pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GMK LIMITED**
LEGAL ENTITY

To operate **RED ROSE MANOR**
NAME OF FACILITY OR AGENCY

Located at **38 COTTAGE AVENUE, LANCASTER, PA 17602**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **30**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 26, 2024** until **January 26, 2025**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **326531**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE:July 26, 2024

[redacted]
GMK Limited
38 Cottage Avenue
Lancaster, Pennsylvania 17602

RE: Red Rose Manor
38 Cottage Avenue
Lancaster, Pennsylvania
17602 License #: 326531

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on March 11-12, 2024 and May 30, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.85(b)	II	28	$5	$140	5 calendar days from mailing date of this letter
2600.185(a)	II	28	$5	$140	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *RED ROSE MANOR* **License #:** *32653* **License Expiration:** *08/30/2024*

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] **Email:** [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:** *27* **Waking Staff:** *20*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *03/12/2024*

Inspection Dates and Department Representative

03/11/2024 - On-Site: [redacted]

03/12/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served:** *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *21* **Are 60 Years of Age or Older:** *19*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability:** *2*

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

Inspections / Reviews

03/11/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/07/2024*

04/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/28/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/26/2024*

05/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/28/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/03/2024*

06/26/2024 - Document Submission

Submitted By: [redacted] *on* **Date Submitted:** *05/28/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On 12/26/2023 at approximately 7:00PM, Resident 1 attempted to physically harm Resident 2. Resident 1 also verbally belittled and degraded Resident 2. This incident was not reported to the local Area Agency on Aging.

Plan of Correction ***Directed [redacted] 05/13/2024)***

At the time of the incident resident 2 did not want us to report the abuse to office of aging, [redacted] was upset but not hurt. Resident 1 was sent to hospital and crisis was called. In future administrator will do all reports even though a resident asks us not to. The administrator will do the reports when first happens. Administrator will educate staff on the guidelines for any and all abuse. staff will be trained 4/29/2024. administrator will as well do a training with residents on 5/6/2024.When a staff witness or are told about any abuse, staff will immediately call administrator, report will be done by administrator all reports will be sent to office of aging and DHS. FAMILY WILL BE NOTIFIED this will all be done by administrator. Training record will be sent after completed.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Administrator or designee will report the incident to the local area agency on aging and complete an Act 13 form by 5/20/24.
- Starting 5/20/24, administrator or designee will review incidents with staff daily to ensure all reportable incidents are reported to the local area agency on aging and an Act 13 form is completed. The administrator or designee will keep completed Act 13 forms and they will be available for review by the Department

Directed Completion Date: *06/03/2024*

Not Implemented [redacted] - 06/26/2024)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 12/26/2023 at approximately 7:00PM, Resident 1 attempted to physically harm Resident 2. Resident 1 was upset that Resident 2 was sitting on the community couch. Resident 1 attempted to cause harm to Resident 2 by sitting on top of Resident 2 and bouncing. Resident 2 then screamed for help being pinned against Resident 1 and the couch. When staff came into the community room, Resident 1 got off Resident 2 and began to belittle, demean, and curse at Resident 2 as well as staff. Resident 1 then physically assaulted staff. Resident 2 reported being fearful during the incident.

42b - Abuse *(continued)*

Plan of Correction ***Directed (- 05/13/2024)***

The incident between resident 1&2 staff did ask resident 2 if they were okay or needed to be seen. resident 1 was asked to move to the dining room area was asked to stop yelling at resident 2. Resident 1 then turned his anger to staff.
The Administrator is searching for a training about violence and the way to handle these situations. after training is complete will have a document. we are hoping to find a class by May 1 ,2024. Training will be for staff and residents. staff date 4/29/2024 resident date 5/6/2024. This will be done by administrator. 42B will be reviewed with staff on 4/29/2024 with administrator. Residents review will be5/6/2024 with administrator. Resources for training are from crisis institute. also, CDC, De-escalation tips .

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/20/24, administrator or designee will complete a weekly sample of resident interviews to ensure residents feel safe and to identify any possible abusive situations. Documentation of these interviews should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Not Implemented - 06/26/2024)

42f - Mail Access

3. Requirements

2600.
42.f. A resident has the right to receive and send mail.

Description of Violation

On 03/12/2024, there were 8 resident letters from the Social Security Administration labeled "Form labeled SSA-1099-SM (1-2024)" located in the administrative office of the home. These letters have not been given to the named residents on the letters and were opened by staff without resident permission.

Plan of Correction ***Directed - 05/13/2024)***

All staff are now aware that all mail is to go to the Residents. This was started March 12,2024 after notifying all staff. The letters were given to office staff by some residents there were a few opened by staff. If a resident needs help with the letter staff will assist with resident present. This will be done by Administrator. on 4/3/2024 memo was also put out training done by administrator all staff and resident are now trained

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/20/24, administrator or designee will complete a weekly sample of resident interviews to ensure residents are receiving their mail as well as review mail in the office to ensure mail is being given to residents. Documentation of these interviews/reviews should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Implemented - 06/26/2024)

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A was hired on [redacted]/2024. However, a criminal background check was not requested for the Staff Person A until 02/01/2024.

