pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: 6/22/26

GMK Limited
38 Cottage Avenue
Lancaster, PA 17602

RE: Red Rose Manor
38 Cottage Avenue
Lancaster, PA 17602
LICENSE/COC#: 32653

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 18, 2025, November 19, 2025 and December 3, 2025 of the above facility, we have determined that your submitted plan of correction is not implemented.

Sincerely,

Enclosure
<Licensing Inspection Summary>

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

Facility Information

Name: *RED ROSE MANOR* **License #**: *32653* **License Expiration**: *02/14/2026*

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

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

Administrator

Name:

Legal Entity

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

Certificate(s) of Occupancy

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

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *12/08/2025*

Inspection Dates and Department Representative

11/18/2025 On Site:
11/19/2025 On Site:
12/03/2025 On Site:

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: *17* **Are 60 Years of Age or Older**: *20*
Diagnosed with Mental Illness: *23* **Diagnosed with Intellectual Disability**: *3*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

11/18/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/17/2026*

01/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/25/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/30/2026*

02/09/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/25/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/27/2026*

06/22/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/25/2026*

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

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On [redacted]/28/25 at approximately 10:00 AM, Resident #1 was hit by Resident #11 on the head in the dining room of the home. On [redacted]/29/25, Resident #1 reported [redacted] had a headache and was dizzy to Staff Member B. On [redacted]/30/25, Resident #1 went to the hospital and was diagnosed with a concussion. However, this incident was not reported to the local Area Agency on Aging until 12/1/25 at 10:00 AM.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Resident1 report was sent to office of aging but not till 12/1 - Older Protection Act states that you have 48 hours to report to Office of Aging. Anytime there is any complaint of suspected abuse in home it will be reported by Administrator immediately. Will be sending required attachments, this will be followed at all times. All reportable will be sent to the Office of Aging DHS and family within 24 hours.
Anytime there is any complaint of suspected abuse in the home it will be reported by Administrator immediately (see memo abuse reporting requirements). This will be followed at all times will be reported to protected services hotline immediately all reportable will be reported to Office of Aging State and family within required times. (requirement 24 hours)
Prevention: All staff trained by following the mandatory requirements, training done by Administrator. Completion date is 1/15/2026

In addition all audits on residents will be done daily ongoing by administrator or designated person. Start date was 1/30/2026 please see attachment.

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will complete daily reviews with staff of incidents that have occurred. Documentation of these daily reviews will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/25 at 6:20 AM, Resident #2 pushed Staff Member A to the ground. The police and emergency medical services were called. Resident #2 was taken to the hospital. However, the home did not report this incident to the Department until [redacted]/6/25 at 2:00 PM.

On [redacted]/28/25 at approximately 10:00 AM, Resident #1 was hit by Resident #11 on the head in the dining room of the home. On [redacted] 29/25, Resident #1 reported [redacted] had a headache and was dizzy to Staff Member B. On [redacted]/30/25,

16c - Written Incident Report (continued)

Resident #1 went to the hospital and was diagnosed with a concussion. However, this incident was not reported to the Department until 12/3/25 at 9:00 AM.

Plan of Correction ***Directed (█ - 02/06/2026)***

All reportables were sent but not in a timely manner. Mandatory that Administrator or designated person report to all departments within the 2600 guidelines within 24 hours. This was discussed in a staff meeting that it is very serious that all reports be reported within mandatory times. Ongoing training for the required timeline is to be followed by Red Rose Manor Administrator or designated staff if the Administrator is not available. All staff trained and signed memo 1/15/2026 on written report within 24 hours. Attachments to follow.

In addition to the plan of correction: Daily review of incidences will be started on 02/02/2026. Staff training was on 1/8/2026 for staff. See attachment for daily reviews for incident report. This will be completed by administrator or designated person. Also see attached training sheet for staff.

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will complete daily reviews with staff of incidents that have occurred. Documentation of these daily reviews will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented █ - 6/22/26)**

17 - Record Confidentiality

3. 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 11/18/25 at 9:02 AM, the following prescriptions were unlocked, unattended and accessible in the medication area located in the entryway of the home:

- *Resident #1's prescription for Linzess 145 mcg.*
- *Resident #9's prescriptions for Alprazolam .5 mg, deep sea nasal spray, and Ayr saline nasal gel spray.*
- *Resident #10's prescription for Trelegy Elipta 200-62.*
- *Resident #12's prescription for acetaminophen 325 mg tablets.*
- *Resident #16"s prescription for Trelegy Elipta 100-62 and Atrovent HFA inhaler.*
- *Resident #14's prescription for Linzess 145 mcg.*
- *Resident #15's prescription to refill her comfort ez pro pen.*
- *Resident #16's prescription for Caplyta 42 mg.*
- *Resident #17's prescription for Clozapine 50 mg.*
- *Resident #18's prescription for Prazosin 2 mg and Jardiance 25 mg.*

On 11/19/25 at 9:07 AM, Resident #8's digestive health medical appointment reminder for 11/18/25 at 10:20 AM

17 Record Confidentiality (continued)

was unlocked, accessible, and unattended lying on top of the home's medication cart in the front entrance of the home.

