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 **August 14, 2025** until **February 14, 2026**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **326533**

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: AUGUST 14, 2025

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

RE: Red Rose Manor
38 Cottage Avenue Lancaster,
Pennsylvania 17602
License #: 326533

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 27, 2025, May 6, 2025, and May 7, 2025 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 THIRD PROVISIONAL license to operate the above facility. A THIRD 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); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed.

If you disagree with the decision to issue a THIRD 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], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
[redacted]

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

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:** *08/11/2025*

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:** *24* **Waking Staff:** *18*

Inspection Information

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

Reason: *Complaint, Incident, Fine* **Exit Conference Date:** *02/27/2025*

Inspection Dates and Department Representative

02/27/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served:** *24*

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: *23* **Diagnosed with Intellectual Disability:** *3*

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

Inspections / Reviews

02/27/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/20/2025*

Inspections / Reviews *(continued)*

03/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/07/2025*

08/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2025*

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

42b - Abuse

1. 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

In June 2024, Resident #1 had been having increased episodes of incontinence and was unable to manage their bowel movements independently. The resident's [redacted] resident assessment and support plan (rasp) reads, the resident needs assistance with bladder and bowel management, wears adult briefs, has "problems at times" with bowel management, staff are to check the resident every 2 hours for toileting needs, and staff must assist the resident with bowel and urine and incontinence. On 2/27/25, Staff Members F and G reported to an agent of the Department that if Resident #1 is incontinent of bowel or bladder, Resident #1 requires staff assistance every occasion to help clean themselves and obtain clean clothing, adult briefs, etc.

On 2/3/25, at 11PM Staff Member A was aware Resident #1 had an incontinent accident and told Resident #1 to change, but did not assist the resident. At approximately 12:10AM on 2/4/25, Resident #10 heard Staff Member A tell Resident #1, "you [redacted], you need to go clean up" before leaving the bedroom and not assisting Resident #1. Multiple residents observed seeing and smelling feces in Resident #1's bedroom, by the bedroom door, and by the bathroom in the hallway. On 2/4/25, at 8AM, Staff Member F observed Resident #1 lying in feces on their bed, that was without sheets or a mattress cover, and Resident #1 was not wearing an adult brief or any clothes on their lower half. Staff Member F also observed feces in the hallway and on Resident #1's bedroom floor, and Resident #1's bedding lying in the hallway was covered in feces. On 2/27/25, per resident interviews, Resident #1 was upset in the morning on 2/4/25 and felt the need to apologize to others.

On 2/4/25, Staff Member A belittled Resident #1 in front of their 3 other roommates for having an incontinence incident, did not check on Resident #1 every 2 hours throughout the night, and was aware Resident #1 had an incontinence episode but did not assist the resident to clean themselves and obtain clean clothing, adult briefs, and clean bedding. Resident #1 laid in their urine and feces until approximately 8AM on 2/4/25, when Staff Member F arrived to assist the resident.

The home terminated Staff Member A on [redacted]

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

Plan of Correction ***Directed ([redacted] - 03/24/2025)***

Resident #1 was provided appropriate care immediately ,staff member A was addressed and investigated immediately .which led to [redacted] termination .All staff was educated on all policy and procedures by OAPSA for abuse. Annual Education ,Immediate investigation of any complaint ,immediate action will take place. Implemented Immediately ongoing training .Administrator did training2/7/2025-3/7/2025. Completion 03/07/2025

(Directed)
In addition to the above plan of correction, beginning 4/1/25, the Administrator will interview 10% of residents at least once per week to ensure their needs are being met and they feel safe in their home. Documentation of education and resident interviews will be kept by the home and available for review by the Department.

42b - Abuse *(continued)*

Directed Completion Date: *04/04/2025*

Implemented (- 07/25/2025)

51 - Criminal Background Check

2. 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

At the time of the 2/27/25 inspection, Staff Member B, hired on and Staff Member C, hired on did not have a Pennsylvania criminal history background check completed, with the summary of results, by their date of hire, or within one year prior to their date of hire.

Repeated violation- 10/22/24, et al., 3/11/24, et al.

Plan of Correction ***Directed (- 03/21/2025)***

New criminal checks were done on staff B , Check for staff C was done at time of inspection it was pending both are done ,see attached. No employee can work until employee check list is completed . so this is not repeated administrator will be using new employee chart order list completed 03/12/2025

(Directed)

- *Background checks for Staff Members B and C were completed by 3/20/25 and will be filed in the staff member's records by the Administrator no later than 4/4/25.*
- *The Administrator and/or any additional staff responsible for staff records will receive education on 2600.51 no later than 4/4/25.*
- *An audit of all remaining staff records will be completed by the Administrator no later than 4/4/25 to ensure background checks have been completed and filed properly.*
- *Beginning 3/12/25, the Administrator will use a new employee chart order list to ensure employee background checks are completed timely. No employee will be permitted to work until the employee check list is completed.*
- *Beginning no later than 4/4/25, the Administrator or designee will complete quarterly audits on all employee records to ensure background checks are completed properly and filed.*
- *Documentation of staff education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

57b - 1 Hour/Day

3. 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.

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

Description of Violation

On 2/11/25, 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 2/12/25, there were 26 residents present in the home, requiring a minimum of 26 hours of direct care services. However, on this day, only 25 hours of direct care service hours were provided.

Repeated Violation - 10/22/24, et al., 5/30/24, 3/11/24, et al.