Plan of Correction ***Directed ([redacted] - 05/13/2024)***

Staff person A was hired and started [redacted] 2024 there was no credit card available to run the background check, administrator asked the owner multiple times for credit card. owner keep forgetting to bring card. To prevent future occurrence's there is now a credit card in the homes safe, administrator has access to safe. this was corrected on 03/15/2024.owner and administrator reviewed reg.51.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Administrator or designee will request a criminal background check by 5/20/24. Documentation of this request and the results of the request should be kept and available for review by the Department.
- Administrator or designee will implement a new hire checklist by 5/27/24, including completing a criminal background check.
- Administrator or designee will review all current employee files by 5/27/24 to ensure compliance. Documentation of this audit should be kept and available for review by the Department.
- Starting 5/27/24, administrator or designee will complete quarterly reviews of all new employee records to ensure all criminal background checks are completed timely. Documentation of these audit should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Implemented [redacted] - 06/26/2024)

57b - 1 Hour/Day

5. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 03/08/2024, there were 27 residents in the home, requiring a minimum of 27 hours of direct care service. On this day, only 24 hours of direct care staffing was provided.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

On 03/08/2024 owner was in building 9am-2pm doing direct care. this was not on the schedule, when inspection was done. In future when the owner is doing direct care, we will have her hours on schedule. Administrator will be making sure that [redacted] hours are recorded. April 12,2024 administrator started reviewing staffing hours this will be reviewed one week prior to posting. administrator and owner reviewed reg. 57 B&D ON 4/22/24. Procedure for call off/sick two-hour notice. Administrator or supervisor oversees coverage they will contact other staff.

57b - 1 Hour/Day *(continued)*

Licensee's Proposed Overall Completion Date: *04/24/2024*

Not Implemented [redacted] 06/26/2024)

57d - Waking Hours

6. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 03/03/2024, a total of 20.25 hours of direct care was required. However, only 20 of the required hours were provided during waking hours.

On 03/08/2024, a total of 20.25 hours of direct care was required. However, only 16 of the required hours were provided during waking hours.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

on 03/03/2024 and 03/08/2024 owner was in building on 03/03/2024 from 9 amto12 noon and 03/08/2024 10 am to2pm. the owner needs to record hours on schedule. owner and administrator will make sure this is being done. Administrator reviewing and ensuring hours are correct start date 4/12/2024. will be reviewed one week prior to posting. 57B D And B reviewed by owner and administrator 4/22/2024. PROCEUDERS 2 HOUR NOTICEIF SICK. Administrator or supervisor will call other staff to look for coverage.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Not Implemented [redacted] 06/26/2024)

65a - FS Orientation 1st Day

7. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, whose first day of work was [redacted] /2024, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable and telephone use and notification of emergency services.

Plan of Correction ***Directed [redacted] 05/13/2024)***

Staff person A did have training on #1,#2 and #7 his paperwork didn't get put in [redacted] file. Due to being short staffed and working on floor i did get behind on filing papers. will send you copies of [redacted] paperwork. papers were found 03/13/2024 by administrator. to prevent re-occurrences of this violation will file papers as soon as possible. check list implemented date! 4/22/2024. the administrator will have designed office hours 2 days a week for files to be

65a - FS Orientation 1st Day (continued)

accounted for. administrator will complete audit on all staff files by 5/17/2024.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/17/24, administrator or designee will complete quarterly reviews of all new employee records to ensure all trainings are completed timely. Documentation of these audit should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Implemented [redacted] - 06/26/2024)

65b - Rights/Abuse 40 Hours

8. 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:
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour on or about 01/12/2024. However, this staff person did not complete training in the following topics: mandatory reporting of abuse and neglect under OAPSA and reporting of reportable incidents and conditions.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Directed [redacted] - 05/13/2024)***

Staff person A did have training #3 #4 this was done 01/05/2024. paperwork found. is now in file. Administrator will file paperwork as soon as possible after completed. attachment sent with above violation. Administrator has generated checklist on 4/22/2024. administrator will have designed office hours two days a week. administrator will complete audit on 5/17/2024 on staff files.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/17/24, administrator or designee will complete quarterly reviews of all new employee records to ensure all trainings are completed timely. Documentation of these audit should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Implemented [redacted] - 06/26/2024)

65c - Ancillary Staff Orientation

9. Requirements

2600.

65c - Ancillary Staff Orientation *(continued)*

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary Staff Person A, whose first day of work was 01/05/2024, did not have a general orientation to [redacted] specific job functions.

Plan of Correction ***Directed [redacted] - 05/13/2024)***

Staff person A did sign job duties, paperwork was not filed found in folder. administrator did not get into file due to working floor. in future administrator will file paperwork as soon as completed. attachment was sent above. administrator generated new lists for first day and 40 hours. audit on staff files will be done 5/17/2024. by administrator

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Administrator or designee will implement a new hire checklist by 5/27/24.
- Starting 5/17/24, administrator or designee will complete quarterly reviews of all new employee records to ensure all trainings are completed timely. Documentation of these audit should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Implemented ([redacted] - 06/26/2024)

65d - Initial Direct Care Training

10. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:

Description of Violation

Direct care Staff Person B, hired on [redacted]/2020, began providing unsupervised ADL services on or around 12/17/2020. However, the staff person did not complete the following initial direct care staff person training until 04/17/2021.

