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

PROVISIONAL

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 **February 11, 2025** until **August 11, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **326532**

ISSUING OFFICER

Juliet Marsala
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: FEBRUARY 11, 2025

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

RE: Red Rose Manor
38 Cottage Avenue
Lancaster, Pennsylvania 17602
License #: 326530

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 October 22-23, 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 SECOND PROVISIONAL license to operate the above facility. A SECOND 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 SECOND 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)
2600.51	II	27	$5	$135	5 calendar days from mailing date of letter
2600.57(b)	II	27	$5	$135	5 calendar days from mailing date of letter
2600.57(d)	II	27	$5	$135	5 calendar days from mailing date of letter
2600.60(a)	II	27	$5	$135	5 calendar days from mailing date of this letter
2600.65(a)	III	27	$3	$81	15 calendar days from mailing date of letter
2600.65(b)	III	27	$3	$81	15 calendar days from mailing date of this letter
2600.65(c)	III	27	$3	$81	15 calendar days from mailing date of this letter
2600.162(c)	III	27	$3	$81	15 calendar days from mailing date of letter
2600.162(e)	III	27	$3	$81	15 calendar days from mailing date of letter
2600.183(e)	II	27	$5	$135	5 calendar days from mailing date of letter
2600.185(a)	II	27	$5	$135	5 calendar days from mailing date of 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 SECOND 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:

Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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:

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

Facility Information

Name: *RED ROSE MANOR* **License #**: *32653* **License Expiration**: *01/26/2025*

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**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *10/23/2024*

Inspection Dates and Department Representative

10/22/2024 - On-Site: [redacted]

10/23/2024 - 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: *20* **Are 60 Years of Age or Older**: *21*

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

Have Mobility Need: *0* **Have Physical Disability**: *4*

Inspections / Reviews

10/22/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/15/2024*

12/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/21/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/20/2024*

12/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/21/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 10/22/24, at 9:15AM, all residents' records and personally identifiable information was unlocked, accessible, and unattended when not in use, in the office of the home, which is located in the basement. Per staff interview, residents and family members access the office with resident records in plain sight throughout the day.

Plan of Correction ***Directed (- 11/20/2024)***

Office door will be locked when office personnel is not present. Key will be available in emergencies. Key will be kept in Medication cart lock box. Key placed in lock box (see attached education and picture of key present)

(Directed)

- *Staff were educated on locking the office when no staff are present on 11/9/24.*
- *Beginning no later than 11/9/24, the office key will be kept in a lock box located in the medication cart.*
- *Beginning no later than 12/15/24, the Administrator or designee will complete random, weekly audits of the home to ensure resident records remain confidential and maintained in a manner that prevents unauthorized access.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/23/2024)

25c6 - Refunds

2. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

Description of Violation

The resident-home contracts for the following residents did not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death:

- *Resident #2's contract, dated*
- *Resident #3's contract, dated*
- *Resident #10's contract, dated*

Plan of Correction ***Directed (- 11/20/2024)***

Red Rose Manor has no Admission fees, Refunds are pro-rated and paid out to Family, POA, R/P, Guardian for upgrade of medical care or death. Information was added to new contract at appropriate place of the new

25c6 - Refunds (continued)

contract and concerned permanent. To ensure no further error on financial contract. Administrator implemented typed in plan and using all new financial contracts- see attached

(Directed)

- *The home's contract was updated by the Administrator or designee by 11/19/24 to specify the conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.*
- *Contracts were updated for Resident's #2, #3 and #10 by 11/20/24 by the Administrator or designee.*
- *The Administrator or designee will audit all remaining resident contracts by 12/15/24 and provide updated contracts as needed.*
- *By 12/15/24, the Administrator or designee will provide education to staff responsible for obtaining resident contracts to ensure the updated contract is used for future admissions.*
- *Documentation of completed audits and education will be kept by the home and available for review as needed.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/23/2024)

25c9 - Termination

3. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
9. The conditions under which the agreement may be terminated including home closure as specified in § 2600.228 (relating to notification of termination).

Description of Violation

The resident-home contracts for the following residents did not include the conditions under which the agreement may be terminated:

- *Resident #2's contract, dated*
- *Resident #3's contract, dated*
- *Resident #10's contract, dated*

Plan of Correction ***Directed (- 11/20/2024)***

On 10/23/24 Administrator implemented pages and corrected resident 2,3,10 contracts. New contracts were made and will be implemented for all new admission. Copy of new admission is attached. All new contracts will be proofread and initialed by administrative staff upon completion

(Directed)

- *The home's contract was updated by the Administrator or designee by 11/19/24 to specify the conditions under which the agreement may be terminated including home closure*
- *Contracts were updated for Resident's #2, #3 and #10 by 10/23/24 by the Administrator or designee.*
- *The Administrator or designee will audit all remaining resident contracts by 12/15/24 and provide updated contracts as needed.*
- *By 12/15/24, the Administrator or designee will provide education to staff responsible for obtaining resident contracts to ensure the updated contract is used for future admissions.*
- *Beginning 12/15/24, all new contracts will be proofread and initialed by administrative staff upon completion.*

25c9 - Termination (continued)

- *Documentation of completed audits and education will be kept by the home and available for review as needed.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/23/2024)

51 - Criminal Background Check

5. 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 Member A was hired . However, staff person's Pennsylvania State Police Criminal background check was not initiated until .