On 11/20/25, a person who is not employed by the home was assisting with preparing lunch for the residents. This person had access to information regarding the diet orders of the residents, which are posted in the kitchen of the home.

Plan of Correction ***Directed [redacted] - 02/09/2026)***

The blue folder containing signatures when medications are delivered are locked up in medication cart. This was done by Administrator on 11/19/2025. on 11/19/2025 staff was retrained to not let Dr. Appointment reminders out on the medication cart. We will be having a staff meeting on 1/15/2026 that residence record reminders will be locked up in medication cart ongoing.
Staff member J was never employed on 11/20/2025, never helped with lunch on 11/20/2025. [redacted] used the bathroom in the office [redacted] is a friend of the owner and will make sure that Staff Only signs are now posted in area, and no guest can use the bathroom in the office. Extensive training was held on 1/15/2026. Please seen attachment of training.
In addition to the plan of correction, we will have ongoing monitoring of confidentiality of resident records this will be done by administrator or designated person. Started 2/2/2026 please see attachment

[Directed]
In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will review complete at least 3 staff interviews per week regarding if staff have witnessed anyone who is not an employee or volunteer of the home having access to resident confidential information. Documentation of these interviews to be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

42b - Abuse

5. Requirements

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

Description of Violation

On [redacted]/24/25 at approximately 12:30 AM, Staff Member H observed Resident #4 on top of Resident #3, and Resident #4 was groping Resident #3. This occurred while Resident #3 was asleep on the couch. Staff Member H intervened and asked Resident #4 to retire to [redacted] room.

On 11/28/25 at approximately 10:00 AM, Resident #1 was hit by Resident #11 on the head in the dining room of the home. On [redacted]/29/25, Resident #1 reported [redacted] had a headache and was dizzy to Staff Member B. On [redacted]/30/25, Resident #1 went to the hospital and was diagnosed with a concussion.

Repeated Violation 2/27/25

42b - Abuse *(continued)*

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Resident #1 and Resident #11 was immediately upon finding the incident the residence was separated to ensure safety. The incident was documented on 11/28/2025 both residents stated it was horse play and Administrator trained both parties about no physical contact.

Resident #4 and Resident #3 were separated by staff H. They were both educated on no physical contact. The Administrator will monitor staff supervision and resident interaction. Routine observation for a 3-month period beginning 1/15/2026. See the 3-month copy of audit. All staff to be trained on awareness that residence may not be neglected, intimidated, physical, or verbal abuse, mistreatment or corporal punishment. See attachment of training and audit.
In addition the administrator or designated staff will do observation on staff while on the floor. Start date is 2/2/2026 staff will be trained monthly. Administrator will do monthly reviews of incident report started on 1/1/2026.

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will complete at least 5 observations of resident-to-resident interactions and staff supervision of residents per week. Documentation of these observations will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

42l - Personal Clothing

6. Requirements

2600.
42.l. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

On an unknown date and time, Resident #5's clothing items had been thrown away from storage. This was confirmed by Staff Members A, C and G. During an interview, Resident #5 reported that [redacted] clothing was retrieved from the dumpster, laundered and returned to the resident. Resident #5 stated that [redacted] has been storing [redacted] items at the neighbor's house because [redacted] was concerned [redacted]r personal things would be discarded.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Resident #5 the residents' rights were reviewed resident receive all clothing and is now satisfied that no clothing is missing. Staff was reeducated how to receive, retain personal belongings. Administrator will monitor compliance to ensure resident rights are maintained through routine observations. Follow ups with staff interviewed on personal belongings all staff will be retrained on residents' rights. The Administrator will do routine observations for the next 3 months which will ensure accuracy to remain in compliance with 42l starting 1/15/2026. Attachment to follow.
In addition the administrator reviewed resident rights with resident #5 on 1/15/2026. Staff was retrained at staff meeting on resident rights 1/15/2026. Weekly checks with residents on violations 42l will be done by administrator or designated staff. See attached.