Plan of Correction ***Directed [redacted] - 05/13/2024)***

Staff person B was hired [redacted]/2020 as a cook did not start direct care 04/20/2021 comp. test done on04/17/2021. went thru file and schedules. the administrator back in2020 confirmed and the owner. new checklist for first day and 40 hours completed by administrator 4/22/2024. audit to be done 5/17/2024 on staff files by administrator. designed 2 days in office for filing.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/17/24, administrator or designee will complete quarterly reviews of all new employee records to ensure all trainings are completed timely. Documentation of these audit should be kept and available for review by the Department.

65d - Initial Direct Care Training (continued)

Directed Completion Date: *06/03/2024*

Implemented [redacted] - 06/26/2024)

85b - Infestation

11. Requirements

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

Description of Violation

On 03/12/2024, the presence of bed bugs was observed in the following locations:
Room 10- Live bed bugs observed on all beds located in the room.
Room 7- Live bed bugs observed on all beds located in the room.
Room 9- Live bed bugs observed on one bed located in the room.
Room 8- Live bed bugs observed on 2 of the beds located in the room.
Room 11- Live bed bugs observed on all beds located in the room.
Room 12- Live bed bugs observed on all beds located in the room.
Room 3- Live bed bugs observed on one bed located in the room.
Room 5- Live bed bugs observed on all beds located in the room.
Room 1- Live bed bugs observed on one bed located in the room.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Directed [redacted] - 05/13/2024)***

Kirchners pest control was called, and appointments were made on March 12,2024. March 13 ,2024 rooms 2,3,7,8,10,11, and sitting room were done. on March 19 ,2024 rooms 1,4,5,6,9 and dining room done. staff will be charting bed checks Tuesdays-first floor, Thursday-second floor every Friday -common areas to be checked by administrator. started 03/26/2024. paperwork sent to DHS on 03/27/2024. on3/12/2024 owner called Kirchner's pest control. training for staff and residents will be done by administrator Kirchner's does not provide training. the administrator obtained training sheets from department of health, CDC , technical resource. training date staff4/29/2024, residents 5/6/2024. staff will report to administrator bed bug sightings, Kirchner's will be called by administrator to set up date for rooms to be sprayed.

Proposed Overall Completion Date: 04/24/2024

[Directed]
- Starting 5/17/24, administrator or designee will complete weekly walkthroughs of the home to inspect for any signs of infestation. Documentation of these audit should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

Not Implemented [redacted] - 06/26/2024)

132b - Safety Inspection/Fire Drill

12. Requirements

132b - Safety Inspection/Fire Drill *(continued)*

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most current observed fire drill by a fire safety expert was conducted on 03/08/2024. However, the prior observed fire drill was conducted on 01/11/2023.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

Fire Chief was called in January 2024, could not come due to the facility had covid in building. first 3 staff starting January10 then January 29 residents. fire chief was contacted after covid cases, could not come till 03/08/2024. In future administrator will do her best to have drill done in March 2025.to prevent this from occurring again, administrator will contact fire safety expert 60 days prior to annual inspection, so inspection does not surpass 365 days. check list will be made for annual items to be set up and by what date. this list will be completed by date 5/17/2024.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 06/26/2024)

141a 1-10 Medical Evaluation Information

13. 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

[redacted]

[redacted]

141a 1-10 Medical Evaluation Information (continued)

183d - Prescription Current

14. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident 4 is prescribed Brimonidine 0.2% eye drops. On 03/12/2024, this medication was located in the medication cart and was expired as of 01/2024.

Plan of Correction ***Accept [redacted]/10/2024)***

Resident #4 The pharmacy was called by administrator 3/15/2024. on 3/16/2024
the pharmacy sent out a new bottle of eye drops they said that bottle should not have been expired the administrator will go thru medication cart weekly for expired items. started April 8 ,2024, staff were educated on checking for expired medications.4/10/2024. administrator will do a audit for3 months April, may ,June, 2024.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Not Implemented [redacted] - 06/26/2024)

184a - Resident's Meds Labeled

15. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident 3 is prescribed Lantus Solostar 10 units subcutaneously in the evening. The insulin pen has been opened. However, the insulin pen was not dated when opened with the staff's initials per manufacturer's instructions to ensure it was not used beyond the expiration date.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

On 3/12/2024 supervisor tracked back to see who was on duty and had them put date and initials on the Lantus pen.4/10/2024 memo put out to staff to make sure that when opening a new insulin to put date and initials. this will be done by administrator. memo signed 4/2/2024. face to face education completed 4/10/2024. Audit to be done by administrator start date 5/6/2024 will be done for 3 months.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 06/26/2024)

185a - Implement Storage Procedures

16. 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

On 03/09/2024 at 6:00AM, Resident 4 had a blood glucose level of 161 recorded on the Medication Administration Record (MAR). However, the blood glucose reading in the glucometer for that specific date and time was 116.