Plan of Correction ***Directed (- 03/21/2025)***

Making sure our direct care hours are met on call offs and any new scheduling. See attached. Schedule in office will be updated immediately as changes occur .All changes will audited by administrator so to meet all direct care hours. 3/15/2025completion

(Directed)

- *The Administrator and/or designee will receive education on 2600.57(b) by 4/4/25.*
- *Beginning 4/4/25, the Administrator or designee will review the staff schedule at least one week in advance to ensure staff persons are scheduled to provide at least 1 hour per day of personal care services to each mobile resident and 2 hours for each immobile resident.*
- *If the Administrator determines that there are not enough staff to provide the needed hours, they will contract with a staff agency no later than 4/4/25 to provide additional staff as needed.*
- *Documentation of staff education and completed audits will be kept by the home and available for review by the Department*

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

57d - Waking Hours

4. 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 2/7/25 there were 26 residents present in the home requiring 19.5 hours of direct care services during waking hours. However, on this day only 18.5 waking hours of direct care service hours were provided.

On 2/11/25 there were 25 residents present in the home requiring 18.75 hours of direct care services during waking hours. However, on this day only 15 waking hours of direct care service hours were provided.

On 2/12/25 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.

On 2/22/25 there were 24 residents present in the home requiring 18 hours of direct care services during waking hours. However, on this day, only 17 waking hours of direct care services hours were provided.

57d - Waking Hours (continued)

Repeated Violation - 10/22/24, et al., 5/30/24, 3/11/24, et al.

Plan of Correction ***Directed (- 03/21/2025)***

Adjusted schedule so all waking hours are met. schedule in office will be updated as changes occur by administrator. Schedules will be audited daily on ongoing basis. 3/15/2025 completed

(Directed)

- *The Administrator and/or designee will receive education on 2600.57(d) by 4/4/25.*
- *Beginning 4/4/25, the Administrator or designee will review the staff schedule at least one week in advance to ensure staff persons are scheduled to provide at least 75% of the personal care service hours required are available during waking hours.*
- *If the Administrator determines that there are not enough staff to provide the needed hours, they will contract with a staff agency no later than 4/4/25 to provide additional staff as needed.*
- *Documentation of staff education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

181c - Self-administration Assessment

10. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #4 self-administers medications to include Ventolin hfa albuterol sulfate inhalant solution. However, Resident #4 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders for the medication.

Resident #5 self-administers medications to include oxygen, and the following inhalant solutions: trelegy, Combivent Respimat, and albuterol. However, Resident #5 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders for the medications.

Resident #8 self-administers fluticasone-salmet (Advair). However, Resident #8 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders for the medication.

Plan of Correction ***Directed (- 03/24/2025)***

Administrator has requested self administer orders from Doctors , For residents 4,5 ,8. House doctor will be in for visit in 7-10 days ,will get orders for resident #4 and #8 . was faxed previously 3/3/2025. Resident #5 we received order 3/17/2025 SEE SELF ADMINISTRATION quarterly reports . completion date will be3/24/2025 .

(Directed)

181c - Self-administration Assessment (continued)

In addition to the above plan of corrections:

- *The Administrator will provide education to all staff and residents in the home on requirements for residents to self administer medications; education to be completed by 4/4/25.*
- *RASP's for residents #4, #5 and #8 will be updated to reflect their ability to self-administer medications per the prescriber's orders by 4/4/25.*
- *Beginning 4/1/25, residents who express a desire to self-administer medications will be assessed per 2600.181(c); RASP's and medical evaluations will be updated, as applicable.*

Directed Completion Date: *04/04/2025*

Not Implemented ([redacted] - 07/25/2025)

183b - Meds and Syringes Locked

12. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 2/27/25 at 10:15AM, Ventolin hfa albuterol sulfate inhalant solution was unlocked, unattended, and accessible in the top dresser drawer in Resident #4's bedroom.

On 2/27/25, at 12PM, Resident #5's trelegy inhaler was unlocked and unattended in the resident's bedroom. Resident #5 shares a room with another resident who is not able to self-administer medications.

Plan of Correction ***Directed ([redacted] - 03/21/2025)***

Resident #4 will keep inhaler in locked med. cart and can request when needed. Resident #5 requesting to keep in lock box in room. All staff trained anyone who self administers must have meds. in a locked box at all times. training will be ongoing.

(Directed)

- *As of 3/20/25, Resident #4's inhaler was placed in the home's locked medication cart.*
- *By 4/4/25, Resident #5 will be provided with a lock box in [redacted] bedroom and will receive education on keeping medications locked by the Administrator.*
- *An initial audit will be completed in all other resident rooms no later than 3/28/25 by the Administrator to ensure medications are kept in a locked box or medication cart per the resident's ability to self-administer medications.*
- *Education on 2600.183(b) will be provided to all staff in the home by the Administrator by 4/4/25.*
- *Beginning no later than 4/4/25, weekly audits of the home will be completed to ensure medications continue to be maintained in an area or container that is locked.*
- *Documentation of completed audits and education to resident(s) and staff will be kept by the home and available for review by the Department.*

183b - Meds and Syringes Locked *(continued)*

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

184a - Resident's Meds Labeled

13. Requirements

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

Description of Violation

The pharmacy label for Resident #3's Humalog insulin does not include the prescribed sliding scale administrations for blood sugars measuring from 251 to greater than 350, or for the units prescribed with high blood sugars measuring with snacks.

One of the pharmacy labels for Resident #5's atorvastatin does not include their current order but reads, atorvastatin 20mg, take 1 tablet by mouth once daily; they are prescribed 40mg daily.

