


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

January 30, 2023


GMK LIMITED
38 COTTAGE AVENUE
LANCASTER, PA, 17602

RE: RED ROSE MANOR
38 COTTAGE AVENUE
LANCASTER, PA, 17602
LICENSE/COC#: 32653

Dear Ms. Karen Gestewitz,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/30/2022, 12/01/2022 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: *RED ROSE MANOR* License #: *32653* License Expiration: *08/30/2023*
 Address: *38 COTTAGE AVENUE, LANCASTER, PA 17602*
 County: *LANCASTER* Region: *CENTRAL*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *GMK LIMITED*
 Address: *38 COTTAGE AVENUE, LANCASTER, PA, 17602*
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *04/18/2007* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *29* Waking Staff: *22*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint* Exit Conference Date: *12/01/2022*

Inspection Dates and Department Representative

11/30/2022 - On-Site: [REDACTED]
 12/01/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *30* Residents Served: *29*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *0*

Number of Residents Who:
 Receive Supplemental Security Income: *17* Are 60 Years of Age or Older: *25*
 Diagnosed with Mental Illness: *18* Diagnosed with Intellectual Disability: *8*
 Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

11/30/2022 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/26/2022*

01/13/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *01/30/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/20/2023*

Inspections / Reviews (*continued*)

01/17/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/30/2023

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 01/24/2023

01/30/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/30/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. 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

At the time of inspection, the required influenza information was not posted anywhere in the home, as required by the Influenza Awareness Act of July 2016.

Plan of Correction

Accept (SK - 01/17/2023)

Influenza posters were posted on site and inspectors were aware that they were visible and posted at time of inspection. In future administrator will make sure are posters are in common area and doorways visible to all residents, staff and upcoming visitors. posters were placed on 1/30/2022 Administrator will in future make sure all posters are in common areas this will be added to our monthly checks. starting 01/01/2023. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

20b1 - Financial Records

2. Requirements

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 financial management record for Resident 6 has a balance of \$228.00, however there was only \$220.00 in cash for the resident within the Personal Care Homes Lock box.

Repeated Violation - 6/14/22

Plan of Correction

Accept (SK - 01/17/2023)

The account for resident #6 was short eight dollars was adjusted on site. The eight dollars was refunded to account while Inspectors were on site. To ensure all residents accounts are correct, all accounts will be counted bi-weekly and documented to assure accuracy this will be done by owner [REDACTED]. funds were replaced on 12/1/2022. bi weekly accounts started on 01/05/2023. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

20b6 - Interest Bearing Account

3. Requirements

2600.

- 20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

20b6 - Interest Bearing Account (continued)

6. If a home is holding more than \$200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

Description of Violation

The Personal Care Home has been holding more than \$200.00 for more than 2 months for Residents 5, 6 and 7.

Plan of Correction

Accept (SK - 01/17/2023)

For residents #5, #6, # 7 There are now charts in each account that has more than \$200.00 in cash balance. The forms for accounts that apply will be checked every two months because sometimes accounts fluctuate. This will be charted and checked to monitor by owner [REDACTED]. 12/05/2022 new forms IMPLEMENTED SEE ATTACHMENT ON RESIDENTS #5,6,7 WILL FAX.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

65b - Rights/Abuse 40 Hours**4. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member A did not receive training in Emergency Medical Plan and Reporting of Reportable Incidents within the first 40 working hours.

Plan of Correction

Accept (SK - 01/17/2023)

Staff member A had training in emergency medical plan and reportable incidents. done [REDACTED]. These training sheets for 40 hours are now in training packet. In future we will make sure checklist is complete. This will be done by administrator. attached staff member A training sheet completed and signed. 12/05/2022 training sheets added to packet by administrator. IMPLEMENTED

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

85a - Sanitary Conditions**5. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The blood glucose levels for Resident 4 for 11/28/22 at 8:00 PM was 210, and on 11/29/22 was 212, as recorded on the medication administration record (MAR). The readings for the blood glucose were measured by using a glucometer that was not dedicated to Resident 4. The glucometer used had been stored in the office, was not labeled and had multiple unknown readings. Staff reported that the glucometer is used to measure the readings of other residents in the home.

85a - Sanitary Conditions *(continued)***Plan of Correction****Accept (SK - 01/17/2023)**

Resident#4 has own monitor now labeled with name, each resident that has a monitor all have their own. on 12/29/2022 had training about using monitors on residents.one machine per person, went over this is unsanitary and if this happens again a written warning will be given, termination will be at administrator's discretion. on 12/15/2022 administrator disposed of community meter. also, on 12/15/2022 audit occurred all residents have own machines and supplies. if it is discovered staff our using another resident's monitor, staff will be given a warning and reeducated on reg.85a.Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

85b - Infestation

6. Requirements

2600.

