ceiling tiles were replaced.
Ongoing Compliance
The maintenance team is responsible for building maintenance. There is a 'maintenance repair' form in each med room for care staff to request building maintenance repairs. The Executive Director completes weekly room and floor rounds to ensure furniture and equipment is in good repair. Documentation of room audits is maintained.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

101j2 - Bedroom Chairs

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

101j2 - Bedroom Chairs *(continued)*

Description of Violation

At approximately 9:35 a.m. room 313, which is occupied by 3 residents, had only 2 chairs available in the room.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action
On 5.21.25 immediately prior to the licensing site inspection, staff inspected each resident room to ensure each resident had a chair in their room. Within 10 minutes two residents in room 313 moved their chairs into the TV room to watch TV, even though there were sufficient chairs in the TV room. Despite continual reminders residents move furniture within the home and their bedroom. On the day of inspection staff immediately obtained 2 chairs more folding chairs and put them in room 313. There are extra chairs under resident beds and in resident closets.
Ongoing Compliance
The Primary Benefit of this regulation per the RCG is to ensure a comfortable environment with appropriate furnishings. Stabon Manor meets the primary benefit of this regulation as there are ample chairs and furnishing for residents enjoyment. Regulation 42l permits "A resident has the right to furnish his room". The primary benefit of 42l is to "Preserves resident choice, independence, and comfort".
At the June Resident Meeting, residents were re-educated about regulation 101j2 and not to move chairs and lamps in their bedrooms.
Housekeeping and Direct Care Staff check and verify chairs are in place for each resident on a continual basis. The Administrator or designee completes weekly resident room audits ensure each resident has a bedroom chair. The Administrator maintains documentation of weekly room audits for Department review upon request.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)

101j7 - Lighting/Operable Lamp

10. 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

At approximately 9:39 a.m. room 303's bedside light source was 5 feet away from the foot of the bed and could not be reached from bedside.
Repeat violation 5/1/24, et al.

Plan of Correction ***Accept (- 07/16/2025)***

The bedside lamp in room 303 was moved back to the bedside table at the time of inspection.
Ongoing Compliance
Many residents choose not to have lights at their bedside a matter of personal preference. Although bedside lamps have been shown to significantly reduce nighttime falls, many residents choose not to have lights at their bedside a matter of personal preference.
At the June Resident Council Meeting the Administrator re-educated residents about regulation 101j7 and not to move the bedside lamp.
Housekeeping and Direct Care Staff check and verify lamps are accessible in place for each resident on a continual

101j7 - Lighting/Operable Lamp (continued)

basis. The Administrator audits weekly for bedroom chairs during resident room checks. The Administrator maintains documentation of weekly room audits for Department review upon request.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer’s instructions.

Description of Violation

At approximately 9:50 a.m. the industrial dryer on the ground floor on the right had a build up of lint in the lint trap.

Plan of Correction ***Accept (█ - 07/16/2025)***

Immediate Action
The dryer lint was removed from the commercial dryer at the time of inspection.
Ongoing Compliance
On 5.22.25 a reminder sign was placed on each dryer to remove the dryer lint after each load of laundry to ensure safety.
Beginning the week of 7.7.25 the Administrator or designee will complete a weekly audit for 4 weeks to ensure dryer lint has been removed.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (█ - 09/05/2025)

132e - Fire Drill Sleeping Hours

12. Requirements

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

Description of Violation

The last sleeping hour drill was conducted on 10/25/24 at 5:05 a.m. The home did not conduct another sleeping hour drill six months later as required.
Repeat violation 5/1/24, et al.

Plan of Correction ***Accept (█ - 07/16/2025)***

Immediate Action
In April 2025 the fire panel was being replaced. To ensure the new fire panel was working correctly the fire drill was completed while the technicians were onsite during waking hours. A nighttime fire drill was held on May 30, 2025.
Ongoing Compliance
Beginning May 2025, the Administrator or designee will ensure that a nighttime fire drill is held every six (6) months to ensure compliance. Documentation of fire drills is maintained for the department review.