Staff Member B was hired on . However, as of , a Pennsylvania State Police Criminal background has not been completed.

Staff Member C was hired on or around . However, staff person's Pennsylvania State Police Criminal background check was not initiated until

Repeated Violation - 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

All criminal background were completed on employee A, B, C- All criminal background will be completed prior to first day. No new employee will be on floor alone, until background is complete. (See attached of employee checklist)

(Directed)

- *Staff Member B's criminal background check was completed on 11/6/24.*
- *As of 11/19/24, the New Hire Training checklist indicates the requirement for a background check to be completed prior to the staff member's first day of work.*
- *Administrative staff received education on the requirements for background checks to be completed prior to the first day on the floor on 11/9/24.*
- *An audit of all staff records will be completed by 12/15/24 by the Administrator or designee.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/23/2024)

57b - 1 Hour/Day

7. Requirements

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

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 10/05/2024, there were 25 residents present in the home, requiring a minimum of 25 hours of direct care services. However, on this day, only 23 hours of direct care service hours were provided.

On 10/13/2024, there were 27 residents present in the home, requiring a minimum of 27 hours of direct care services. However, on this day, only 25.5 hours of direct care service hours were provided.

On 10/18/2024, there were 26 residents present in the home, requiring a minimum of 26 hours of direct care services. However, on this day, only 23 hours of direct care service hours were provided.

Repeated Violation - 5/30/24, 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

Present schedule was reviewed, to meet 1 hour to meet daily. Schedule for November 22 to December 5, 2024 was revised before posting. (see attached schedules)

(Directed)

- *Schedule for November 22 to December 5, 2024 was revised before posting by 11/19/24.*
- *Education on 2600.57(b) will be provided to the Administrator or designee by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will review the staff schedule at least one week in advance to ensure direct care staff persons are available to provide at least 1 hour per day of personal care services to each mobile resident.*
- *Documentation of completed education and schedule reviews will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

57d - Waking Hours

8. 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 10/05/2024, there were 25 residents present in the home, requiring 18.75 hours of direct care services during waking hours. However, on this day only 17 waking hours of direct care service hours were provided.

On 10/13/2024, there were 27 residents present in the home, requiring 20.25 hours of direct care services during waking hours. However, on this day only 19.5 waking hours of direct care service hours were provided.

On 10/18/2024, there were 26 residents present in the home, requiring 19.5 hours of direct care services during waking hours. However, on this day only 17 waking hours of direct care service hours were provided.

57d - Waking Hours (continued)

Repeated Violation - 5/30/24, 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

Present schedule was review and staff was added to provide 1 hour of care per resident daily, see attached

(Directed)

- *Present schedule was reviewed, to meet 1 hour to meet daily by 11/19/24.*
- *Education on 2600.57(d) will be provided to the Administrator or designee by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will review the staff schedule at least one week in advance to ensure at least 75% of the personal care service hours are available during waking hours.*
- *Documentation of completed education and schedule reviews will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

60a - Staff/Support Plan

9. 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 Member B successfully completed a department-approved medications administration course on However, as of 10/22/2024, Staff Member B has not completed any Medication Administration Record reviews or Observations since their initial passing of the course on . On the following dates and times, Staff Member B was the only employee on shift and several residents have PRN (as needed medications):

- *09/28/2024 from 9:00PM to 6:00AM.*
- *09/29/2024 from 9:00PM to 6:00AM.*
- *10/04/2024 from 10:00PM to 6:00AM.*
- *10/09/2024 from 10:00PM to 6:00AM.*
- *10/12/2024 from 10:00PM to 6:00AM.*
- *10/13/2024 from 10:30PM to 6:00AM.*

Repeated Violation - 5/30/24.