Plan of Correction ***Directed (- 03/24/2025)***

contacted Pharmacy3/17/2025 new labels were sent over for Resident #3 pharmacy said label is in file but was missed ,will make correction. see attachment . on resident #5 had pharmacy send out new bottle of medications with correct label ,see attached. staff training on mars direct orders should match with labels training will be on going training will be done by administrator. completed 3/13/2025.

(Directed)

- *In addition to the above plan of correction, beginning no later than 4/4/25, the Administrator will complete monthly audits on all resident pharmacy labels and compare them to the physician's order.*
- *Documentation of staff education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Implemented (- 07/25/2025)

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

On 2/27/25 at 11:30 AM, Resident #3's glucometer was not calibrated to the correct time as the glucometer indicated it was 10:51 AM.

185a - Implement Storage Procedures (continued)

Plan of Correction ***Directed (- 03/24/2025)***

Resident # 3 glucometer is now calibrated, see attachment. 3/14/2025 Staff retained on how to calibrate meters. will have ongoing training ,to be done by administrator. completion 3/14/2025. [redacted]

(Directed)

In addition to the above plan of correction:

- *The Administrator will complete an initial audit of all remaining glucometers in the home to ensure they are all properly calibrated to the correct date and time. This audit will be completed no later than 3/31/25 and will be completed at least monthly beginning 4/1/25.*

Directed Completion Date: *04/01/2025*

Implemented (- 07/25/2025)

187a - Medication Record

16. Requirements

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

Description of Violation

Resident #3 is prescribed albuterol inhaler as needed and does not have a February 2025 Medication Administration Record (MAR) that includes this medication.

Resident #3's February 2025 MAR does not include the diagnosis or purpose of their prescribed Truplus and Baqsimi.

Resident #4 is prescribed Oxcarbazepine for schizoaffective disorder. However, the resident's February 2025 MAR indicates that they are prescribed this medication for mood disorder.

Resident #6 is prescribed Polyethylene glycol 3350, mix 17gm in liquid and take by mouth daily. May use every other day if stooling 2-3 times per day and stools are soft. However, their February 2025 MAR reads, take 17gr by mouth daily, hold for loose stools.

187a - Medication Record (continued)

Repeated Violation - 10/22/24, et al.

Plan of Correction ***Directed ([redacted] - 03/24/2025)***

Resident #3 Albuterol inhaler is now on mar for Feb.2025 and March 2025 they have been corrected. Diagnosis is now on for Truplus Glucose and BAQSIMI for Feb. and MARCH 2025. Resident #4 Please see attach not sure about this violation Oxcarbazepine 600mg is for mood disorder ,Olanzepine 15mg is for Schizophrenia . These are two different meds. Resident #6 there were two different orders MAR for March is now correct ,we have also called PCP asking change to PRN 3/10/2025 .Staff retrained that mars have the 5 rights and Diagnosis Admiistrator to do training.

(Directed)

- *Resident #3's Albuterol inhaler was added to the March 2025 MAR by 3/20/25. Additionally, the diagnosis was added to the March 2025 MAR for the medication Truplus Glucose and BAQSIMI.*
- *Per Resident #4's medication packet and order, Resident #4 receives Oxcarbazepine 600mg "twice daily for Schizoaffective". Resident #4's MAR will be revised by 3/31/25 to match the purpose of the medication per the order.*
- *Education will be provided to all staff who administer medications by 4/4/25 on 2600.187(a) by the Administrator.*
- *Beginning 4/1/25, the Administrator will complete audits on each resident's MAR and physician's order to ensure continued compliance with 2600.187(a).*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Implemented ([redacted] - 07/25/2025)

187c - Refusal of Medication

18. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #2 refused to take scheduled doses of Linzess from 2/8/25-2/14/25 and on 2/20/25. The home did not notify the resident's prescribing physician of the refusals until after the 2/20/25 refusal.

At the time of the 2/27/25 inspection, Resident #3 refused to take polyethylene glycol powder daily since 2/15/25. The home did not notify the resident's prescribing physician of the refusals.

At the time of the 2/27/25 inspection, Resident #6 refused to take polyethylene glycol powder daily from, February 1st-3rd, 11th-13th, 15th-16th, 19th-21st, and 26th, 2025. The home did not notify the resident's prescribing physician of

187c - Refusal of Medication (continued)

the refusals.

Plan of Correction ***Directed (- 03/24/2025)***

Resident#2 staff has faxed and called PCP ,Dr. [redacted] on 2/11/25 ,3/4/25 3/13 /25 Resident told us [redacted] PCP is aware [redacted] is refusing due to loose stools. on starting on3/02/25 resident 2 restarted [redacted] LInzess, [redacted] IS NOT A RESIDENT AT RED ROSE MOVED [redacted]. Resident#3 now has a order for miralax that is PRN .resident was refusing due to loose stools staff has called and faxed since 3/1/2025 did get order 3/14/2025. Resident #6 as of 3/17/2025 we are still waiting on order to have changed to PRN .STAFF EDUCATED ON CALLING PCP 2 DAYS ON ANY REFUSALS.

(Directed)
In addition to the above plan of correction:

- *Education will be provided to all staff who administer medications on 2600.187(c) by 4/4/25.*
- *Beginning no later than 4/1/25, the Administrator will complete weekly audits of resident MAR's to ensure refusals are documented and the prescriber was notified within 24 hours and documented in the resident's record.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Implemented (- 07/25/2025)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #2 is prescribed Zofran ODT 4mg, take 1 tablet by mouth every 6 hours as needed. However, Resident #2 was administered Zofran on 2/5/25 at 1:15AM and again at 6AM.