42l Personal Clothing (continued)

[Directed]
In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will complete weekly interviews with residents regarding their right to retain their personal clothing to ensure compliance. Documentation of these resident interviews will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

42s - Privacy

7. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 11/19/25, during an interview with Resident #6, it was reported that [redacted] enjoys doing diamond painting craft. Resident #6 stated that [redacted] craft supplies had been removed from [redacted]r room on an unknown date and time. The resident said [redacted] was not aware of who had removed the items but had been informed that it had been done by a staff member. Staff Member G reported that they were instructed to get rid of the resident's craft supplies. Staff Member G stated they had put most of the items in a box and put the box in the closet located Resident #6's room. However, Staff Member G reports many of the gems had been swept up and disposed of.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Resident #6 was given [redacted] craft supplies that were found by staff G [redacted] was explained that some of the items were found on the floor that had to be discarded.
Procedures related to residence personal property were reviewed about discarding property. The staff was reeducated in the meeting on 1/15/2026 that residence belongings can't be discarded without residence consent or administrators' approval except for safety or sanitation. The administrator will monitor compliance staff oversight when documentation reviews. Audit is in place 0n 1/8/2026 and will monitor for the next 3 months.
in addition the Administrator will do weekly interviews with residents starting 1/8/2026.

[Directed]
In addition to the above steps, beginning no later than 2/23/26, the Administrator or designee will complete weekly interviews with residents regarding their right to self and possessions to ensure compliance. Documentation of these resident interviews will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

51 - Criminal Background Check

8. 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).

51 - Criminal Background Check *(continued)*

Description of Violation

Staff Member J has performed ancillary duties to include cooking and doing dishes; however, the home has not requested a Pennsylvania Criminal History Background Check for Staff Member J.

Repeated Violation - 5/6/25, et al and 2/27/25

Plan of Correction ***Directed █ - 02/06/2026)***

Staff member J was never an employee or volunteer on an ongoing basis. If we have a volunteer or new employee in the future, we acknowledge that the requirement would be to do a background check before first day of employment. Our most current hire had a criminal check done and we will continue to perform criminal background checks in a timely manner, so no violations are occurring. Our policy shall insure accuracy on permanent employees or volunteers.
In addition the administrator or designated staff member will train on policy statement on the rules and regulations on 51 on 2/2/2026. New employee checklist will be reviewed with new employees. This form has the date and results of criminal background checks. The start date was 3/20/2025 the process is ongoing. See attachments.

[Directed]
- In addition to the above steps, education will be provided to all staff, including the Administrator, regarding regulation 2600.51, including only employees and volunteers with completed background checks are to be providing ancillary duties. Education to be completed by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Beginning no later than 2/23/26, the Administrator or designee will review complete at least 3 staff interviews per week regarding if staff have witnessed anyone completing ancillary duties in the home, who is not an employee or volunteer of the home with a completed background check. Documentation of these interviews to be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented █ - 6/22/26)**

57b - 1 Hour/Day

9. Requirements

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

Description of Violation

On 11/14/25, there were 25 residents in the home, requiring a minimum of 25 hours of direct care service. On this day, only 21 hours of direct care staffing were provided.

Repeated Violation - 2/27/25

Plan of Correction ***Directed █ - 02/06/2026)***

Administrator and owner reviewed staff schedule for 11/14/2025 according to our schedule there were enough direct care hours. On first shift we had 6:00 am to 6:00 pm which is 12 hours. 2nd shift we had 6:00 pm to 6:00 am there was 7 hours of direct care. From 9:00 am to 4:00 pm we had 7 hours of direct care. Our census was 25 and we had 26 hours of direct care. In addition, Administrator worked kitchen and cleaning for 4 hours. Please see attached schedule. Completed on 11/18/2025.

57b - 1 Hour/Day (continued)

In addition the administrator on 2/2/2026 reviewed education steps on 57B ongoing monitoring step will be administrator or designated staff will review the schedule prior to posting owner will also review schedule initials will be at the bottom of the schedule and reviewed 1 week prior to posting.

[Directed]
- In addition to the above steps, beginning no later than 2/23/25, the Administrator or designee will review the work schedule a week prior to posting to ensure compliance. Documentation of these reviews will be kept and available for review by the Department.
- Education to be provided to staff who will act as a designee for the Administrator with reviewing the work schedule regarding regulation 57(b). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

62 - Contact List

10. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The home's staff list does not include Staff Members D, E or J.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

After reviewing the contact list changes were made now all current staff including substitute personnel and volunteers are current. Administrator will implement this as part of hiring procedure. See updated attachment for current employee staff list and new employee check-off sheet. Completed 1/15/2026
In addition the administrator educated on rules and regulations for 62. on 2/2/2026. Contact list was updated on 1/23/2026. Administrator will continue to update current list upon a new hire.

