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

August 19, 2026

[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 04/07/2026, 04/08/2026 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**: *04/21/2027*

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**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/08/2026*

Inspection Dates and Department Representative

04/07/2026 - On-Site: [redacted]

04/08/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *160* **Residents Served**: *108*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *89* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *68* **Diagnosed with Intellectual Disability**: *22*

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

Inspections / Reviews

04/07/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2026*

05/12/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/13/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/14/2026*

Inspections / Reviews *(continued)*

08/19/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/13/2026*

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

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/7/26 at approximately 9:40 a.m. a dried reddish-brown substance covered 2/3 of the bottom of the overflow freezer located in the basement of the home.

On 4/8/26 at approximately 11:33 a.m. the bed protector belonging to Resident #4 was observed to be covered in large areas of black spots on both sides of the bed cover. Staff of the home stated the spots on the bed cover were caused by dead bed bugs.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

Plan of Correction – 2600.85(a) Sanitary Conditions

Regulation: 2600.85(a) – Sanitary conditions shall be maintained.

1. How the violation was corrected for residents affected
On 4/7/26, the overflow freezer located in the basement was immediately taken out of service, emptied, and thoroughly cleaned and disinfected using an approved sanitizing agent. The dried reddish-brown substance was completely removed. The freezer was inspected by management and returned to service once sanitary conditions were confirmed.
On 4/8/26, the bed protector belonging to Resident #4 was immediately removed and discarded. The bed was remade with clean linens and a new bed protector.
Resident #4's room and surrounding areas were cleaned and treated per pest control protocol. The facility's licensed pest control company, which services the home weekly every Friday, was notified and additional attention was given to the affected area during the next scheduled visit.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a full facility sanitation audit, including:
All resident beds, linens, and bed protectors
All common areas and storage areas
Kitchen equipment, including refrigerators and freezers
Any items identified as unsanitary were immediately cleaned, removed, or replaced.
Residents were observed for any signs of pest activity or skin concerns, and any findings were reported and addressed promptly.
3. Measures put in place to ensure the violation does not recur
The facility reinforced a cleaning and sanitation schedule which includes:
Routine cleaning of all kitchen equipment, including weekly inspection of refrigerators and freezers
Ongoing sanitation of storage and basement areas
A daily linen inspection protocol has been implemented:
Staff will inspect all beds and linens during routine care
Any linen or bed protector showing signs of damage, staining, or pest activity will be immediately removed and replaced
The facility maintains a contract with a licensed pest control provider that services the home weekly (every Friday):

85a - Sanitary Conditions (continued)

Each visit includes inspection, treatment as needed, and documentation
Any signs of pest activity identified between visits are reported immediately for prompt intervention
Staff were re-educated on sanitation, infection control practices, and pest identification, including:
Proper cleaning procedures
Recognition of unsanitary conditions
Immediate reporting requirements
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly sanitation audits for 4 weeks, then monthly thereafter
Perform random weekly linen and room inspections
Review and maintain weekly pest control service reports
Any issues identified will be corrected immediately, and trends will be addressed through additional staff training or corrective action as needed.
5. Date of compliance
The facility will achieve full compliance by: 4/8/2026 Monitoring ongoing after compliance

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented (- 07/31/2026)

85b - Infestation

2. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 4/8/26 at approximately 1:56 p.m., 5 live bedbugs were observed scurrying out from under the mattress of the bed located on the right side of room 110.

Plan of Correction ***Accept (- 05/12/2026)***

How the violation was corrected for residents affected
On 4/8/26, upon observation of live bedbugs in room 110, the affected bed was immediately taken out of service to be cleaned.
The mattress and any infested items were removed, bagged, and disposed of per infection control and pest management protocols and placed on the exterminators list for next visit.
The resident's bed was replaced with clean, pest-free bedding and a new mattress/encasement.
The room was thoroughly cleaned, including vacuuming, laundering of all linens, and reduction of clutter.
The facility's licensed pest control company, which services the home weekly every Friday, was notified immediately, and targeted treatment of room 110 and surrounding areas was completed.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a full inspection of all resident rooms, with focus on:
Mattresses, box springs, and bed frames
Linens and upholstered furniture
Baseboards and cracks/crevices
Any signs of pest activity were addressed immediately with cleaning, removal of affected items, and pest control follow-up.
Residents were monitored for signs of bites or skin irritation, and any concerns were reported and addressed.