132e - Fire Drill Sleeping Hours (continued)

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

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

On 6/25/24 the home conducted a fire drill at 10:36 a.m. During the fire drill resident #3 refused to evacuate.
Repeat violation 5/1/24, et al.

Plan of Correction ***Accept (█ - 07/16/2025)***

Immediate Action
The fire drill from 6/25/24 cannot be corrected. Resident #3 no longer resides in the home. All residents have been compliant with evacuation to the designated meeting place for all fire drills since 6/25/24.
Ongoing Compliance
At the Resident Council Meeting in June 2025, the residents were re-educated about mandatory participation in fire drills. The Administrator or designee is responsible to ensure that all residents comply with fire drill evacuation procedures. Documentation of fire drill participation is maintained for the department review.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #4’s annual medical evaluation dated █ does not address if the resident requires body positioning or not.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action

Resident #4's Medical Evaluation from [redacted] was corrected by the CRNP on 5.27.25.

Ongoing Compliance

The Director of Wellness is responsible to ensure that the Medical Evaluations are completed and review after the MD/CRNP has completed the DME to ensure the accuracy and no check boxes have been missed. Beginning the week of 7.7.25 the Administrator or designee will review DMEs to ensure accuracy.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 09/05/2025)

144c1 - Smoking Area Guidelines

15. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At approximately 10:00 a.m. the outside stairwell from the ground floor up to the smoking area had cigarette butts in the stairway. In the smoking area, there were cigarette butts found on the ground.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action

On the day of inspection the housekeeper cleaned up the cigarette butts on the outside stairwell and on the ground in the smoking area.

Ongoing Compliance

At the June Resident Council Meeting residents were again re-educated about putting cigarette butts in the receptacles in the smoking areas. This will be reviewed at each resident council meeting on a monthly basis. Many residents at Stabon Manor have a diagnosis of IDD, MH and Development Disabilities that contribute to non-compliance with smoking policies and procedures. The staff continually remind and re-educate the residents about smoking procedures.

Beginning 6.1.25 the housekeeper is responsible to check the smoking area and pick up any cigarette butts as part of the housekeeper daily job responsibilities.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)

183a - Original Containers and Injections

16. Requirements

2600.

183a - Original Containers and Injections *(continued)*

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

The medication Oxycodone 5mg tablets prescribed for residents #5 and #6 were being stored in two different bottles. The home stores two tablets in the new bottle of Oxycodone in the medication cart for resident #5 and stores the remaining tablets in the old bottle which is kept locked in a safe in an office. The home also stores two tablets in the new bottle of Oxycodone in the medication cart for resident #6 and stores the remaining tablets in the old bottle which is kept locked in a safe in an office.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action
The home contacted the contracted pharmacy provider. Controlled substances will no longer be filled in vials. The contracted pharmacy provider will dispense the CII controlled medications in unit dose/blister dose packaging.
Ongoing Compliance
Beginning the week of 7.7.25 the Director of Wellness or designee will be responsible for oversight of the controlled substance count with 2 signatures that account for each CII controlled substance. The CII's will continue to be locked in the safe in the doctor's office. The Director of Wellness or designee will obtain each days individually packaged and labeled unit dose from the safe, with a 2nd person sign out the CII and place it in the medication cart for the medication technician to administer.
Beginning the week of 7.7.25 the Administrator will complete a weekly random audit for 4 weeks of the controlled substance count sheets and med cart audit to ensure compliance with the new process.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 09/05/2025)

183e - Storing Medications

17. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #7's Breo Ellipta inhaler was not labeled with the date it was removed from the foil pouch for use.
Resident #8's Anora Ellipta inhaler was not labeled with the date it was removed from the pouch for use.
Resident #7's Trelegy Ellipta inhaler was removed from the foil pouch for use on 2/29/25 as per the label on the inhaler and, according to the manufacturer's instructions, expired 6 weeks later. The inhaler was still being stored in the medication cart for use on 5/21/25

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action
Resident #7 and Resident #8 Inhalers were discarded at the time and date of the inspection. New inhalers were ordered for Resident #7 and Resident #8.
Ongoing Compliance

183e - Storing Medications (continued)