Resident #5 is prescribed Vitamin D3 daily. At the time of the 2/27/25 inspection, the home did not have orders to discontinue the supplement nor was the home administering the supplement.

Resident #6 is prescribed Polyethylene Glycol powder daily. At the time of the inspection, the home did not administer the medication from February 5th-10th, 14th, 17th-18th, and 22nd-25th, 2025.

Repeated Violation - 8/1/24, 5/30/24.

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Directed (- 03/24/2025)***

See attached

(Directed)

- *An audit on all resident orders and MAR's will be completed by 3/31/25 by the Administrator to ensure orders are current and present.*
- *An audit on all resident medications compared to the physician's orders will be completed by 3/31/25 by the Administrator to ensure medications are available as ordered.*
- *Education will be provided to all staff who administer medications on making sure medications are available in the home as ordered and that medications are being administered as prescribed. Education will be completed no later than 4/4/25 by the Administration.*
- *Beginning no later than 4/1/25, the Administrator will complete monthly audits of resident medication records to ensure medications are administered as ordered.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #7 is prescribed the following medications at 8AM: atorvastatin 80mg, escitalopram 20mg, vitamin d3, omega-3, and pantoprazole 40mg. Resident #7 did not return home in the morning on 2/11/25, did not have their 8AM doses of medications with them, and was not administered their 8AM medications on 2/11/25. The medication error was not reported to the resident's prescriber.

Plan of Correction ***Directed (- 03/24/2025)***

Resident #7 Violation should be for 2/10/2025. see mar page .All staff retrained to call PCP and designated person to report any error for medications ,documentation will be on back of mar who was called and date ,time . see attached administrator did training 3/15/2025 completion

(Directed)

188b - Medication Error Reporting (continued)

In addition to the above plan of correction, beginning no later than 4/4/25, the Administrator will complete audits on resident medication administration records and notification to the prescriber at least once monthly to ensure errors were reported to the prescriber. Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: *04/04/2025*

Not Implemented (- 07/25/2025)

251b - Record Entries Legible

21. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on Resident #1's 1/27/25 MA51 examination record, altering the date the resident and physician signed the record for completion.

Plan of Correction ***Accept (- 03/24/2025)***

Resident#1 Dr. had put wrong date on old MA51 and DME white out fluid was used ,on 3/4/2025 Dr made the correction and faxed back to us. see attachment . Resident#8 Metformin was changed when in hospital see med. list 2/14/2025. med. change should have been rewritten on mar correctly not crossed out see 3/1/2025 sheet where error was corrected . training on proper way to make changes on mars training is ongoing . 3/5/2025 training complete. to ensure accuracy Mars will be monitored daily by administrator .3/17/2025 completion.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Not Implemented (- 07/25/2025)

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

Facility Information

Name: *RED ROSE MANOR* **License #:** *32653* **License Expiration:** *08/11/2025*

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:** *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *25* **Waking Staff:** *19*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date:** *05/07/2025*

Inspection Dates and Department Representative

05/06/2025 - On-Site: [redacted]

05/07/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served:** *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *19* **Are 60 Years of Age or Older:** *20*

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

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

Inspections / Reviews

05/06/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/08/2025*

06/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/17/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/18/2025*

07/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/17/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/18/2025*

07/28/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/17/2025*

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

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.

Description of Violation

The last quality management review by the home was conducted on 1/6/23 and did not address the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.

Plan of Correction ***Accept (- 06/10/2025)***

On 5/26/05 when DHS inspectors visited the facility, the quality management records for the year 2024 were found complete but misplaced.
Immediate Actions: On 5/06/2024, the administrator reviewed the binders and located the completed quality management records.
Corrective actions: The administrator will organize the binders by 7/1/2025, using labeled tabs for better organization. A check-off sheet will be placed at the front of the binders for the administrator to initial and sign monthly after completing a review of the binders for compliance. This process will continue for 6 months beginning on 7/1/2025 once the binders are organized.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Not Implemented (- 07/25/2025)

51 - Criminal Background Check

2. 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 on and worked in the home on , and The home did not obtain staff member A's Pennsylvania criminal history background check until

Repeated Violations: 10/22/24, et al

51 - Criminal Background Check *(continued)*

Plan of Correction ***Accept (- 06/10/2025)***

On , the administrator conducted a background check on staff member A, who was scheduled to be hire on . The results on the background check returned with an 'under review' status. On the administrator reviewed the status on the background check, revealing that staff member A had a record. Subsequently, the owner consulted staff member A, who asserted that there was nothing on record.
Despite this, staff member A commenced orientation on , with second day of orientation taking place on .
On April 16,2025, the owner instructed the administrator to contact Patch to investigate the background check further. After Patch reviewed the background, they identified an error and confirmed that there was no record for staff member A, providing the facility with a copy of the clean background check.
Moving forward, all background checks will be completed before the first day of employment. If a background check is pending under review, the staff member will not commence work until the administrator has assessed the reasons for the pending status to determine whether the staff member can work in a personal care home given any reported violations.
Background checks are now incorporated into the new hire check-off sheet, with the date of the background check and its outcome duly recorded.
These employee check-off sheets will be maintained on an ongoing basis with no end date.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Not Implemented (- 07/25/2025)

60a - Staff/Support Plan

3. 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 has not successfully completed and passed the Department-approved medication administration course; however, on the following dates and from 10:00 PM to 6:00 AM Staff member B was the only staff member present in the home: 4/25/25, 4/28/25, 4/29/25, 4/30/25, 5/1/25, 5/3/25, 5/4/25, and 5/5/25.