Resident 4 is prescribed Enema Ready-to-Use saline as needed. On 03/12/2024, this medication was not available in the home.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Accept [redacted] - 05/10/2024)***

on 3/9/2024 staff person on duty recorded 161 as blood sugar but was 116, no extra units were given staff wrote wrong number by accident. staff person was told and asked to more careful by administrator. Resident #4 has a order for enema ready to use pharmacy did not send due to has suppositories and PCP WAS CALLED by administrator enema not needed was discontinued,3/13/2024. on 4/4/2024 administrator did train with med techs on missing meds. administrator will do audit. Starting 5/6/2024, for three months. administrator will audit blood sugar readings are documented and match machine. audit will start, 5/18/2024.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Not Implemented [redacted] - 06/26/2024)

187a - Medication Record

[redacted]

187a - Medication Record *(continued)*

[redacted]

221b - Activity Types

19. Requirements

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

The March 2024 activity calendar of the home had no activities listed, only holidays and global events were listed. Upon interviewing residents, there are no planned activities offered by the home.

Plan of Correction ***Accept [redacted] 05/10/2024)***

See attached. new activity calendar. staff will encourage residents.
April 1, 2024, new Activities calendar, went into effect. administrator made calendar and will continue to make monthly. Administrator will educate staff on encouraging residents to participate in activities. date 4/29/2024 for training.

Licensee's Proposed Overall Completion Date: *04/25/2024*

Not Implemented [redacted] - 06/26/2024)

224a - Preadmission Screen Form

20. Requirements

2600.
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 2's preadmission screening form, dated 08/15/2022, does not include a determination that the needs of the resident can be met by the services provided by the home, and it doesn't include if the resident is able to safely use and avoid poisonous materials.

Plan of Correction ***Directed [redacted] - 05/13/2024)***

prescreening done on resident#2 administrator filled in with initials. in future administrator will check and double check all forms. on 3/12/2024 form was fixed. on 3/12/24 administrator completed the prescreening on resident #2. administrator will due audit on all prescreening to ensure they are complete date 5/20/2024. administrator will review all new prescreening within 24 hours. administrator will be given office time to ensure all admission forms are complete.

Proposed Overall Completion Date: 04/25/2024

[Directed]
- Starting 5/20/24, administrator or designee will complete quarterly reviews of new resident files to ensure prescreens are completed. Documentation of these audits should be kept and available for review by the Department.

Directed Completion Date: *06/03/2024*

224a - Preadmission Screen Form *(continued)*

Implemented [redacted] 06/26/2024)

227g -Support Plan Signatures

21. 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 4 participated in the development of [redacted] support plan on [redacted] /2023. However, the resident did not sign and date the support plan.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Directed [redacted] - 05/13/2024)***

Resident #4 did participate in [redacted] support plan, she then went to hospital when she returned, finished but i the administrator did forget to have her sign. to correct the error on 3/12/2024 had resident #4 sign. Administrator will do audit on all support plans date 5/20/2024. administrator will review support plans before filing with in 24 hours to ensure completed. administrator will have office time to complete all documents. will be in office 2 days a week.

Proposed Overall Completion Date: 04/25/2024

[Directed]
- Starting 5/20/24, administrator or designee will complete quarterly reviews of current RASPs to ensure all RASPs are signed and dated by the participants. Documentation of these audits should be kept and available for review by the Department.

Directed Completion Date: *04/25/2024*

Implemented (AC - 06/26/2024)

254a - Records Discharge/Active

22. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 03/11/2024 at 9:51AM, there was a red "911 Binder," a blue binder, and a binder with resident special diets located in the Medication/Nurse station of the home. These binders contained residents' personal information and this area was unlocked, unattended, and accessible.

Plan of Correction ***Accept (SK - 05/10/2024)***

03/11/2024 staff did have 911 binder on medication cart also the mar binder. Memo was put out to staff to make sure all records will be locked up to prevent unauthorized access. administrator removed 911 binder and Mar book on 3/11/2024, mar was locked in med cart ,911 book was locked in cabinet. administrator sent out memo on 4/8/2024 to all staff. audit will be done by administrator to ensure sensitive information is secure. audit to begin date4/22/2024 for next three weeks.

Licensee's Proposed Overall Completion Date: *04/25/2024*

254a - Records Discharge/Active *(continued)*

Implemented (AC - 06/26/2024)

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

Facility Information

Name: *RED ROSE MANOR* **License #:** *32653* **License Expiration:** *08/30/2024*

Address: *38 COTTAGE AVENUE, LANCASTER, PA 17602*

County: *LANCASTER* **Region:** *CENTRAL*

Administrator

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

[redacted]

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: **Total Daily Staff:** *28* **Waking Staff:** *21*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date:** *05/30/2024*

Inspection Dates and Department Representative

05/30/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served:** *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older:** *18*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability:** *4*

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

Inspections / Reviews

05/30/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/21/2024*

Inspections / Reviews *(continued)*

06/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/21/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On 04/22/2024, Resident 1 had a physical altercation with Resident 2. On 05/30/2024, Staff Person A reported that no verbal call was ever placed to the Local Area on Aging for this suspected resident abuse.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

Starting on 6/17/2024 Administrator created a check off list for reportable incidents, to help with not missing any steps when reporting an incident. List includes dates of who was called, and times and forms completed. Checklist will be kept in the reportable incident book; forms will be filled in by administrator