On 5.22.25 the Administrator printed a copy of Inhaler Expiration Dates which were posted in each Med Room by the Director of Wellness.
On 5.22.25 reference materials with expiration dates for inhalers, were posted on the bulletin boards in each med room to educate med techs about expiration dates for inhalers and to document the date the foil is removed from inhalers, including the expiration date of the inhaler per manufacturer's directions.
The Director of Wellness is responsible for oversight of compliance with storing medications and ensuring expired medications are removed from the med cart. The Director of Wellness or designee completes a weekly med cart audit. Documentation of the weekly med cart audits is maintained for Department review.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (█ - 09/05/2025)

184a - Resident's Meds Labeled

18. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #10 has an order for Admelog Solostar insulin100 unit/ml, inject 16 units three times a day before meals plus sliding scale. The prescription label on the medication does not include the dosage and instructions for administration; the prescription label only indicates: Use as directed.

Plan of Correction ***Accept (█ - 07/16/2025)***

Immediate Action
The home's current pharmacy provider was contacted by the Director of Wellness to educate about the requirements of 184a. The pharmacy will immediately begin sending a resealable plastic bag with the full pharmacy label affixed to the outside of the bag that includes full dosage and instructions, including sliding scale directions, for insulin pen storage in the med cart.
Ongoing Compliance
The Director of Wellness is responsible for oversight of the new procedure which will be monitored through the weekly med cart audit. Beginning the week of 7.7.25 the Administrator will complete a random weekly audit for 4 weeks of insulin pens to ensure compliance with pharmacy labeling on insulin pens. Documentation of the audits is maintained for Department review.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (█ - 09/05/2025)

185a - Implement Storage Procedures

19. Requirements

185a - Implement Storage Procedures *(continued)*

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #11 has an order for Acetaminophen 650mg, one tablet twice daily as needed. The home did not have this medication available for administration if needed. The home's distribution and documentation of controlled drugs policy states the following:
• Director of Nursing will stock the med cart with two cassettes or 1 bottle of any narcotic per resident
• A perpetual inventory format of record keeping includes documentation of all receipts and disposition transactions, as well as an inventory accounting at each shift exchange with each staff member initialing the inventory record.
Resident #5's controlled substance count sheet was not maintained in a manner consistent with the home's policy. From 4/7/25 to 5/15/25 a total of 44 tablets were documented as "tablets given" but only 28 tablets were initialed as administered on the Medication Administration record. There was no indication that the Oxycodone medication was counted at shift exchange from 5/15/25 to 5/21/25.

Resident #6's controlled substance count sheet was also not maintained in a manner consistent with the home's policy. From 4/11/25 to 5/19/25 a total of 33 tablets were documented as "tablets given" but only 11 tablets were initialed as administered on the Medication Administration record. There was no indication that the Oxycodone medication was counted at shift exchange from 5/19/25 to 5/20/25.
Also, for both residents, the controlled substance count sheet was signed by only one staff person and the controlled substance count sheet for resident #6 was not signed by any staff person for tablets marked as given from 4/30/25 to 5/19/25.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action
Resident #11's Acetaminophen 650mg, one tablet twice daily as needed WAS AVAILABLE in the home. The pharmacy delivery was in the Director of Wellness Office with resident #11's medication. The inspector was informed that there were medications that were in house but due to the inspector completing the med cart audit, the med cart was not accessible for staff to put the medication away. The inspection process should not interfere with the home's standard procedures, preventing med techs from doing their job and then cite the home for non-compliance.
The home contacted the contracted pharmacy provider. Controlled substances will no longer be filled in vials. The contracted pharmacy provider will dispense the CII controlled medications in unit dose/blister dose packaging.
Ongoing Compliance
The Director of Wellness or designee will be responsible for oversight of the controlled substance count with 2 signatures that account for each CII controlled substance. The CII's will continue to be locked in the safe in the doctor's office. The Director of Wellness or designee will obtain each days individually packaged and labeled unit dose from the safe, with a 2nd person sign out the CII and place it in the medication cart for the medication technician to administer.
Beginning the week of 7.7.25 the Administrator will complete a weekly random audit for 4 weeks of the controlled substance count sheets and med cart audit to ensure compliance with the new process.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 09/05/2025)