Residents' #2,#3,#4 are all prescribed PRN or as needed medications and were present in the home during these dates and times.

Staff member C has not successfully completed a Department-approved medication administration course; however, on the following dates and times, Staff member C was the only staff member present in the home.

- *4/25/25 from 8:00 PM-10:00 PM*
- *4/26/25 from 8:30 PM until 6:00 AM on 4/27/25*
- *4/27/25 from 8:30 PM until 6:00 AM on 4/28/25*
- *4/28/25 from 2:00 PM-4:00 PM and 8:30 PM-10:00 PM*
- *5/2/25 from10:00 PM until 6:00 AM on 5/3/25*

Residents' #2,#3,#4 are all prescribed PRN or as needed medications and were present in the home during these dates and times.

60a - Staff/Support Plan (continued)

Repeated Violations: 5/30/24, 10/22/24, et al

Plan of Correction ***Accept ([redacted] - 06/30/2025)***

Both staff Members B AND C were immediately removed from the medication cart. On May 8,2025 the owner contacted a certified medication administration trainer for staff members in medication administration. Both staff Members B and C were subsequently enrolled in a class, which they successfully completed by the beginning of June. The Administrator/medication Trainer will ensure that all medication technicians remain up to date through MAR (Medication Administration Record) reviews and observation. Moving forward, no staff members will be permitted to administer medication without proper training from a certified trainer. Additionally, a staff member role sheet will be developed to assist the scheduler in assigned responsibilities appropriately. These tasks are ongoing and will not have specified and date

To ensure compliance with the staffing plan, the administrator will take proactive steps to monitor and maintain staff members trained in medication administration. By adding specific roles to the schedule, the administrator will help the scheduler identify and confirm that a medication technician is present on every shift. All current staff are up to date with their medication administration training

Clear communication between the medication trainer and the scheduler will be maintained to confirm when a newly trained team member is ready to assume the role of med tech. This ensures that new team members are adequately prepared before being placed on the schedule.

The administrator will review the schedule and verify the presence of a med tech on all shifts. Once confirmed, the administrator will sign off at the bottom of the schedule, signing its readiness before posting it for staff this careful approach aims to maintain compliance, avoid repeat violations, and streamline the medication administration process across all shifts

Licensee's Proposed Overall Completion Date: *06/18/2025*

Implemented ([redacted] - 07/25/2025)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/2/25, 26 residents were present in the home and no staff members who were certified in obstructed airway techniques and CPR worked in the home.

On 5/6/25, 25 residents were present in the home and no staff members who were certified in obstructed airway techniques and CPR worked in the home from 6:00 AM to 12:00 AM.

63a - First Aid/CPR Training *(continued)*

Plan of Correction ***Directed (- 06/30/2025)***

On May 2,2025, all staff underwent first aid and CPR training conducted by a certified trainer. Additionally, on May 6,2025, trainer returned to the facility to provide hands -on training for staff members who had attended class on March 23,2025, and May 3,2025.
Moving forward, the administrator will ensure that all staff receive training from certified instructors, including hands-on sessions. These training courses will remain ongoing and continuously update without any expiration date. To ensure that all team members are certified in CPR/FA training, the administrator will arrange for a certified CPR/FA Instructor to conduct the full course, including hands-on training, before departing the facility. to monitor the completion of this process the administrator will schedule the training during times when either the administrator or the owner is present at the facility. This oversight will ensure that all aspects of the training including the instructional component, written examinations and hands-on practical training, are thoroughly completed. Ongoing with no end date

Proposed Overall Completion Date: 06/18/2025

(Directed)
-In addition to the plan above, beginning 7/15/25 the Administrator will review the schedule on a bi-weekly basis to ensure that there are enough staff working on each shift who are certified in CPR/First Aid

Directed Completion Date: *07/15/2025*

Implemented (- 07/25/2025)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

Description of Violation

Staff member B, hired on did not receive training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept (- 06/11/2025)***

As part of the onboarding process on June 6,2025, the administrator introduced a streamlined New Hire Check Off Sheet. This document encompasses all the essential training requirements for new employees and is set to be implemented immediately. once a new hire completes the necessary training under the guidance of the assigned trainer, the sheet will be reviewed in detail by the administrator. After ensuring all steps have been thoroughly addressed, the administrator will initial the bottom of the document and safely file it in the employee's records, marking the completion of this critical step in direct care training.
These forms will be ongoing with no end date.

Licensee's Proposed Overall Completion Date: *06/07/2025*

Not Implemented (- 07/25/2025)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
3. Care for residents with dementia and cognitive impairments.
5. Personal care service needs of the resident.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff member C hired on [redacted] did not receive annual training during the 2024 training year in caring for residents with dementia and cognitive impairments, personal care service needs of the resident, and caring for residents with mental illness and an intellectual disability, as both populations are served in the home