Plan of Correction ***Directed (- 11/20/2024)***

Staff B-did have record review done 11-20-2023, review done 6-15-2024 also 7-3 -2024 review administration found in training book.
Administrator will go through training books, combine all trainings for medication record reviews and observations, will be easier for inspectors to find Will combine training books by December 1, 2024 (see attached)

(Directed)

60a - Staff/Support Plan (continued)

- *The Administrator or designee will be educated on medication administration annual practicum requirements and documentation requirements by 12/15/24.*
- *The Administrator or designee will complete an audit on all staff records who administer medications to ensure annual practicum documentation is completed thoroughly and within 1 year from the date of the initial medication administration certification by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will review the staff schedule at least one week in advance to ensure at least one staff member who is current in medication administration requirements is available when residents are present in the home.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

65a - FS Orientation 1st Day

11. 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.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

At the time of the 10/22/2024 inspection, Staff Member A, hired on Staff Member B, hired on , and Staff Member C, hired on or around have not received 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.*
3. *The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.*
4. *Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.*
5. *The location and use of fire extinguishers.*
6. *Smoke detectors and fire alarms.*
7. *Telephone use and notification of emergency services.*

Repeated Violation - 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

All new employees will get first day orientation (see new hire checklist) New orientation checklist will be completed by administrator prior to employee working independently on floor (see Orientation and New hire checklist attached)

65a - FS Orientation 1st Day (continued)

(Directed)

- *The Employee Orientation Checklist was updated by 11/19/24 to include training topic as outlined in 2600.65(a). Beginning no later than 12/15/24, the Administrator or designee will review the Employee Orientation Checklist for each new hire by the end of the employees first work day to ensure compliance.*
- *Staff Members A, B and C will receive training in evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms and telephone use and notification of emergency service by 12/15/24.*
- *The Administrator or designee will complete an audit of all staff records to ensure they have received training in the topics outlined in 2600.65(a) by 12/15/24.*
- *The Administrator or designee will receive education on 2600.65(a) by 12/15/24.*
- *Documentation of completed audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

65b - Rights/Abuse 40 Hours

12. 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:

1. Resident rights.
2. Emergency medical plan.
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

At the time of the 10/22/2024 inspection, Staff Member A, hired on , has completed 40th scheduled work hour. However, Staff Member A did not complete training in the following topics:

- *Emergency medical plan.*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102).*
- *Reporting of reportable incidents and conditions.*

At the time of the 10/22/2024 inspection, Staff Member B, hired on and Staff Member B, hired on or around have completed 40th scheduled work hour. However, Staff Member B and Staff Member C did not complete training in the following topics:

- *Resident rights.*
- *Emergency medical plan.*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102).*
- *Reporting of reportable incidents and conditions.*

65b - Rights/Abuse 40 Hours (continued)

Repeated Violation - 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

All new employees will get first day orientation (see new hire checklist) New orientation checklist will be completed by administrator prior to employee working independently on floor (see Orientation and New hire checklist attached) Tracking of 40hours will be kept on these forms

(Directed)

- *The Employee Orientation Checklist was updated by 11/19/24 to include training topics as outlined in 2600.65(b). Beginning no later than 12/15/24, the Administrator or designee will review the Employee Orientation Checklist for each new hire within 40 working hours to ensure compliance.*
- *Staff Member A will receive education on the emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102) and reporting of reportable incidents and conditions by 12/15/24.*
- *Staff Members B and C will receive education on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102), and reporting of reportable incidents and conditions by 12/15/24.*
- *The Administrator or designee will complete an audit of all staff records to ensure they have received training in the topics outlined in 2600.65(b) by 12/15/24.*
- *The Administrator or designee will receive education on 2600.65(b) by 12/15/24.*
- *Documentation of completed audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

65c - Ancillary Staff Orientation

13. Requirements

2600.
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 Member B, whose first day of work was on or around , did not have a general orientation to specific job functions.

Repeated Violation - 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

All new employees will get first day orientation (see new hire checklist) New orientation checklist will be completed by administrator prior to employee working independently on floor (see Orientation and New hire checklist attached) Tracking of 40hours will be kept on these forms

(Directed)

- *Beginning no later than 12/15/24, the Administrator or designee will review the new hire ancillary staff record before the first work day to ensure compliance.*
- *Staff Member B will receive a general orientation to their specific job functions as it relates to*

65c - Ancillary Staff Orientation (continued)

position by 12/15/24.