187d - Follow Prescriber's Orders

20. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 has an order for Oxycodone 5mg, one tablet every 8 hours as needed. On 5/15/25 the medication was administered at 8:35 p.m. and again at 9:30 p.m.
Resident #12 has a prescription for Alprazolam 1.0 mg take one tablet by mouth 3 times a day. On 5/21/25 the resident did not receive their medication scheduled at 2pm because the resident could not be located. Staff initialed the Medication Administration Record (MAR) indicating the resident was out of the facility. The resident did not receive the 2pm dose of the medication.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action
On 5.15.25 the med tech inadvertently signed the documentation twice for Resident #6 Oxycodone 5mg tablet one tablet every 8 hours as needed. The resident did not receive two doses as there was only 1 tablet in the med cart to administer. This was a documentation error. The med tech was re-educated to check the MAR for documentation.
On 5.21.25 the inspector was completing the med cart inspection from 1pm to 3pm which interfered with the med tech administering 2pm medications for Resident #12. The resident left the community with during this time as the resident was tired of waiting for the inspector to finish. The regulatory inspection process should not disrupt the home's operations and residents receiving their medications as prescribed. The inspector insisted a reportable incident be completed for the missed medication which was done. The home contacted the prescriber who gave an order for a late administration of the medication informing the home that this is not a medication error. The medication was administered per the late order following the prescriber's order. The prescriber signed a policy for the home to follow when residents are out of the community, with directions for late administration of medications, and the prescriber's process for refusals of medications.
The home contacted the contracted pharmacy provider. Controlled substances will no longer be filled in vials. The contracted pharmacy provider will dispense the CII controlled medications in unit dose/blister dose packaging.
Ongoing Compliance
The Director of Wellness or designee will be responsible for oversight of the controlled substance count with 2 signatures that account for each CII controlled substance. The CII's will continue to be locked in the safe in the doctor's office. The Director of Wellness or designee will obtain each days individually packaged and labeled unit dose from the safe, with a 2nd person sign out the CII and place it in the medication cart for the medication technician to administer.
Beginning the week of 7.7.25 the Administrator will complete a weekly random audit for 4 weeks of the controlled substance count sheets and med cart audit to ensure compliance with the new process.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 09/05/2025)

224a - Preadmission Screen Form

21. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #13's preadmission screening form dated [redacted] does not address the resident's sensory needs, medical, psychological or behavioral diagnosis, or problematic behaviors. The areas on the form are blank.

Plan of Correction ***Accept (- 07/16/2025)***

Immediate Action

Resident # 13's prescreen was corrected by the current administrator, initialed and dated as an amended Prescreen.

Ongoing Compliance

The Administrator is responsible for completing the Preadmission Screen. After the prescreen is completed and saved in TabulaPro, the administrator will review the completed screen the following day to ensure that it was completed accurately to ensure compliance with all requirements.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)

225c - Additional Assessment

22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

The medical evaluation dated [redacted] for resident #15 notes the resident is unable to self-administer medication. Resident #15's assessment dated [redacted] notes the resident is able to self-administer medication with no assistance. The resident does not self-administer medications. The resident has not been assessed accurately according to their care needs.

Plan of Correction ***Accept (- 07/15/2025)***

Immediate Action

The department inadvertently identified Resident #15 on the LIS violation report. There is no Resident #15 on the LIS.

Resident #14's DME dated [redacted] is correct; the resident cannot self-administer medications.

The wrong box on Resident #14's Assessment dated [redacted] was inadvertently checked.

On 5.22.25 the RASP dated [redacted] was corrected. The Assessment was corrected, checking the box that the resident "cannot self-administer medications". The support plan portion of the RASP was correct.

Ongoing Compliance

The Administrator or designee is responsible for completing resident RASPs.

Beginning the week of 7.7.25 after completion of a new or updated RASP, a second review will be completed by the Director of Wellness or designee to ensure the accuracy of the RASP.

Licensee's Proposed Overall Completion Date: *07/07/2025*

Implemented (- 09/05/2025)