Repeated Violations: 10/22/24, et al

Plan of Correction ***Accept ([redacted] - 07/10/2025)***

On May8,2025, the administrator organized a comprehensive training day for staff member C to address critically missed training topics. The sessions included guidance on caring for residents with dementia and cognitive impairments, understanding and addressing personal care needs for residents, and providing care for residents dealing with mental illness, intellectual disabilities, or both, especially when the population is served within the home.
Looking ahead, the administrator emphasized the importance of proactive training for all staff members to ensure continuous compliance with home care standards. A structured approach will be implemented, with the administrator personally overseeing the attendance of each staff member. To ensure accountability, the administrator will initial the training documents before securely filing them, confirming that every team member has participated fully. This commitment aims to strengthen the quality of care and uphold the homes high standards of service.
To ensure comprehensive compliance, all mandatory training will be documented with a signature sheet that requires all staff member to acknowledge their awareness of the date and time of the training These dates and times will be communicated well in advance to allow sufficient time for necessary arrangements to be made. For staff on planned leave during mandated training sessions, a make -up sessions will be scheduled between the team member and the administrator. this will guarantee that every staff member receives the required training, maintaining adherence to the 2600 regulations
Administrator will post at beginning of each month of in-service topic and with date and time of in-service.
The administrator will sign and date the in-service sheet when all staff have been trained and sheet signed

Proposed Overall Completion Date: 06/18/2025

Licensee's Proposed Overall Completion Date: *06/18/2025*

Not Implemented ([redacted] - 07/25/2025)

65g - Annual Training Content

7. 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:

65g - Annual Training Content *(continued)*

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff member C hired on [redacted], did not receive annual training during the 2024 training year in The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)

Repeated Violations: 10/22/24, et al

Plan of Correction ***Accept ([redacted] - 07/10/2025)***

On May 8,2025, the administrator conducted training for staff member C on the older Adult Protective Services Act. Moving forward, the administrator will ensure that all staff members receive training on the Mandatory topics required to comply with the 2600 regulations. The administrator will also confirm attendance by requiring all staff to attend the training sessions and will initial the training sign-in sheet afterward as documentation of their participation.
To ensure comprehensive compliance, all mandatory training will be documented with a signature sheet that requires all staff member to acknowledge their awareness of the date and time of the training These dates and times will be communicated well in advance to allow sufficient time for necessary arrangements to be made. For staff on planned leave during mandated training sessions, a make -up sessions will be scheduled between the team member and the administrator. this will guarantee that every staff member receives the required training, maintaining adherence to the 2600 regulations
Administrator will post at beginning of each month of in-service topic and with date and time of in-service.
The administrator will sign and date the in-service sheet when all staff have been trained and sheet signed
This will be ongoing with no end date.

Proposed Overall Completion Date: 06/18/2025

Licensee's Proposed Overall Completion Date: *06/18/2025*

Implemented ([redacted] - 07/25/2025)

65i - Training Record

8. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff member H's training record did not include the date that they received training on demonstration of job duties, followed by supervised practice.

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

The administrator will be responsible for making sure that the form for first day and first 40 hours will be completed in a timely matter and audited will be completed within the first seven days of employment. The administrator will sign and date the sheet within the first 40 hours of training
Administrator will ensure all sheets are signed and dated within the first forty hours of new hire employment to keep compliance with first forty.

Proposed Overall Completion Date: 06/18/2025

65i - Training Record (continued)

(Directed)
- In addition to the plan above, beginning 7/15/25, the administrator will audit all new hires to ensure that this requirement is met. If any training/information is missing from the training record, the Administrator will be responsible for amending the record to reflect the date of the training.

Directed Completion Date: *07/15/2025*

Not Implemented ([redacted] - 07/25/2025)

103f - Refrigerator/Freezer Temps

9. 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 5/6/25, at 9:50 AM, there was no thermometer in the basement refrigerator located in the pantry.

On 5/6/25, at 10:00 AM, the freezer of the refrigerator/freezer in the dining room was not equipped with a thermometer, and several residents use this freezer to store food.

Repeated Violations: 10/22/24, et al

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

On June 5, 2025, the administrator introduced a new procedure to enhance the refrigerator and freezer temperature logging system by integrating a thermometer verification step/ This was established to ensure that proper measure is consistently followed for accurate temperature monitoring.
Daily temperature checks
-staff members are required to check and document the refrigerator and freezer temperature daily
-during each temperature check, staff must also verify and document the presence of thermometer within the unit as part of the log entry
This procedure is designed as an ongoing task with no predetermined end date
consistency in verification and logging is crucial to maintain compliance and operational

Proposed Overall Completion Date: 06/18/2025

(Directed)
-In addition to the plan above, all staff will be trained in this new procedure for logging temperatures by 7/31/25

Directed Completion Date: *07/31/2025*

Implemented ([redacted] - 07/25/2025)

103i - Outdated Food

10. Requirements

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

Description of Violation

On 5/6/25, at 9:52 AM, the refrigerator located in the basement contained one cucumber with multiple mold spots and one green pepper with a mold spot on it.

Repeated Violations: 10/22/24, et al

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

On 6/5/2025 Administrator had a meeting with all staff on outdated foods.
Maintain a clean and organized refrigerator and freezer is not only a matter of contamination but also a way to reduce food waste and ensure your meals are safe for consumption. Conducting a weekly food check helps keep your kitchen in optimal condition and prevents old or moldy food from going unnoticed.

Proposed Overall Completion Date: 06/18/2025

(Directed)
-Beginning 7/15/25 staff will be responsible for conducting weekly food checks, any items that are outdated or visibly not fit for consumption will be removed and discarded.

Directed Completion Date: *07/15/2025*

Implemented ([redacted] - 07/25/2025)

183b - Meds and Syringes Locked

11. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/6/25, at 10:05 AM, the following inhalant medications were unlocked and accessible in the top dresser drawer and sitting on the window sill of bedroom [redacted]
1 Trelegy, 1 Combivent, and 2 Albuterol inhalers. These medications belonged to resident #5 who is assessed to self administer these medications, however [redacted] resides with another resident who is not capable of self-administering medications.