85b - Infestation (continued)

3. Measures put in place to ensure the violation does not recur
The facility reinforced its pest management program, including:
Continued contract with a licensed pest control provider for weekly (Friday) service
Each visit includes inspection, treatment as needed, and written documentation
An enhanced pest surveillance protocol has been implemented:
Staff perform routine visual checks of beds and furniture during daily care
Any signs of pests are reported immediately to management
A bedbug response protocol has been reinforced:
Immediate isolation of affected items
Proper bagging and handling of linens
Prompt notification of pest control
Staff were re-educated on pest identification, prevention, and reporting, including:
Recognizing live bugs and signs of infestation
Proper cleaning and containment procedures
Timely escalation of concerns
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly room inspections for 4 weeks, then monthly thereafter
Review weekly pest control service reports to ensure concerns are addressed
Any identified pest activity will be addressed immediately, with follow-up inspections to confirm resolution.
Documentation of inspections, treatments, and corrective actions will be maintained for surveyor review.
5. Date of compliance
The facility will achieve full compliance by: 5/1/2026 Immediate actions taken; ongoing weekly extermination and monitoring in place

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented ([redacted] - 08/19/2026)

87 - Lighting

3. Requirements

2600.
87. Lighting - The home's rooms, 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

On 4/8/26 at approximately 10:36 a.m. the overhead light in room 312 did not light when the switch was turned on.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

1. How the violation was corrected for residents affected
On 4/8/26, the overhead light in room 312 was immediately addressed.
The light bulb was replaced and the fixture tested.

87 Lighting (continued)

Proper lighting was restored the same day, ensuring safe visibility for the resident.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee or maintenance staff conducted a full inspection of lighting throughout the facility, including:
Resident rooms
Hallways and stairwells
Bathrooms and common areas
Exit routes and outdoor walkways
Any lighting issues identified were immediately corrected.
3. Measures put in place to ensure the violation does not recur
The facility implemented a routine lighting inspection program, which includes:
Weekly checks of all resident room lighting
Ongoing monitoring of common areas and exit pathways
A maintenance reporting system has been reinforced:
Staff are required to report any lighting issues immediately
Maintenance will respond promptly to ensure timely repair
Staff were re educated on environmental safety, including:
The importance of proper lighting for resident safety and evacuation
Immediate reporting procedures for hazards
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly environmental and lighting audits for 4 weeks, then monthly thereafter
Review maintenance logs to ensure timely completion of repairs
Any deficiencies identified will be corrected immediately and tracked for follow up.
5. Date of compliance
The facility will achieve full compliance by: 4/8/2026 Monitoring ongoing after compliance

Licensee's Proposed Overall Completion Date: *04/29/2026*

Implemented ([redacted] - 05/29/2026)

88a - Surfaces

4. 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

On 4/7/26 at 9:32 a.m. in shared bathroom 314 the bathroom floor was covered with shower water that created a potential slipping hazard.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

On 4/7/26 at 9:32 a.m. in shared bathroom 314 the bathroom floor was covered with shower water that created a potential slipping hazard.

88a Surfaces (continued)

1. How the violation was corrected for residents affected
On 4/7/26, the standing shower water in shared bathroom 314 was immediately cleaned and dried.
The floor was mopped and dried to eliminate the slipping hazard.
The bathroom was inspected to ensure it was safe for resident use before being placed back into service.
A "wet floor" warning sign was placed temporarily during cleaning to prevent risk of falls.
2. How the facility identified other residents who could be affected
On 4/7/26, the Administrator/designee conducted a walk through of all resident bathrooms and common wet areas to ensure no additional hazards were present.
Any areas with moisture or safety concerns were immediately corrected.
3. Measures put in place to ensure the violation does not recur
A bathroom monitoring protocol has been reinforced:
Staff must check shared bathrooms multiple times per shift
Floors must be kept dry and free of standing water
Staff were re educated on environmental safety, including:
Immediate cleanup of spills or standing water
Use of wet floor signage during cleaning
Reporting maintenance or drainage issues promptly
Housekeeping procedures were reinforced to ensure routine cleaning and inspection of bathrooms throughout each shift.
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly environmental audits for 4 weeks, then monthly thereafter
Randomly inspect bathrooms for cleanliness and slip hazards
Staff compliance will be monitored through shift rounds and supervisory checks
Any hazards identified will be corrected immediately and documented.
5. Date of compliance
The facility will achieve full compliance by: 4/7/26 Monitoring ongoing after compliance

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

95 - Furniture and Equipment

5. Requirements

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

Description of Violation

On 4/8/26 at 10:40 a.m. Resident #1's box spring was broken causing the box spring and mattress to slump towards the floor.