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

Description of Violation

Resident 1 reported recently having been bitten by bed bugs between 11/20/2022 and 11/26/2022, while sleeping. Upon examining the bed of Resident 1, one live bed bug was found located in between the folds of the mattress cover of the resident's bed.

Repeated Violation - 6/14/22

Plan of Correction**Accept (SK - 01/17/2023)**

RESIDENT #1 Room was completely stripped all beds in room#2 everything was wiped down. We started spraying this room daily, [REDACTED] Pest control will be out to spray room on 1/4/2023. no activity found see attachment. In future will call [REDACTED] if needed to rectify the problem. 12/03/2022 the staff have started to check rooms daily. spray and strip beds as needed. we have had monthly meetings with the residents on 01/06/2023 talked to the residents about any concerns and to come to staff if any activity is found. Implemented.

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

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

The door of the bathroom located next to Resident Room #8 (2nd floor) has no doorknob attached to the door. Residents have been using fingers in the doorknob hole to open and close the door.

There is a bathroom on the first floor (bathroom with two toilets) that has a vanity. The one door of the vanity is unhinged and off the vanity sitting to the side of it.

88a - Surfaces (continued)

Plan of Correction**Accept (SK - 01/17/2023)**

Doorknob to bathroom outside room#8 came of door, staff fixed knob 12/01/2022. 12/9/22 Had meeting with all staff to tell someone in management if repairs need done. they can report to supervisor, administrator, owner. vanity door was fixed 12/6/22 Administrator will monitor/look for any repairs needed weekly. will have a checklist and will report to owner. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

103f - Refrigerator/Freezer Temps

8. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

-There is a refrigerator located in the basement, beside the kitchen labeled "Refrigerator 1." The Freezer section temperature was 10 degrees Fahrenheit, and the Refrigerator section was 50 degrees Fahrenheit.

-There is a chest freezer in the laundry room located in the basement; its thermometer read 10 degrees Fahrenheit.

-There are 3 refrigerators in the basement pantry:

The thermometer in the chest freezer on the left read 5 degrees Fahrenheit.

The thermometer in the freezer of the refrigerator on the right also read 5 degrees Fahrenheit.

Plan of Correction**Accept (SK - 01/17/2023)**

All thermometers were replaced 12/18/2022, they were monitored for 3 days our now reading zero degrees they were monitored on 12/19,20,21 2022. Refrigerator now 3 degrees monitored December 19, 20,21 2022 by administrator. monthly book on charts for temps. will continue thru 2023. responsible person administrator. 01/16/2023 monthly checks started. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

123c - Evacuation Diagrams

9. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 29 residents. However, on the diagrams of the 2nd floor and basement, there are no keys labeling any of the icons on the diagram, such as what are the pull stations and the fire extinguishers.

123c - Evacuation Diagrams (continued)

Plan of Correction

Accept (SK - 01/17/2023)

Evacuation plans for 2nd floor/basement are now marked so it is visible to all pull stations and fire extinguishers this was done 12/27/2022. fire chief will check all fire/evacuation plans at annual fire drill and inspection to ensure safety. our drill is january.11,2023 at 3:30pm Implementd

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

132d - Evacuation

10. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The maximum safe evacuation time specified in writing on 03/15/22 by the fire safety expert is 2 minutes and 45 seconds. The following drills exceeded that maximum safe evacuation time:

4/28/2022 (11:04 PM) - 2min and 51 sec

6/30/2022 (10:40 AM) - 3min and 10 sec

08/28/2022 (11:02 PM) - 2min and 49 sec

Plan of Correction

Accept (SK - 01/17/2023)

called fire chief [redacted] fire company explained about violation he did a revised evacuation time for drill 3/15/22 to 2minutes and 55 seconds, so 4/28/22 and 8/28/22. we would be in compliance. on 6/30/22 we were not. In future will repeat a drill that is over our time in the same month. administrator will see this is done. fire chief was called 12/30/2022 by administrator. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

132g - Fire Drills Days/Times

11. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home is staffed with one overnight staff person during the 11 PM to 7 AM shift. Since the fire drill on 12/28/2019 was conducted with only one staff person participating, the home has included additional staff persons that are not included in the typical overnight staffing complement.

132g - Fire Drills Days/Times (continued)

Plan of Correction**Accept (SK - 01/13/2023)**

Overnight fire drills will be done w/one staff. in past we included person doing the timing. Next overnight drill will be in February 2023. administrator will see this is done, we will also pick different times of the day and different days.