- *The Administrator or designee will complete an audit of all ancillary staff records to ensure they have received a general orientation to their specific job function(s) by 12/15/24.*
- *The Administrator or designee will receive education on 2600.65(c) by 12/15/24.*
- *Documentation of completed audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

65f - Training Topics

14. Requirements

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

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct Care Staff Member E did not receive training on the following topics in the 2023 annual training year:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Safe management techniques.*
- *Care for residents with mental illness or mental retardation, or both, if the population is served in the home.*

Plan of Correction ***Directed (█ - 11/21/2024)***

All new employees will get first day orientation (see new hire checklist) New orientation checklist will be completed by administrator prior to employee working independently on floor (see Orientation and New hire checklist attached) Tracking of 40hours will be kept on these forms

(Directed)

- *By 11/20/24, the Administrator or designee reviewed and made necessary updates on the 2025 Annual Training Plan to ensure training topics identified in 65(f) are scheduled.*
- *Education on 2600.65(f) will be provided to the Administrative staff by 12/15/24.*
- *The Administrator or designee will review all staff training records for training year 2024 to ensure training topics outlined in 65(g) have been obtained by each staff member by 12/15/24.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

65g - Annual Training Content

15. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Direct Care Staff Member E did not receive training in fire safety, completed by a fire safety expert or by a staff person trained by a fire safety expert, during the 2023 training year.

Plan of Correction ***Directed (- 11/21/2024)***

All new employees will get first day orientation (see new hire checklist) New orientation checklist will be completed by administrator prior to employee working independently on floor (see Orientation and New hire checklist attached) Tracking of 40hours will be kept on these forms

(Directed)

- *By 11/20/24, the Administrator or designee reviewed and made necessary updates on the 2025 Annual Training Plan to ensure fire safety training is scheduled.*
- *Education on 2600.65(g) will be provided to the Administrative staff by 12/15/24.*
- *The Administrator or designee will review all staff training records for training year 2024 to ensure training topics outlined in 65(g) have been obtained by each staff member by 12/15/24.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

103c - Food Protected

16. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 10/22/24, at approximately 10AM the lower left drawer of the refrigerator in the dining room, contained a layer of brown liquid with tiny black specks floating in it. There were tomatoes, lemon juice and other food items stored in this drawer, sitting in the brown liquid.

Plan of Correction ***Directed (- 11/20/2024)***

Resident refrigerator was cleaned immediately all foods spoiled or outdated were removed. This refrigerator will be cleaned daily on 11-7 shift to prevent food not dated or with names. If no name and/or outdated food will be removed. Signage was placed and education was completed. (see attached)

(Directed)

- *Resident refrigerator was cleaned by 11/19/24 and education was provided to staff by the Administrator or designee.*
- *By 11/19/24, a sign was posted on the refrigerator to inform staff of cleaning requirement during the overnight shift.*
- *Daily cleanings of the refrigerator by staff was implemented by 12/15/24.*

103c - Food Protected *(continued)*

Directed Completion Date: *12/15/2024*

Implemented (█ - 12/24/2024)

103f - Refrigerator/Freezer Temps

18. 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

On 10/22/24, at approximately 10AM, there was no thermometer in the refrigerator or freezer in the dining room of the home.

Plan of Correction ***Directed (█ - 11/20/2024)***

Thermometers placed in right upper corner of refrigerator. Taped to back wall of refrigerator (see picture attached. All refrigerators are checked for temperature (see attached log)

(Directed)

- *A thermometer was placed in the right upper corner of the refrigerator by 11/20/24.*
- *Education will be provided to all staff on 2600.103(f) by 12/15/24.*
- *Beginning no later than 12/15/24, weekly audits of all refrigerators and/or freezers will be completed by the Administrator or designee to ensure a thermometer is present and the temperatures are compliant.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

103i - Outdated Food

19. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 10/22/24, at approximately 10AM, a partially eaten and rotting rotisserie chicken with a label indicating to use by 9/14/24, was in the dining room refrigerator.

Plan of Correction ***Directed (█ - 11/20/2024)***

Resident refrigerator was cleaned immediately all foods spoiled or outdated were removed. This refrigerator will be cleaned daily on 11-7 shift to prevent food not dated or with names. If no name and/or outdated food will be removed. Signage was placed and education was completed. (see attached) Resident will store items in refrigerator in containers if not it will be removed. This refrigerator will be cleaned daily on 11-7 shift to prevent food not dated or with names. If no name and/or outdated food will be removed. Signage was placed and education was completed.

103i - Outdated Food (continued)

(see attached)

(Directed)

- *Resident refrigerator was cleaned immediately and all foods found to be spoiled or outdated were removed*
- *By 12/15/24, this refrigerator will be cleaned daily on 11PM-7AM shift to remove outdated food.*
- *By 11/20/24, a sign was posted on the refrigerator with directions to clean the fridge nightly and to remove outdated items.*
- *Education was provided to staff by 11/20/24.*

Directed Completion Date: *12/15/2024*

Implemented (█ - 12/24/2024)

123b - Emergency Procedures Posted

20. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's written emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed (█ - 11/20/2024)***

Copy of current Emergency Preparedness Plan was place in back of white survey results and Emergency Preparedness book hanging on peg board by nurse's station. (see attached copy of emergency preparedness) Administrator will check monthly when doing rounds for temperatures that items are still in book.