On 4/8/26 at 11:25 a.m. in bedroom 11 the electric baseboard heating element that runs along the frontside of the building did not have a protective cover.

95 Furniture and Equipment (continued)

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

Plan of Correction 2600.95 Furniture and Equipment

Regulation: Furniture and equipment must be in good repair, clean, and free of hazards.

1. How the violation was corrected for residents affected
On 4/8/26, Resident #1's bed was inspected after it was observed that the mattress and box spring were slumping toward the floor.
It was determined that the box spring was not broken; rather, the bed frame was not properly hooked together/secured, which caused the instability.
The bed frame was immediately properly reassembled and secured, and the box spring and mattress were correctly positioned.
The bed was checked for stability and safety prior to continued use by the resident.
On 4/8/26, the electric baseboard heating element in Bedroom 11 was found without a protective cover.
A protective cover was immediately installed and eliminating the hazard.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee completed a facility wide inspection of all resident rooms, including:
Bed frames and connections
Box springs and mattresses
Furniture stability
Heating units and protective covers
Any identified hazards were immediately corrected or repaired. No others found at the time of maintenance inspection
3. Measures put in place to ensure the violation does not recur
A bed assembly verification process has been implemented:
Staff must ensure all bed frames are fully connected and secure after any movement or adjustment
Beds must be checked for stability prior to resident use
A preventive maintenance program has been reinforced for:
Furniture safety and integrity
Heating units and protective cover compliance
Staff were re educated on environmental safety, including:
Proper assembly of bed frames
Identifying and reporting unstable furniture
Ensuring immediate correction of hazards
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly environmental and furniture safety audits for 4 weeks, then monthly thereafter
Randomly inspect resident beds for proper assembly and stability

95 Furniture and Equipment (continued)

Verify all heating units have intact protective covers
Any deficiencies identified will be corrected immediately and documented.
5. Date of compliance
The facility will achieve full compliance by: 4/15/26 Monitor on going

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 05/29/2026)

101j6 - Mirror

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

On 4/8/26 at approximately 10:25 a.m. Resident #2 did not have a mirror in their room.

Plan of Correction ***Accept (- 05/12/2026)***

Plan of Correction 2600.101(j)(6) Mirror Requirement

Regulation: Each resident shall have a mirror in the bedroom.

1. How the violation was corrected for residents affected
On 4/8/26, it was identified that Resident #2 did not have a mirror in their bedroom.
A mirror was immediately provided and installed in the resident's room the same day.
The mirror was placed in a safe and accessible location for resident use.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a facility wide check of all resident bedrooms to ensure required furnishings, including mirrors, were present.
All other rooms were found to be in compliance (or "any missing items were immediately replaced," if applicable).
3. Measures put in place to ensure the violation does not recur
A room setup and furnishing checklist has been implemented to ensure all required items are present in each resident room, including mirrors.
The checklist will be used:
During room readiness/pre admission
After room changes, transfers, or maintenance activities
Staff were re educated on regulatory requirements for resident room furnishings, including:
Required items per regulation
Responsibility to report missing items immediately
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly room audits for 4 weeks, then monthly thereafter
Verify that all required furnishings, including mirrors, are present and properly maintained
Any missing items identified will be replaced immediately and documented.
5. Date of compliance

101j6 - Mirror (continued)

The facility will achieve full compliance by: 4/8/26 See attached.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

101j7 - Lighting/Operable Lamp

7. 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 4/8/26 at approximately 10:35 a.m. room 312a's bedside lamp's switch was broken, preventing the light from turning on.

Repeated violation: 5/21/25

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

1. How the violation was corrected for residents affected
On 4/8/26, it was identified that the bedside lamp in Room 312A had a broken switch and was not operable.
The lamp was immediately removed and replaced with a functioning bedside lamp.
The replacement lamp was tested to ensure it was fully operable and accessible to the resident at bedside.

2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a facility-wide check of all resident bedside lamps to ensure they were present and operable.
Any non-functioning lamps identified were immediately repaired or replaced.