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *The administrator or designee will report this incident to the local Area Agency on Aging and complete an Act 13 form by 7/26/24. Documentation of this report and a copy of the Act 13 form will be kept and available for review by the Department.*
- *The administrator or designee will educate all staff on mandatory reporting of abuse and neglect under the Older Adult Protective Services Act by 7/26/24. Documentation of education will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete daily reviews of reported incidents in the home and will complete reports to the local Area Agency on Aging as required. Completed reports and Act 13 forms will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 05/25/2024, there was a physical altercation between Resident 1 and Resident 2. Resident 1 was verbally threatening Resident 2 and then Resident 1 attacked Resident 2. It was reported by Residents who witnessed the incident that Resident 1 pushed/threw Resident 2 to the ground located on the porch of the Personal Care Home.

On 04/22/2024, Resident 1 stole cigarettes from Resident 2 by taking the cigarettes out of [redacted] pocket. When Resident 2 confronted Resident 1 about taking [redacted] cigarettes, Resident 1 then pushed and shoved Resident 2 to the ground.

42b - Abuse (continued)

On 03/26/2024, Resident 1 and Resident 3 had a verbal altercation which led to a physical altercation. Resident 1 was getting coffee from a restricted resident area. Resident 3 told Resident 1 that [redacted] was not allowed in there. The two residents got into a verbal altercation which led to Resident 3 slapping Resident 1 across the face. Resident 1 then punched Resident 3 twice in the face, resulting in facial bruising to Resident 3.

On the morning of 03/18/2024, Resident 4 had an accident which resulted in feces being on the Resident's floor, bed and linens. Staff Person A and Staff Person B both report that the Resident 4 has 2-hour checks to aid with incontinence per the Resident's support plan. It was reported by Resident 4 and staff that Staff Person's A and B that Staff Person C worked the night of 03/17/2024 into the morning of 03/18/2024. Resident 4 Reported that Staff Person C never woke/checked on [redacted] throughout the night. When Resident 4 awoke in the morning, Resident 4 called for Staff Person C for help. Resident 4 reported that Staff Person C wouldn't help [redacted] and told the Resident to get out of bed and go get Staff Person B. When Resident did this, Staff Person C acted like [redacted] didn't know about the mess and said to Resident 4, "why didn't you come get me?" Staff Person B did aid and clean Resident upon discovery of the mess. Resident 4 reported to have cried in their bed and was distraught about how Staff Person C wouldn't help them and left them to lay in their mess.

Plan of Correction ***Directed ([redacted] - 06/25/2024)***

On the following dates 12/1/2021 ,8/19/2022 ,12/20/2022 ,4/24/2024, has given resident #1 30-day notices, but each time resident 1 would state that he was going to obey the rules of the home and stop fighting and stealing from other residents. resident 1 was moved from the room [redacted] was in on 1/15/2023 to see if this would help with behaviors after incident on 4/22/24. On 5/25/2024 there was another incident, so administrator and owner agreed that resident 1 had to leave facility. manor township police also said we can't keep giving him chances. Resident 1 no longer resides at the facility; [redacted] was sent to Lancaster general hospital and the facility will not accept back due to not following home rules and behaviors toward other residents. resident 1 left facility on 5/25/2024.
On incident with resident #4 and staff b &c, there was an investigation, there was a lot of discrepancies with the stories administrator and owner talked, we didn't believe that staff c did this on purpose and staff 2b should have called staff c to have [redacted] return to work and investigate the problem. In future administrator will do reports and then investigate. this will start on 5/30/2024.

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *The administrator or designee will educate all staff on the following: the importance of 2-hour toileting checks for residents, abuse and identifying and managing behaviors by 7/26/24. Documentation of education will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete a random sample of resident interviews monthly to ensure residents feel safe and cared for in the home. Documentation of these interviews will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

57b - 1 Hour/Day

4. Requirements

2600.

57b - 1 Hour/Day *(continued)*

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

Description of Violation

On 05/18/2024, there were 29 residents in the home, requiring a minimum of 29 hours of direct care service. On this day, only 19 hours of direct care staffing was provided.

On 05/26/2024, there were 28 residents in the home, requiring a minimum of 28 hours of direct care service. On this day, only 27 hours of direct care staffing was provided.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

Requirements on 57.b to correct this violation the owner bought a help wanted sign on 06/06/2024 also reached out to other personal care home administrators in the area to see if they any applications they were not in need of. after receiving a few applications two people were hired one on [redacted]/2024 and the other on [redacted]/2024 by owner and administrator This will help maintain the hours needed to stay in compliance

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review all work schedules before they are posted to ensure the required amount of personal care service hours are met for each day.*
- *Beginning no later than 7/26/24, the administrator or designee will create a call off system with back up options, to ensure the home is able to provide the required amount of personal care service hours each day.*
- *The administrator or designee will educate all staff on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

57d - Waking Hours

5. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 05/18/2024, a total of 21.75 hours of direct care was required. However, only 12 of the required hours, or 55.17% percent, were provided during waking hours.

On 05/24/2024, a total of 21.75 hours of direct care was required. However, only 21 of the required hours, or 96.55% percent, were provided during waking hours.