(Directed)

- *By 11/20/24, a copy of the home's Emergency Preparedness Plan was placed in the back of the white survey results and Emergency Preparedness book hanging on peg board by the nurse's station.*
- *Education on 2600.123(b) will be provided to the Administrator or designee by 12/15/24.*
- *Beginning no later than 12/15/24, a monthly audit will be completed by the Administrator or designee to ensure the plan remains posted in a public and conspicuous place in the home.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

141a - Medical Evaluation

21. 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.

141a - Medical Evaluation *(continued)*

Description of Violation

The medical evaluation for Resident #3, dated [redacted] was not complete within 60 days prior to admission or within 30 days after admission on [redacted]

Plan of Correction ***Directed ([redacted] - 11/20/2024)***

All Medical evaluation will be completed entirely before 30 post admission. This will be logged by administrator and reviewed and verified by two employees before filed into record. (see education attached) (see copy of log to be used to track MA 51 or medical evaluations)

(Directed)

- *Education on 2600.141(a) will be provided to the Administrator or designee by 12/15/24.*
- *A log was created by 11/20/24 to track resident admission dates and medical evaluation completion dates.*
- *Beginning no later than 12/15/24, new admission medical evaluations will be completed within 60 days prior to admission or 30 days after. This will be logged by the administrator and reviewed and verified by two employees before filed into record.*
- *Documentation of education and completed log will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented ([redacted] - 12/24/2024)

162c - Menus Posted

22. 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 10/22/24, the home's menu for the week of 10/20/24-10/26/24, was posted. However, the menu for the week in advance, 10/27/24-11/2/24, was not posted.

Repeated Violation – 5/30/24.

Plan of Correction ***Directed ([redacted] - 11/20/2024)***

Revised menu completed (see attached) sign by management staff. Red Rose Manor to be initiated 2 weeks in advance Menus. Posted menu will be post by nurses' station on peg board for all resident to see in advance (see education and menu)

(Directed)

- *By 12/15/24, the Administrator or designee will be educated on 2600.162(c).*
- *Beginning no later than 12/15/24, the Administrator or designee will complete weekly audits to ensure the current week's menu and a menu prepared for 1 week in advance are posted in a conspicuous and public place in the home.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

162c - Menus Posted *(continued)*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

162e - Menu Changes

23. 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 on 10/22/24 and 10/23/24, there are frequent changes to the menu options and the residents are not informed of the changes in advance.

Repeated Violation – 5/30/24.

Plan of Correction ***Directed (- 11/20/2024)***

Administrator will review menu first thing each morning making sure that items are available for menu. If not posting will be posted on menu of changes by crossing out menu items adding posted with new menu items no later than 10 am for 12 pm lunch or 4pm for 6pm supper (see education and menus attached)

(Directed)

- *Education was provided by 11/9/24 to staff in the home.*
- *Beginning no later than 12/15/24, the Administrator or designee will review the daily menu first thing each morning to make sure the menu items are available. If the menu items are not available, a change will be made to the menu by crossing out menu items and adding the new menu items no later than 10AM for scheduled lunch and 4PM for the scheduled supper.*
- *Documentation for completed education and menu changes will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Implemented (- 12/24/2024)

182b - Prescription Medication

24. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 10/7/24 and 10/21/24, at 6AM, Staff Member H administered Trulicity injection to Resident #1 and on 10/14/24, at 6AM, Staff Member G administered Trulicity injection to Resident #1. Staff Member G and Staff Member H do not have the qualifications to administer this injection.

182b - Prescription Medication (continued)

Resident #2 is prescribed glucagon injection kit, inject intramuscularly as needed for low blood glucose and unconscious. However, the home does not have licensed medical professionals to administer the medication when needed.

Plan of Correction ***Directed (- 11/20/2024)***

Medication was changed to Lantus insulin due to no license staff onboard that this time. Staff members were educated that no one on board are able to administer GLP-1. (See education attached) No intramuscular medication are in house and medication was change to tablets.

(Directed)

- *Medication for Resident #1 and #2 was changed per physician's orders to insulin injection and tablets.*
- *Staff were educated not to administer GLP medications by 11/19/24.*
- *The Administrator or designee will audit all other resident physician orders to ensure the route of administration is in compliance with staff member training for medication administration by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will review any new physician's orders to ensure the route of administration is in compliance with staff member training for medication administration.*

Directed Completion Date: *12/15/2024*

Implemented (- 12/24/2024)

183c - Refrigerated Meds Locked

25. 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

On 10/22/24, at 9:19AM, multiple residents' insulin and GLP-1 injection pen medications were unlocked, accessible, and not in use in the refrigerator in the basement.