On 5/6/25, at 10:08 AM, a small bottle of MiraLAX belonging to resident #1 was unlocked, accessible, and unattended sitting on the dresser inside their bedroom. Resident #1 is not assessed to self administer medications and resides with three other residents in the same room, all of which are not assessed to self administer medications.

Plan of Correction ***Accept ([redacted] - 06/11/2025)***

On June 6,2025, the administrator emphasized the critical importance of securely storing self-administered medications when not in use during a discussion with Resident5. This educational effort aimed to prevent

183b - Meds and Syringes Locked (continued)

unauthorized access and ensure the safety of both the residents and others in the vicinity.
To further reinforce these measures, the administrator established a system on June 6,2026, requiring staff to utilize a sign-off sheet for room during each shift. This initiative ensures that all medications are securely placed in the lock box, with no items left on windowsills, nightstands, or dressers. should any medications be found outside their designated storage, staff are instructed to notify the administrator immediately. The sign-off sheets will be employed consistently for four weeks, after which ongoing monitoring will continue without the check sheets.
To ensure medication safety, the administrator on June 6,2025, emphasized to resident 1 that no medications should be kept in their room unless prescribed by their PCP, WITH SELF-ADMINISTRATION APPROVAL, and secured in a lockbox.
There will be no end date to this.

Licensee's Proposed Overall Completion Date: *06/07/2025*

Not Implemented (- 07/25/2025)

186a - Authorized Prescriber

12. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 5/6/25, at 10:08 AM, a small bottle of MiraLAX, belonging to resident #1 was observed in a basket of the resident's belongings, sitting on the dresser in their bedroom. The home did not have a current physician's order for this medication.

Plan of Correction ***Directed (- 06/30/2025)***

On June 6,2025 the administrator had a conversation with resident 1 about the importance of not having medications laying in room. That all medications quire a PCP order and is administered by the med techs on duty following prescriber's orders.
The administrator expressed to resident 1 that if felt that needed or wanted a certain medication that should discuss this with PCP. will then decide if it would be good recommendation and will write the order for such medications.
Staff will be aware of monitoring the residents' rooms daily any medications lying around. If medications are found, they will be given to the administrator. The administrator will then discuss with the resident and provider.
This will be an ongoing task with no end date.
This will be ongoing tasks with no end date.

Proposed Overall Completion Date: 06/18/2025

(Directed)
-By 7/31/25, all staff will be made aware of the expectation to monitor residents rooms for medications

Directed Completion Date: *07/31/2025*

Implemented (- 07/25/2025)

187b - Date/Time of Medication Admin.

13. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Staff member B administered levothyroxine and pantoprazole to resident #2 at 6:00 AM on 5/1/25 and did not record their name and initials on the residents' medication administration record (MAR).

Staff Member B administered centrum tablet, clonazepam, co q-10, escitalopram, fenofibrate, fish oil, levothyroxine, omeprazole, paliperidone, and solifenacin to resident #6 at 6:00 AM on 5/1/25, 5/2/25, 5/4/25, and 5/5/25 but did not record their name and initials on the residents' MAR.

Staff member I administered olanzapine, mirtazapine, atorvastatin, guanfacine, quetiapine fumarate, metoprolol and clonazepam to resident #1 at 8:00 PM on 3/4/25 and 3/12/25 but did not record their name and initials on the residents MAR.

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

On 6/6/2025, the administrator/med trainer verbally discussed with the med tech staff the critical importance of documenting all medications, whether administered or omitted. med tech staff are instructed to review their MAR AFTER EACH ADMINISTRATION OF MEDICATIONS, and again after the entire med pass is complete, to ensure all entries are accurate and complete. Additionally, the administrator will conduct random MAR checks along with the3 month MAR checks, to confirm compliance. If any undocumented medications are identified, the med tech responsible will undergo re-education emphasizing the significance of proper documentation.
These administrative checks will continue for six weeks as part of an ongoing effort to uphold meticulous medical records. The 3-month MAR check have no end date.

Proposed Overall Completion Date: 06/17/2025

(Directed)
-Beginning 7/15/25, the Administrator will conduct random MAR checks along with the 3 month MAR checks, to confirm compliance.

Directed Completion Date: *07/15/2025*

Not Implemented ([redacted] - 07/25/2025)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #6 did not receive their vitafusion fiber well gummy on 5/1/25. The home documented on the resident's medication administration record that the medication wasn't available in the home for administration.

Repeated Violations: 5/30/24, 8/1/24

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept (- 06/30/2025)***

Starting Immediately weekly cart audit will be completed by the house manager to ensure all medications that are prescribed are in-house and available for administration
If the medication is not available, it will be ordered immediately and checked on by calling the pharmacy at the end of shift to check the status of the medication,
Also, any med techs that are aware of medications that are low or empty they will order immediately and make house manager aware.
This will be an ongoing task with no end date
This verbal training underscores the responsibilities of each member of the team to maintain accurate and detailed record of medication administration. On June 6, 2025, the administrator held a verbal discussion with all medication technicians, emphasizing the critical importance of documenting every medication-whether given, refused, or otherwise affected by circumstances at the time. To reinforce this practice, the administrator will immediately implement random MAR audits as an added measure to ensure compliance. These random audits will supplement the routine three-month audits already in place.