3. Measures put in place to ensure the violation does not recur
A room equipment checklist has been implemented to ensure all required items, including operable bedside lighting, are present and functioning.
The checklist will be used:During routine room audits
After room changes, maintenance, or cleaning
Staff were re-educated on resident room requirements, including:Ensuring bedside lamps are working and accessible
Reporting broken or non-functioning equipment immediately

4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:Conduct weekly room audits for 4 weeks, then monthly thereafter
Verify that all bedside lamps are present and operable
Any deficiencies will be corrected immediately and documented.

5. Date of compliance
The facility achieved compliance on: 4/8/26 (same-day correction is appropriate)

Root Cause Statement
"The root cause of the deficient practice was a lapse in identifying non-functioning bedside equipment. A routine inspection process has been implemented to ensure all required items are present and operable."

101j7 - Lighting/Operable Lamp *(continued)*

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 4/7/26 at 9:43 a.m. the back stairwell's double doors were locked creating a blocked egress.

On 4/7/26 at approximately 9:30 a.m. the door leading to the 3rd floor fire escape near room 315 stuck when opened and prevented egress as the door was impeded from opening freely by the metal grate of the fire escape.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

Plan of Correction – 2600.121(a) Egress Routes

Regulation: Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

1. How the violation was corrected for residents affected
On 4/7/26, the back stairwell double doors were found to be locked.
The doors were immediately unlocked and verified to be fully accessible and unobstructed for emergency egress.
On 4/7/26, the 3rd floor fire escape door near room 315 was found to stick and not open freely due to interference from the exterior metal grate.
The obstruction was immediately corrected, and the door was adjusted/repaired to ensure it opens freely and without impediment.
The door was tested to confirm proper function and safe egress.
2. How the facility identified other residents who could be affected
On 4/7/26, the Administrator/designee conducted a full inspection of all egress routes, including:
Stairwells
Exit doors
Fire escapes
Hallways and passageways
All exits were checked to ensure they were unlocked, unobstructed, and functioning properly.
Any issues identified were immediately corrected.
3. Measures put in place to ensure the violation does not recur
The facility implemented an egress safety check protocol, which includes:
Routine verification that all exit doors remain unlocked and unobstructed
Ensuring all doors open freely without resistance
A daily environmental safety check has been reinforced:
Designated staff will check all exit pathways each shift or daily (based on your policy)
Staff were re-educated on fire safety and egress requirements, including:
Importance of keeping all exits accessible at all times

121a Unobstructed Egress (continued)

Prohibition of locking or obstructing egress doors
Immediate reporting of any door malfunctions or obstructions
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly egress and fire safety audits for 4 weeks, then monthly thereafter
Randomly test exit doors to ensure they open freely and remain unobstructed
Any issues identified will be corrected immediately and documented.
5. Date of compliance
The facility achieved compliance on: 4/7/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 07/31/2026)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's medication evaluation dated does not include if the resident needs can be met by the personal care home or if the resident would require care in a skilled nursing facility.

Plan of Correction ***Accept (- 05/12/2026)***

SeePlan of Correction 2600.141(b)(1) Annual Medical Evaluation

Regulation: A resident shall have a medical evaluation at least annually.

1. How the violation was corrected for residents affected
On 4/8/26, it was identified that Resident #3's medical evaluation dated did not include documentation indicating whether the resident's needs could be met in the personal care home or if a higher level of care was required.
The deficiency was corrected immediately by obtaining updated documentation from the resident's physician that clearly states the resident's needs can be met in the personal care home (or specify if otherwise, if applicable).
The updated evaluation was placed in the resident's record.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a review of all resident medical evaluations to ensure:
Annual evaluations are current
Required components are complete, including level of care determination
Any incomplete or missing information was promptly obtained and corrected.
3. Measures put in place to ensure the violation does not recur
A medical evaluation review process has been implemented:
All evaluations will be reviewed upon receipt to ensure all required elements are completed, including appropriateness of placement
A tracking system has been reinforced to monitor:

141b1 Annual Medical Evaluation (continued)

Annual due dates
Completeness of documentation
Staff were re educated on regulatory requirements for medical evaluations, including:
Required content of evaluations
Timely follow up for incomplete documentation
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly chart audits for 4 weeks, then monthly thereafter
Verify that all medical evaluations are current and complete
Any deficiencies will be addressed immediately, including follow up with providers.
5. Date of compliance
The facility achieved compliance on: 4/8/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 08/19/2026)

144c1 - Smoking Area Guidelines

10. 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

On 4/7/26 at 9:29 a.m. on the 2nd floor back porch there were 2 cigarette butts discarded on the porch floor.