Plan of Correction ***Directed (- 11/20/2024)***

All insulin locked container for all med tech to log that items are locked is placed in front of MAR book to reassure items are locked and discarded when needed. New refrigerator was purchased to be at nurses' station to placed locked box for insulin

(Directed)

- *The Administrator and staff who administer medications will receive education on 2600.183(c) by 12/15/24.*
- *A new refrigerator was purchased by 11/19/24 and placed in the nurse's station to store the locked box of insulin.*
- *Beginning no later than 12/15/24, the Administrator or designee will complete weekly audits of the lock box to ensure continued compliance.*
- *Documentation of education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

183e - Storing Medications

26. Requirements

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

Description of Violation

Resident #1's anoro ellipta inhaler indicates the medication is to be discarded 6 weeks after opening. On 10/23/24 at approximately 12:45pm, Resident #1's anoro ellipta medication was not labeled with the date it was opened.

Resident #9's trelegy ellipta inhaler indicates the medication is to be discarded 6 weeks after opening. On 10/22/24, Resident #9's trelegy ellipta inhaler was not labeled with the date it was opened.

Resident #11's clonazepam 2mg pill, was popped from the individual pill pocket, placed back into the pocket and held in with tape. On 10/23/24, the tape on the clonazepam package appeared to have crushed, white, pill residue still on the tape.

Repeated Violation - 5/30/24.

Plan of Correction ***Directed (█ - 11/20/2024)***

inhaler log was implemented to prevent outdated and expired inhaler in drawer. name will be added to device to prevent it be placed in wrong container. If no container for medication is available, items need discard and new one ordered

(Directed)

- *Education was provided to staff on logging insulin and inhaler dates to discard on 11/9/24.*
- *Staff will receive education on disposing of medication that was mistakenly popped from a blister pack no later than 12/15/24 by the Administrator or designee.*
- *Beginning no later than 12/15/24, staff will document the date insulin or an inhaler was opened and the date it is to be discarded on the log.*
- *Beginning no later than 12/15/24, the Administrator or designee will audit the medication cart to ensure medications are discarded in accordance with the manufacturer's instructions and are not taped into blister packs.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

185a - Implement Storage Procedures

27. 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 #2 is prescribed nurtec, as needed. On 10/23/24, the medication was not available in the home.

185a - Implement Storage Procedures (continued)

Repeated Violation -5/30/24, 3/11/24, et. al

Plan of Correction ***Directed (- 11/21/2024)***

PCP was contacted and pharmacy was contact on several times. Medication needed prior authorization to be obtained. We are unable to perform and not responsible to do prior authorizations for medications. Insurance did not approve of medication. Pharmacy request was sent to use to verify that medication was not processed or approved. Pharmacy was unable to dispense medications. When happens again with any resident mediation will not be placed until approval is received or medication is obtained. see attached education

(Directed)

- *By 11/20/24, the PCP and pharmacy was contacted regarding Resident #2's medication. As of 11/20/24, this medication is unable to be dispensed due to prior authorization. The physician will be contacted to either discontinue the medication or receive authorization to have the medication dispensed from the pharmacy by 12/15/24.*
- *An audit on all resident medications will be completed by 12/15/24 by the Administrator or designee to ensure medications are available as ordered.*
- *Education will be given to all staff who administer medications on ordering medications timely so medications are available as ordered by the physician. Education to be completed by the Administrator or designee by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will complete monthly audits on resident medications to ensure continued compliance.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

187a - Medication Record

28. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
8. Frequency of administration.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 is prescribed nystatin powder, apply topically to affected area twice daily as needed. However, October 2024 medication administration record (MAR) reads, apply topically as needed 4x/day.

Resident #2 is prescribed nasal spray as needed. However, October 2024 MAR does not include this medication.

Resident #3's October 2024 MAR does not include the diagnosis or purpose for Eliquis.

187a - Medication Record (continued)

Plan of Correction ***Directed (█ - 11/21/2024)***

New procedure was implemented that when any medication is sent in original containers or package with be kept with item, name placed on device itself. Any items without original container will be discarded and reordered by administrator immediately to prevent items being used without original container.

(Directed)

- *Resident #3's October 2024 Medication Administration Record (MAR) was updated by 11/20/24.*
- *The physician for Resident #2 will be contacted by 12/15/24 to clarify orders for nasal spray and Nystatin powder. Resident #2's MAR will be updated by 12/15/24.*
- *An audit of all other resident MAR's will be completed by 12/15/24.*
- *Education will be provided to all staff who administer medications on 2600.187(a) by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will complete monthly audits on all resident MAR's to ensure continued compliance.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (█ - 12/24/2024)

190a - Completion Medication Course

29. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member E successfully completed a department-approved medications administration course on █. However, as of 10/22/2024, Staff Member E has not completed any Medication Administration Record reviews or Observations since █ Staff Member E has administered the following medications to Resident #1: Risperidone 1.5mg at 5:00PM on 10/01/2024, 10/4/2024, 10/05/2024, 10/06/2024, and 10/09/2024.