Licensee's Proposed Overall Completion Date: *06/18/2025*

Not Implemented (- 07/25/2025)

188b - Medication Error Reporting

15. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #6 did not receive their vitafusion fiber well gummy on 5/1/25. The home did not report this medication error to the resident's prescriber.

Plan of Correction ***Accept (- 06/30/2025)***

the Starting immediately, all missed medications will be documented and faxed to the PCP. Med Tech staff have been informed and are fully aware of this new protocol. Furthermore, all missed medications will also be documented by the administrator, who will oversee the process and monitor it to determine the necessity for staff re-education. This approach aims to strengthen accountability and ensure prompt corrective action, enhancing the overall quality of care provided.
This will have no end date.

Licensee's Proposed Overall Completion Date: *06/17/2025*

Implemented (- 07/25/2025)

190a - Completion Medication Course

16. Requirements

2600.

190a - Completion Medication Course *(continued)*

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 B, hired on [redacted], has been administering medications to residents since June 2024 and has not completed and passed the Department's online, initial medication administration training course, which was the only acceptable form of course completion since 1/1/24.
The following are examples of when staff member B administered medications to residents:
- levothyroxine 88mcg and pantoprazole 20mg at 6:00 AM on 5/1/25 to resident #2
- centrum tablet, clonazepam, co q-10, escitalopram 30mg, fenofibrate, fish oil, levothyroxine, omeprazole, paliperidone, solifenacin, and vitafusion at 6:00 AM on 5/1/25, 5/2/25, 5/4/25 and 5/5/25, to resident #6

On 5/6/25 , Staff member C, hired on [redacted] has not completed the Department's medication administration training course, including annual requirements since [redacted]. Staff member C administered medications to residents in the home in April 2025.

Staff member J administered medications to the following residents on the following days and has not completed the Department's annual medication administration training requirements:

• centrum tablet, clonazepam, co q-10, escitalopram, fenofibrate, fish oil, levothyroxine, omeprazole, paliperidone, solifenacin, and vitafusion to resident #6 at 6:00 AM on 5/3/25.
• Amiloride, amiodarone, aripiprazole, doxazosin, metformin, trelegy ellipta, alprazolam, and famotidine at 8:00 AM on 5/1-3/2025 to resident #3.

Staff member I administered medications to the following residents and has not completed the Department's annual medication administration training requirements:

• olanzapine, mirtazapine, atorvastatin, guanfacine, quetiapine fumarate, metoprolol and clonazepam at 8:00 PM on 3/4/25 and 3/12/25 to resident #1

Repeated Violations: 10/22/24, et al

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

On May 8th, the owner reached out to certified medication trainer to ensure [redacted] staff could complete the required medication course. By early June 2025, all personnel were successfully trained under the certified trainer's guidance, equipping them to administer medication completely. The trainer remains actively involved, overseeing education Administration Records (MAR) and conducting Observation reviews, ensuring that all med techs maintain compliance and uphold the highest standards of care

Proposed Overall Completion Date: 06/18/2025

(Directed)

190a - Completion Medication Course (continued)

-Beginning 7/15/25, the Administrator will be responsible for auditing all staffs medication administration training on a monthly basis to ensure that staff who are passing medications have the correct training. If any issues are discovered, the Administrator will ensure that there are additional staff on shift that are trained to administer medications.

Directed Completion Date: *07/15/2025*

Implemented (- 07/25/2025)

224a - Preadmission Screen Form

17. 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 #1'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.

Plan of Correction ***Accept (- 07/10/2025)***

The administrator is responsible for creating and maintaining a checklist that includes all items required for compliance. The checklist will be attached to the front of the resident's chart until every item is documented as complete. Below are the key steps for using the checklist; See checklist attached

The administrator will be responsible for the completion of all prescreening and that all areas are checked

Proposed Overall Completion Date: 06/18/2025

Licensee's Proposed Overall Completion Date: *06/18/2025*

Implemented (- 07/25/2025)

251b - Record Entries Legible

18. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #1's March 2025 Medication Administration Record (MAR) was altered for the administration time of Omeprazole. In the location to record the time of administration, information is crossed off and a new time of administration of 8:00 AM is recorded; however, the name of the person making the change and the date the change was made was not recorded on the MAR.

Resident #1's May 2025 Medication Administration Record (MAR) was altered for the administration time of Omeprazole. In the location to record the time of administration, information is crossed off and a new time of

251b - Record Entries Legible (continued)

administration of 8:00 AM is recorded; however, the name of the person making the change and the date the change was made was not recorded on the MAR.

Plan of Correction ***Directed ([redacted] - 06/30/2025)***

on 6/6/2025
To ensure compliance, all med tech staff were educated on the critical importance of maintaining legibility in any documentation they write or sign. Furthermore, strict guidelines were reinforced stating that no times on the MAR should ever be altered. In cases where changes are needed-whether regarding the time, dosage (mg), or any other aspect of the medication-a new entry must be made in accordance with the provider's order. These orders must be accurately documented and communicated to all med techs to guarantee clarity and uniformity. This educational effort is part of an ongoing process with no set end date, underscoring the organization's commitment to process and accountable medication management practices

Proposed Overall Completion Date: 06/18/2025

(Directed)
-Beginning 7/15/25 the Administrator will be responsible for auditing a sample of the MARS to ensure compliance with this regulation. Any issues noted during this audit will be documented and corrected by the Administrator.

Directed Completion Date: *07/15/2025*

Not Implemented ([redacted] - 07/25/2025)