Repeated violation: 5/21/25

Plan of Correction ***Accept (- 05/12/2026)***

Plan of Correction 2600.144(c)(1) Smoking Safety

Regulation: A home that permits smoking shall develop and implement written fire safety policies and procedures, including proper safeguards to prevent fire hazards.

1. How the violation was corrected for residents affected
On 4/7/26, two cigarette butts were observed discarded on the floor of the 2nd floor back porch, creating a potential fire hazard.
The cigarette butts were immediately removed, and the area was cleaned.
Residents were re educated immediately on the facility's smoking policy, including:
Smoking only in designated areas
Proper disposal of smoking materials in approved fireproof receptacles
2. How the facility identified other residents who could be affected
On 4/7/26, the Administrator/designee inspected all designated smoking areas, both inside and outside, to ensure:
Proper use of fireproof ashtrays/receptacles
No improperly discarded smoking materials

144c1 - Smoking Area Guidelines (continued)

Any concerns identified were immediately addressed.
3. Measures put in place to ensure the violation does not recur
The facility reinforced its smoking safety policy, including:
Smoking permitted only in designated areas
Required use of fireproof ashtrays/receptacles for disposal
Staff will provide ongoing supervision of smoking areas as appropriate to ensure compliance.
Residents were re-educated on safe smoking practices, including:
Proper disposal of cigarette butts
Fire safety risks associated with improper disposal
Staff were re-educated on monitoring smoking areas and reporting concerns immediately.
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly inspections of smoking areas for 4 weeks, then monthly thereafter
Ensure fireproof receptacles are present, in good condition, and being used properly
Any issues identified will be corrected immediately and documented.
5. Date of compliance
The facility achieved compliance on: 4/7/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #8 has a physician's order for Hydrocodone APAP 10-325 tab to be administered twice daily for pain. The resident's medication administration record indicates that the facility is administering the medication at 4:00 p.m.; however, the label on the medication indicates a 2:00 p.m. administration time. The label is incorrect.

Repeated violation: 5/21/25

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

Plan of Correction – 2600.184(a)(4) Medication Labeling

Regulation: The original container for prescription medications shall be labeled with a pharmacy label that includes the prescribed dosage and instructions for administration.

1. How the violation was corrected for residents affected
On 4/8/26, it was identified that Resident #8's Hydrocodone APAP 10-325 medication label indicated a 2:00 p.m. administration time, while the Medication Administration Record (MAR) reflected administration at 4:00 p.m..
Review of the physician's order confirmed the medication was ordered "twice daily (AM and PM)" and did not specify exact administration times.
The prescription was reviewed with the pharmacy (Health Direct) to clarify appropriate administration timing.

184a Resident's Meds Labeled (continued)

The medication profile was updated, and the MAR was corrected to reflect a consistent and appropriate administration time of 2:00 p.m. in alignment with the pharmacy label and facility scheduling.
Medication administration practices were immediately aligned to ensure consistency between the MAR and pharmacy label.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a medication audit, including:
Review of physician orders
Comparison of pharmacy labels and MAR entries
Verification of administration instructions and timing
Any discrepancies identified were clarified with the pharmacy and corrected immediately.
3. Measures put in place to ensure the violation does not recur
A medication reconciliation process has been reinforced:
All medications will be reviewed upon receipt to ensure physician orders, pharmacy labels, and MAR entries are consistent
When physician orders do not specify exact times:
The facility will establish standardized administration times in coordination with the pharmacy
All documentation will be aligned accordingly
Staff were re educated on medication administration procedures, including:
Ensuring consistency across physician orders, pharmacy labels, and MAR
Clarifying and resolving discrepancies prior to administration
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly medication audits for 4 weeks, then monthly thereafter
Review a sample of medications to ensure label and MAR consistency
Any discrepancies will be corrected immediately and documented, with follow up as needed.
5. Date of compliance
The facility achieved compliance on: 4/8/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
8. Frequency of administration.

Description of Violation

Resident #5 is prescribed Lorazepam 2mg tablets to be administered 3 times daily as needed. The resident's April 2026 medication record indicates the medication should be administered every 8 hours as needed while the medication label indicates to administer the medication 3 times daily as needed. The medication administration record is incorrect.