On 05/26/2024, a total of 21 hours of direct care was required. However, only 19 of the required hours, or 90.48% percent, were provided during waking hours.

57d - Waking Hours *(continued)*

Plan of Correction ***Directed [redacted] 06/25/2024)***

On 6/12/2024 and06/17/2024 two new hires were started to help with the required hours needed for resident, administrator will make sure that staff will provide the needed care for each resident. administrator will make sure hours are met.

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review all work schedules before they are posted to ensure the required amount of personal care service hours provided during waking hours are met for each day.*
- *Beginning no later than 7/26/24, the administrator or designee will create a call off system with back up options, to ensure the home is able to provide the required amount of personal care service hours provided during waking hours each day.*
- *The administrator or designee will educate all staff on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

60a - Staff/Support Plan

6. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Staff Person D worked the following nights from 11:00PM-6:00AM as the only staff person in the Personal Care Home: 05/10/2024, 05/14/2024, 05/15/2024, 05/16/2024, 05/18/2024, 05/19/2024, 05/22/2024, 05/23/2024, 05/24/2024, 05/27/2024, 05/28/2024 and 05/29/2024. Staff Person D is not certified in medication administration, and there are multiple residents in the home who are prescribed PRN medications.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

Staff person D started [redacted] medication training on [redacted]/4/2024, written examinations and module 4 skills were completed. observations were not complete till 6/7/2024. she then was certified. Hand washing and gloving were completed 3/4/2024 test was completed 3/4/2024. employee D does work another job and must leave as soon as [redacted] shift is done. On the 6/7/2024 date staff D and administrator we able to connect. In future administrator will complete entire class so this does not happen again. Staff person D is now completely certified .

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review all work schedules before they are posted to ensure there is a med tech available on each shift.*
- *The administrator or designee will educate all staff on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

60a - Staff/Support Plan *(continued)*

Directed Completion Date: *07/26/2024*

85b - Infestation

7. Requirements

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

Description of Violation

On 05/30/2024 at 9:28AM, several live bed bugs were located in resident room 7. Resident 5's bed had at least 4 live bed bugs in the sheets and pillows. Several more live bed bugs were observed around the baseboard of Resident 5's bed.

On 05/30/2024 at 9:49AM, a dead bed bug was located on Resident 6's bed in resident room 10.

On 05/30/2024 at 10:05AM, a dead bed bug was located on Resident 7's bed located in resident room 3.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Directed [redacted] - 06/25/2024)***

We are working with Kirchner's pest control there are 3 treatments that our to be done to help with the infestation we have had two done and only have one room with very light activity. the second round was done 5/21/2024- 6/10/2024. we are waiting to hear when Kirchner's will come do round three. the owner is handling this matter.

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *The administrator or designee will ensure the third bed bug treatment is completed no later than 7/26/24. Following the 3rd treatment, the home will follow the recommendations of the pest control business for on-going treatment. Documentation and receipts of all bed bug treatments will be kept and available for review.*
- *The administrator or designee will educate all staff on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

101a - Bedroom Square Footage

8. Requirements

2600.
101.a. Each single bedroom must have at least 80 square feet of floor space measured wall to wall, including space occupied by furniture.

Description of Violation

Resident 8's single bedroom measures 71.83 square feet.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

The owner will be doing paperwork to receive a waiver. Room8 has been the same size for over 30 plus years. nothing has ever been changed in that room. waiver will be applied for by June 28,2024

101a - Bedroom Square Footage (continued)

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *The resident is to be moved into another bedroom by 7/26/24. In the event that a waiver is approved, the provisions of the waiver must be followed and will supersede this POC.*
- *The administrator and the owner were educated on this regulation by inspectors on 5/30/24.*

Directed Completion Date: *07/26/2024*

132c - Fire Drill Records

9. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 05/19/2024 does not include the amount of time it took for evacuation.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

On 5/19/2024 this was no drill there was smoke in building from food spilling in oven. when alarm went off, we immediately had all residents evacuate. the administrator did not set a timer, my first thought was getting residents out. we did a repeat drill on 5/31/2024 time was 2:46. done by supervisor .

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review fire drill documentation within 72 hours of the monthly fire drill being completed to ensure all required documentation is included. Fire drill documentation will be kept and available for review by the Department.*
- *The administrator or designee will educate all staff involved with documenting fire drill information on this regulation by 7/26/24. Documentation of education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

162c - Menus Posted

10. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 05/30/2024, the home's menu for the current week of 05/26/2024-06/01/2024 was posted. However, the menu for the week of 06/02/2024-06/08/2024 was not posted.

162c - Menus Posted *(continued)*

Plan of Correction ***Directed [redacted] - 06/25/2024)***

immediately the owner posted the menu for the following week 6/2/24-6/8/24 going forward the menu will be checked by the administrator every morning to make sure 2 menus are posted the administrator will sign off on the chart that there were two weeks of menus when administrator is off supervisor will check.

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review menu postings to ensure the two weeks' worth of menus are posted. Documentation of these reviews will be kept and available for review by the Department.*
- *The administrator or designee will educate all staff on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

162d - Past Menus

11. Requirements

2600.
162.d. Past menus of meals that were served, including changes, shall be kept for at least 1 month.