Plan of Correction ***Directed (█ - 11/21/2024)***

Med Tech trainer will monitor staff quarterly to prevent issues with medication being passed inappropriately. Administrator will use required form to meet this regulation. Have items available for inspection.

(Directed)

- *The Administrator or designee will be educated on medication administration annual practicum requirements and documentation requirements by 12/15/24.*
- *The Administrator or designee will complete an audit on all staff records who administer medications to ensure annual practicum documentation is completed thoroughly and within 1 year from the date of the initial medication administration certification by 12/15/24.*
- *Beginning 12/15/24, the Administrator or designee will complete quarterly audits of staff medication*

190a - Completion Medication Course (continued)

administration training records to ensure requirements for medication administration practicums are completed timely and thoroughly.

- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

224a - Preadmission Screen Form

30. 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 #3's preadmission screening form, dated , does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeated Violation - 3/11/24, et al.

Plan of Correction ***Directed (- 11/20/2024)***

All prescreening will be completed entirely before 30 before admission. This will be logged by administrator and reviewed and verified by two employees before filed into record. (see education attached) see copy of log to be used to track MA 51 or medical evaluations, prescreening

(Directed)

- *Resident #3's preadmission screening was revised on 10/25/24.*
- *An audit of all remaining resident records will be completed by the Administrator or designee by 12/15/24 to ensure documentation includes the needs of the resident can be met by the services provided by the home.*
- *The Administrator or designee will receive education on 2600.224(a) by 12/15/24.*
- *Beginning no later than 12/15/24, preadmission screenings will be reviewed and verified by two employees before being filed in the resident's record.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

225a - Assessment 15 Days

31. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident #1's assessment, dated [redacted] does not include the residents diagnoses of depression and type 2 diabetes mellitus or the support plan to meet these medical needs.

Plan of Correction ***Directed ([redacted] - 11/20/2024)***

All RASP will be logged and completed as required by DSH. All spaces on RASP will be completed within 15 days of admission and Support plan will be completed within 30 days. Two administrative staff to review and verify that form is completed before filed with appropriate signatures (See tracking attached)

(Directed)

- *Resident #1's assessment will be updated by the Administrator or designee no later than 12/15/24.*
- *An audit of all other resident assessments will be completed by the Administrator or designee by 12/15/24 to ensure the assessment is accurate and current.*
- *Education will be provided to staff responsible for assessment completion by 12/15/24.*
- *Beginning 12/15/24, the Administrator or designee will complete quarterly audits of resident assessments to ensure they remain current and accurate.*
- *Documentation of education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented ([redacted] - 12/24/2024)

225c - Additional Assessment

32. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's assessment, dated [redacted], reads, the resident cannot self-administer their medications, can give own eye drops, and also give own insulin after staff draw up. However, the resident's ability to self-administer medications has changed multiple times in August and September 2024, and the assessment and support plan never reflected the significant changes. The following changes to their ability to administer medications are:

- *8/17/24, physician indicated resident can self-administer insulin and medications when out of facility.*
- *9/4/24, physician indicated resident can self-administer all eye drops suppositories, and muscle rubs.*
- *9/21/24, physician indicated resident can't self-administer most medications, but did not indicate the medications they were capable of self-administering.*
- *9/21/24, physician indicated resident is not capable of self-administering medications.*

Resident #10's assessment, dated [redacted] reads, the resident is independent with orientation, irritability, agitation, aggression, hallucinations and does not have a support plan in place, but requires minimal assistance with judgement as [redacted] doesn't use the best judgement at times. On [redacted], the home documents the resident experienced a medical emergency due to depression, and staff had to seek emergency medical services for the resident. On [redacted], the resident was hospitalized for depression, [redacted], and diagnosed with [redacted]

225c - Additional Assessment (continued)

On , the resident was hospitalized Per staff report, they had to provide frequent one on one support to the resident during times of distress, offer as needed medications, and reach out to medical services for further support for Resident #10. Resident #10 was diagnosed with suicidal The home never updated Resident #10's assessment to include their diagnoses of , or included the plan of support offered to the resident during times of need.