Plan of Correction ***Accept ([redacted] - 05/12/2026)***

Plan of Correction 2600.187(a)(8) Medication Record Accuracy

187a - Medication Record (continued)

Regulation: A medication record shall be kept to include the frequency of administration for each resident receiving medications.

1. How the violation was corrected for residents affected
On 4/8/26, it was identified that Resident #5's Lorazepam 2 mg medication record reflected a frequency of "every 8 hours as needed," while the pharmacy label indicated "three times daily as needed."
The pharmacy label and physician order were reviewed and verified, confirming the correct frequency as "three times daily as needed."
The Medication Administration Record (MAR) was immediately corrected to accurately reflect the prescribed frequency.
Medication administration instructions were updated to ensure consistency between the MAR and pharmacy label prior to administration.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee completed a full medication record audit, including:
Comparison of MAR entries with pharmacy labels
Verification of medication frequencies for all residents receiving medications
Any discrepancies identified were immediately corrected in coordination with the pharmacy.
3. Measures put in place to ensure the violation does not recur
A medication reconciliation and MAR verification process has been implemented:
All new and active medication orders will be checked for consistency between physician orders, pharmacy labels, and MAR entries
Staff were re-educated on medication documentation requirements, including:
Accurate transcription of frequency of administration
Ensuring MAR matches pharmacy label and physician orders
Immediate reporting of discrepancies
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly medication MAR audits for 4 weeks, then monthly thereafter
Randomly compare MAR entries to pharmacy labels for accuracy and consistency
Any discrepancies will be corrected immediately and documented, with follow-up as needed.
5. Date of compliance
The facility achieved compliance on: 4/8/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/29/2026)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident #6 has an order for Propranolol 10 mg tab to be administered twice daily for Akathisia. The medication is to be held for a SBP less than 90, a DBP less than 60 or a pulse less than 60. On 4/2/26 at 8:00 p.m. the resident's DBP was 58 and the medication was administered. On 4/6/26 at 8:00 p.m. the resident's DBP was 52 and the medication

187d - Follow Prescriber's Orders (continued)

was administered.

Repeated violation: 5/21/25

Plan of Correction ***Accept (- 05/12/2026)***

Plan of Correction – 2600.187(d) Follow Prescriber Directions

Regulation: The home shall follow the directions of the prescriber.

1. How the violation was corrected for residents affected
On 4/2/26 and 4/6/26, Resident #6 received Propranolol 10 mg despite documented blood pressure parameters indicating the medication should have been held.
On 4/2/26 at 8:00 p.m., DBP was 58
On 4/6/26 at 8:00 p.m., DBP was 52
Upon identification, the medication administration process was immediately reviewed.
Staff were immediately re-educated on holding parameters for Propranolol, including:
Hold if SBP < 90
Hold if DBP < 60
Hold if pulse < 60
The MAR was reviewed to ensure clear visibility of hold parameters prior to administration.
2. How the facility identified other residents who could be affected
On 4/8/26, the Administrator/designee conducted a facility-wide medication audit, including:
Review of all medications with hold parameters or clinical conditions
Verification that parameters are clearly documented on MARs
Review of PRN and scheduled medications requiring vital sign checks
Any unclear or missing parameters were clarified with the prescriber or pharmacy immediately.
3. Measures put in place to ensure the violation does not recur
A Vital Sign Parameter Verification Process has been implemented:
Staff must verify and review all hold parameters prior to medication administration
Vital signs must be documented and reviewed before administration when required
The MAR format will be reinforced to ensure:
Hold parameters are clearly visible and highlighted or flagged
Staff were re-educated on medication administration safety, including:
Requirement to follow prescriber orders exactly
Understanding and applying hold parameters
Holding medications and notifying supervisor when parameters are met
4. How the facility will monitor to ensure ongoing compliance
The Administrator or designee will:
Conduct weekly medication audits for 4 weeks, then monthly thereafter
Review medications with hold parameters for proper adherence to prescriber instructions
Any discrepancies will be:
Corrected immediately
Reported to prescriber if needed
Documented and tracked
5. Date of compliance
All staff education was completed: 4/20/26

187d Follow Prescriber's Orders (continued)

Full compliance initiated: 4/8/26

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 05/29/2026)