Description of Violation

Per staff and resident interviews, the home's menu is not regularly followed. Menu items are often changed/substituted depending on availability. However, menu changes are not kept.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

on 6/12/2024 the administrator got a binder to keep all past menus in the binder will be kept in office menus will be paced in their once they are complete. administrator asked owner to purchase a white board where the menu will be written by staff at 7am daily. any changes that may be made will be with a sticky note and changed on white board when the change of food choice happens staff were educated on 6/14/2024 on the importance of the change in menu they have the right to know in a timely manner .
Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will review binder with all past menus to ensure menus and menu changes for the past month are available. This review will occur weekly.*

Directed Completion Date: *07/26/2024*

162e - Menu Changes

12. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

Per staff and resident interviews, the home's menu is not regularly followed. Menu items are often

162e - Menu Changes (continued)

changed/substituted depending on availability. Per staff and residents, these changes are not posted when they occur and/or the residents are not informed of these changes.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

having the white board to post changes will help this problem owner and administrator will see this is complete, as in 162c violation

Proposed Overall Completion Date: 06/20/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator or designee will complete daily reviews of the meals being served to ensure any menu changes are identified and documented.*
- *The administrator or designee will educate all staff on this regulation and the home's process for identifying, documenting and notifying residents of all menu changes. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident 9's Insulin Lispro Kwikpen 3M was opened on 04/23/2024, manufacture instructions state to discharge after 28 days from opening. However, as of 05/30/2024 at 4:09PM, it was still in the home's medication cart, in use and not discarded as per manufacture instructions.

Resident 5's Zofran 4mg Tab expired on 08/04/2023. However, as of 5/30/2024 at 4:17PM, it was still in use and inside of the home's medication cart.

On 05/30/2024 at 4:29PM, a prescription for NebuSal 3% Give one vial orally via nebulizer twice daily for Bronchitis for Resident 10 was located in the home's medication cart. Staff Reported that this medication has been discontinued for at least a month and is still present in the Medication cart.

Resident 1 left the home on 05/25/2024, However as of 05/30/2024, the resident's medications are still present in the home's medication cart.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

On June 6,2024 staff were educated on the importance of keeping the medication cart clean and current with resident meds. the cart will have an audit weekly done by administrator and supervisor will be done on Wednesdays after the first med. pass of the day. a check off sheet will be kept keeping track of the audits. this will be an ongoing weekly task, to keep the cart free of expired meds., discharged residents, non-labeled, non-dated and loose pills.

Proposed Overall Completion Date: 06/20/2024

183d - Prescription Current (continued)

[Directed]

- *The administrator or designee will complete an initial audit of all medications in the home by 7/26/24 to ensure all expired medication, medication of residents no longer in the home and all discontinued medications are properly disposed of. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete weekly medication audits to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

183e - Storing Medications

14. 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

On 05/30/2024 at 4:18PM, there was a loose white oval pill labeled "EP 137" located in the medication cart drawer.

Plan of Correction ***Directed[redacted] - 06/25/2024)***

Staff were educated on the importance of checking med. cart to ensure all storage of meds are organized. administrator and supervisor will be doing weekly checks every Wednesday. This will help for the future. training done on 6/6/2024 .

Proposed Overall Completion Date: 06/21/2024

[Directed]

- *Beginning no later than 7/26/24, the administrator will complete weekly audits of the med cart to ensure all medications are properly stored. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

185a - Implement Storage Procedures

15. 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

Resident 10 does not have the following PRN's on hand as of 05/30/2024:
Albuterol Sul 205 MG/3ML (Nebulizer ampule).
Albuterol HFA 90 MCG Inhaler.
Polyethylene Glycol 3350 (Miralax powder).

185a - Implement Storage Procedures (continued)

Resident 10 has the following discrepancies between the readings on the medication administration record (MAR) and the glucometer:
On 05/25/2024 at 5:00PM, the MAR had a blood sugar reading of 205. However, the blood sugar reading on the glucometer was 215.
On 05/24/2024 at 6:00AM, the MAR had a blood sugar reading of 239. However, the blood sugar reading on the glucometer was 263.
On 05/23/2024 at 6:00AM, the MAR had a blood sugar reading of 304. However, the blood sugar reading on the glucometer was 302.
On 05/18/2024 at 6:00AM, the MAR had a blood sugar reading of 214. However, the blood sugar reading on the glucometer was 212.

Resident 9 does not have the following PRN's on hand as of 05/30/2024:
Muscle Rub Cream (Bengay Greaseless cream).

Resident 9 has the following discrepancies between the readings on the MAR and the glucometer:
On 05/28/2024 at 8:00PM, the MAR had a blood sugar reading of 179. However, this reading was not found in the Glucometer.
On 05/13/2024 at 6:00AM, the MAR had a blood sugar reading of 143. However, on the glucometer, the blood sugar reading is 141.
On 05/12/2024 at 5:00PM, the MAR had a blood sugar reading of 321. However, on the glucometer, the blood sugar reading is 327.
On 05/07/2024 at 5:00PM, the MAR had a blood sugar reading of 128. However, on the glucometer, the blood sugar reading is 123.
On 05/05/2024 at 6:00AM, the MAR had a blood sugar reading of 158. However, on the glucometer, the blood sugar reading is 156.
On 05/01/2024 at 6:00AM, the MAR had a blood sugar reading of 75. However, on the glucometer, the blood sugar reading is 117.