Plan of Correction ***Directed (- 11/21/2024)***

All RASP will be logged and completed as required by DSH. All spaces on RASP and Support plan will be completed. Two administrative staff to review and verify that form is completed before filed with appropriate signatures. Copy will be kept by administrator in notebook to allow for ongoing changes to be addressed on RASP and tracking if significant change needs completed. (See tracking attached)

(Directed)

- *Residents #2 and #10 will have updated assessments completed by the Administrator or designee no later than 12/15/24.*
- *An audit of all other resident assessments will be completed by the Administrator or designee by 12/15/24 to ensure the assessment is accurate and current.*
- *Education will be provided to staff responsible for assessment completion by 12/15/24.*
- *Beginning no later than 12/15/24, two administrative staff will review and verify that form is completed before filed with appropriate signatures. Copy will be kept by administrator in notebook to allow for ongoing changes to be addressed on RASP and tracking if significant change needs completed*
- *Beginning 12/15/24, the Administrator or designee will complete quarterly audits of resident assessments to ensure they remain current and accurate.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

227d - Support Plan Medical/Dental

33. Requirements

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

Description of Violation

The assessment for Resident #1, dated , indicates the resident has a need for assistance with making and keeping appointments. The resident's support plan, dated does not document how this need will be met.

The assessment for Resident #10, dated includes social and recreational needs. The resident's support plan, dated , does not document how this need will be met.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction ***Directed (- 11/21/2024)***

All RASP will be logged and completed as required by DSH. All spaces on RASP and Support plan will be completed. Two administrative staff to review and verify that form is completed before filed with appropriate signatures (See tracking attached)

(Directed)

- *Residents #1 and #10's support plans were updated on 10/25/24.*
- *An audit of all other resident support plans will be completed by the Administrator or designee by 12/15/24 to ensure the assessment is accurate and current.*
- *Education will be provided to staff responsible for completing support plans by 12/15/24.*
- *Beginning no later than 12/15/24, two administrative staff will review and verify that form is completed before filed with appropriate signatures.*
- *Beginning 12/15/24, the Administrator or designee will complete quarterly audits of resident support plans to ensure they remain current and accurate.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

252 - Record Content

34. Requirements

2600.
252. Content of Resident Records - Each resident’s record must include the following information:
   2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
   3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #1's record does not include identifying marks.

Resident #2's record does not include identifying marks.

Resident #3's record does not include identifying marks.

Resident #4's record does not include their eye color.

Plan of Correction ***Directed (- 11/21/2024)***

All information will be completed on Face sheet of all residents that live at Red Rose Manor as part of the admission process. When completed it will be added to the 911 book as part of emergency management plan.

(Directed)

- *Resident records for Residents #1, #2, #3, and #4 were updated by 11/4/24.*
- *An audit of all other resident records will be completed by 12/15/24 by the Administrator or designee.*

252 - Record Content (continued)

- *The Administrator will be educated on 2600.252 by 12/15/24.*
- *Beginning no later than 12/15/24, the Administrator or designee will review new admission face sheets within 1 week of admission to ensure all required information is identified in the resident record.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

253a - Record 3 Years

35. Requirements

2600.
253.a. The resident's entire record shall be maintained for a minimum of 3 years following the resident's discharge from the home or until any audit or litigation is resolved.

Description of Violation

The home discharged Resident #5 on , Resident #6 on , and Resident #7 on . However, at the time of the 10/22/24 inspection, the home has destroyed Resident #5's, Resident #6's, and Resident #7's records.

Plan of Correction ***Directed (- 11/21/2024)***

Discharge and destruction log will be updated by administrator daily of any discharge or destroyed charts. No chart will be destroyed without two administrative staff approval and or greater then 3 years (see attached sample of log) education attached

(Directed)

- *Education will be provided to all staff on 2600.253(a) by 12/15/24.*
- *The Administrator or designee will audit records for all residents discharged from 11/1/2022 through current date to ensure the record is available.*
- *The Administrator developed a record destruction log that will document when a resident was discharged and when a record is or may be destroyed. Destruction log to be implemented no later than 12/15/24.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)

253c - Records Log

36. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

The home discharged Resident #5 on , Resident #6 on and Resident #7 on At the time of the 10/22/24 inspection, the home has destroyed Resident #5's, Resident #6's, and Resident #7's records. However, the home does not have a log of the residents' records destroyed to include the resident's name, record number, birth date, admission date and discharge date.

253c - Records Log *(continued)*

Plan of Correction ***Directed (- 11/21/2024)***

log was made for keeping track of all discharge and destroyed charts, administrator will log and maintain. All record will be destroyed after 3 years unless underage of 21. (21 plus 3)(see attached) Now implement closed /destroy log into our procedure

(Directed)

- *By 11/20/24, a log was made for keeping track of all discharged residents and destroyed charts. The Administrator will be responsible to log and maintain this document.*
- *Education will be provided to all staff on 2600.253(c) by 12/15/24.*

Directed Completion Date: *12/15/2024*

Not Implemented (- 12/24/2024)