Licensee's Proposed Overall Completion Date: 01/05/2023

Implemented (SK - 01/30/2023)

141a - Medical Evaluation

12. 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.

Description of Violation

-The Documentation of Medical Evaluation (DME) for Resident 1 (DOA [REDACTED]) was completed on [REDACTED], however the evaluation of Resident 1 occurred on [REDACTED].

-The DME for Resident 2 (DOA [REDACTED]) is missing the date that the resident was evaluated by the physician as well as the date the form was completed.

-The DME for Resident 3 (DOA [REDACTED]) was completed [REDACTED]. 39 days after admission.

Repeated Violation - 7/20/21

Plan of Correction**Accept (SK - 01/17/2023)**

resident 1 [REDACTED] put the wrong date on DME, but ma51 was right, had [REDACTED] initial on [REDACTED] see attachment. resident 2 dr. [REDACTED] signed and dated first page 2nd was done. Resident3 this was due to unable to get into [REDACTED] PCP UNTIL THAT DATE. IN future paperwork will be double checked before admission. administrator will ensue that all DME PAPERWORK is done within 60 days of admissions. Implemented dates are on dme for resident 1

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

183c - Refrigerated Meds Locked

13. Requirements

2600.

183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

In the basement there is a refrigerator labeled "Refrigerator 1." Inside the refrigerator, there are 2 black lock boxes that contain various medications, including insulin. The refrigerator was unsecured and accessible to anyone, as it had no lock and the keys to the lock boxes were still inside the locks/tumblers.

183c - Refrigerated Meds Locked (*continued*)**Plan of Correction****Accept (SK - 01/17/2023)**

on 11/30/202 owner [REDACTED] removed keys while inspectors were present. keys are now in medication cart marked insulin keys. all staff aware. on 12/05/2022 all staff aware of regulation 183c. Administrator will check refrigerated med. storage monthly will be on check list. start 01/15/2023. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

185a - Implement Storage Procedures

14. Requirements

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

The blood glucose level for Resident 2 was recorded on the medication administration record (MAR) as 329 on 11/30/22 at 6:48 AM, however the glucometer reading is 320.

The glucometer for Resident 8 is not calibrated to the correct date as it is off by one day, as follows:

MAR reads 140 on 11/30/22 at 7 AM, Glucometer says this reading was done on 11/29/22.

MAR reads 136 on 11/29/22 at 7 AM, Glucometer shows this reading was done on 11/28/22.

MAR reads 144 on 11/28/22 at 7 AM, Glucometer shows this reading was done on 11/27/22.

The glucometer for Resident 8 does not show a reading for 12/01/2022, however a reading of 146 is recorded in the MAR.

Repeated Violation - 7/20/21

Plan of Correction**Accept (SK - 01/17/2023)**

Resident #2 had wrong name on privacy sheet this was done 12/03/2022. Resident#2 monitor was reset and starting 12-1-2022 Mar and monitor were matching. resident #8 monitor calibrated to correct date was done 12-1-22. Had meeting with staff to check mar to monitor will be done by administrator or supervisor. staff meeting was 12/16/2022 on 12/19/2022 monitoring of meters and mars will be done for the next 2 months if any discrepancies will reeducation. Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

227g -Support Plan Signatures

15. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 1's RASP, completed on [REDACTED] is not signed by the resident, nor was a box checked to indicate/document if the resident refused or was unable to sign.

227g -Support Plan Signatures (continued)

Resident 4's RASP, completed on [redacted] s not signed by the resident, nor was a box checked to indicate/ document if the resident refused or was unable to sign.

Repeated Violation - 7/20/21

Plan of Correction

Accept (SK - 01/17/2023)

on 12-01-22 was corrected for resident#1 while inspectors present. RASP. RESIDENT#1 Was corrected also RASP. In future Administrator will have resident sign support plans and dates also if copy was given. [redacted] should be resident#1 resident [redacted] should be resident 4 privacy coding was wrong. Administrator will ensure that all RASPS are signed immediately and dated before filing. resident #1 and resident#4 were signed [redacted] not [redacted] Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)

252 - Record Content

16. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.

Description of Violation

Resident 3's record contains a face sheet that has a Date of Admission (DOA) on [redacted]. According to staff and the resident contract, it was determined that the resident entered the home on [redacted].

Plan of Correction

Accept (SK - 01/17/2023)

Resident#3 face sheet was redone with correct date [redacted] don on [redacted] given to inspectors. in future administrator will check files that all dates are correct on paperwork have a check list to follow.01/09/2023 list will be Implemented

Licensee's Proposed Overall Completion Date: 01/16/2023

Implemented (SK - 01/30/2023)