Repeated Violation - 11/30/2022, et al

Plan of Correction ***Directed [redacted] - 06/25/2024)***

Resident # 10 administrator called pulmonary Dr. about [redacted] albuterol nebulizer ample and inhaler albuterol. explained how resident #10 refuses to use both meds. we are waiting to hear back from there office. resident 10 was missing his MiraLAX his PCP reordered. resident 9 didn't have [redacted] muscle rub in cart, was reordered by [redacted] PCP. Administrator called pharmacy about glucometer readings having discrepancies with readings, The meters checked fine. Staff was recording wrong numbers administrator and supervisor will be doing checks every Wednesday and a sign off sheet. this was started 6/19/2024.

Proposed Overall Completion Date: 06/21/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current residents' PRN medications to ensure all current PRN medications are available on-site. This audit will be completed by 7/26/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete weekly medication audits to ensure all current PRN medications are available on-site. Documentation of these audits will be kept and*

185a - Implement Storage Procedures (continued)

available for review by the Department.

- *Beginning no later than 7/26/24, the administrator or designee will complete weekly reviews of resident Medication Administration Records (MARs) and glucometer readings to ensure compliance. Documentation of these reviews will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident 9 has an order for Insulin Lispro Kwikpen 3M Sub-Q Per SS before meals & bedtime as follows:
BS: 0-150= 0 units
151-200= 1 unit
201-250= 3 units
251-300= 5 units
301-400= 8 units
However, the home had no glucometer test strips on the following dates and times to test the resident's blood sugar levels resulting in the resident not receiving any insulin per their order:
05/10/2024 at 8:00PM.
05/11/2024 at 6:00AM.
05/11/2024 at 11:00AM.
05/11/2024 at 5:00PM.

Resident 10 has an order for Insulin Lispro Kwikpen/Humalog 100units/ml sliding scale 3 times daily with meals as follows:
150-200= 1 unit
201-250= 2 units
251-300= 3 units
301-350= 4 units
350= 5 units, max 45 units per day.
On 05/27/2024 at 12:00PM, the resident had a blood sugar reading of 189 and was given 2 units of insulin. However, the resident should have received 1 unit of insulin.
On 05/22/2024 at 6:00AM, the resident had a blood sugar reading of 224 and was given 1 unit of insulin. However, the resident should have received 2 units of insulin.
On 05/20/2024 at 6:00AM, the resident had a blood sugar reading of 139 and was given 1 unit of insulin. However, the resident should have received 0 units of insulin.
On 05/19/2024 at 5:00PM, the resident had a blood sugar reading of 216 and was given 0 units of insulin. However, the resident should have received 2 units of insulin.
On 05/18/2024 at 5:00PM, the resident had a blood sugar reading of 253 and was given 0 units of insulin. However, the resident should have received 3 units of insulin.
On 05/15/2024 at 6:00AM, the resident had a blood sugar reading of 58 and was given 2 units of insulin. However,

187d - Follow Prescriber's Orders (continued)

the resident should have received 0 units of insulin.

Plan of Correction ***Directed [redacted] - 06/25/2024)***

The administrator and owner will make sure that resident 9 always has test strips. This should have not happened staff needs to tell administrator when [redacted] is down to 3days, and [redacted] will call. resident 10 meter was checked, resident 10 was giving staff wrong numbers, staff now keeps his monitor at nurse's desk, there is a sliding scale checks list that will be done weekly by administrator and supervisor. This was started on 6/19/2024

Proposed Overall Completion Date: 06/21/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current routine medications in the home by 7/26/24 to ensure all current medications are in the home. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete weekly medication audits to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*
- *Beginning no later than 7/26/24, the administrator or designee will complete weekly reviews of resident Medication Administration Records (MARs) to ensure residents on a sliding scale are receiving the prescribed dose of insulin. Documentation of these audits will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation by 7/26/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*

221b - Activity Types

17. Requirements

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

Per interviews with residents and staff, it was reported that the activity of "Bingo" scheduled for 05/29/2024 at 1:30PM never occurred due to a shortage of staffing. Furthermore, on 05/30/2024 the activities' schedule had "Exercise" listed at 1:30PM. Representatives never witnessed an activity preformed at this time slot and staff reported that due to staffing shortages, no activity would occur today (05/30/2024).

Plan of Correction ***Directed [redacted] - 06/25/2024)***

on 6/19/2024staff were educated on the importance of activities for the residents that the activity schedule must be followed activities must happen daily. Staff should allow time at the end or middle of their shift for activities that are posted. THERE IS NOW A LIST STAFF MUST SIGN, THIS WAS STARTED 6/19/2024.

Proposed Overall Completion Date: 06/21/2024

[Directed]

221b - Activity Types (continued)

- *Beginning no later than 7/26/24, the administrator or designee will complete weekly reviews of the activities and complete a same of resident interviews to ensure activities are being provided. Documentation of these reviews will be kept and available for review by the Department.*

Directed Completion Date: *07/26/2024*