[Directed]
- In addition to the above steps, beginning no later than 2/23/25, the Administrator or designee will complete quarterly audits of the staff list to ensure it is current. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

63a - First Aid/CPR Training

11. 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

During the following dates/times, there were no staff present in the home who were certified in CPR and First Aid:

- *11/14/25 from 6:00 PM - 6:00 AM on 11/15/25*
- *11/15/25 from 2:00 PM - 10:00 PM*

63a First Aid/CPR Training (continued)

- *11/16/25 from 2:00 PM 10:00 PM*
- *11/17/25 from 6:00 PM 10:00 PM*

Repeated Violation 5/6/25, et al

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Staff member K and I were on duty 11/14/2025 11/17/2025. They both completed CPR and First Aid training on 02/29/2024 by CPR and First Aid instructor. [redacted] requested employee's emails to be sent to [redacted] so they could receive their cards. on 11/19/2025 [redacted] brought us a copy of the letter that the training was completed. Inspector was showed this letter on 11/19/2025. In the future the administrator will explain to the instructor that CPR and First Aid cards are mandatory. If this would occur again will have staff redo CPR and First Aide upon discovering no cards were available. Completed on 1/15/2026.
See attachments.
In addition on 2/2/2026 administrator updated the CPR First Aid chart. Staff member K and I were recertified on 1/14/2026. Administrator will work with trainer to keep all staff in compliance This will be ongoing. See attached.

[Directed]
In addition to the above steps, beginning no later than 2/23/25, the Administrator or designee will complete an audit of all current certified CPR and First Aid staff to ensure there are CPR and First Aid certifications in the staff records. If not available, the Administrator or designee will enroll that staff in a CPR and First Aid class by 2/27/26. Documentation of this audit will be kept and available for review by the Department.
Education will be provided to all staff, including the Administrator, regarding regulation 2600.63(a), including that all current CPR and First Aid certifications need to be available on site. Education to be completed by 2/23/26. Documentation of education to be kept and available for review by the Department.
Beginning no later than 2/23/26, the Administrator or designee will complete quarterly audits of all current CPR and First Aid certifications to maintain compliance. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/27/2026*

Implemented [redacted] - 06/18/2026)

65a - FS Orientation 1st Day

12. 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:

Description of Violation

Staff Member D, hired in [redacted] of 2025, and Staff Member J, who performed ancillary duties in the home on 11/21/25, has not received training on the following topics:

- *Evacuation Procedures.*
- *Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.*
- *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.*

65a - FS Orientation 1st Day (continued)

- *The location and use of fire extinguishers.*
- *Smoke detectors and fire alarms.*
- *Telephone use and notification of emergency services.*

Plan of Correction ***Directed - 02/06/2026)***

Staff Member D and Staff Member J are no longer present at the home. Upon hiring substitutes personal ancillary staff and volunteers will have orientation in general fire and safety and emergency preparedness that include the following 1) Evacuation procedures 2) Staff duties and responsibilities during fire drills as well as emergency evacuation and transportation to an emergency location 3) fire safe area meeting place in the event of a fire 4) Smoking safety procedure and policy and location of smoking areas. 5) Location and use of fire extinguishers 6) Smoke detector and fire alarms 7) Telephone use and notification of emergency services. Orientation will be documented and monitored by Administrator to ensure on going compliance for orientation first day. Completed on 1/15/2026 See attachments.
In addition on 2/3/2026 all staff files were reviewed on regulation 65A. The administrator or designate will do quarterly audits on employee files. Start date 3/3/2026 see attachment on newest employee, audits and training.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to staff who will act as a designee for the Administrator with completing quarterly audits regarding regulation 2600.65(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented - 06/18/2026)

65b - Rights/Abuse 40 Hours

13. 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:

Description of Violation

Staff Member D, hired in of 2025, and Staff Member J, who performed ancillary duties in the home on 11/21/25, has not received training on the following topics:

- *Resident's rights.*
- *Emergency Medical Plan.*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.*
- *Reporting of reportable incidents and conditions.*

Plan of Correction ***Directed 06/2026)***

To answer violation all regular staff or volunteers will have orientation training within 40 hours including resident rights, emergency medical plan, mandatory reporting of abuse and neglect, and reporting of reportable incidence and conditions. All new staff has training on first 40 scheduled hours. This will be followed ongoing to ensure no

65b - Rights/Abuse 40 Hours (continued)

repeat violations. Completed 01/15/2026. Please see attachments. administrator or designee will do Quarterly reviews on the first 40 hours for new hires. see attached on newest hires.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to staff who will act as a designee for the Administrator with completing quarterly audits regarding regulation 2600.65(b). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Per Administrator's plan of correction for 65(a), Staff Member D and Staff Member J are no longer employed at the home.
- An initial audit of all current staff records to be completed by 2/23/26 by the Administrator or designee. Documentation of this audit is to be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee, will complete quarterly audits of all new staff records to ensure compliance. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented [redacted] - 06/18/2026)

65c - Ancillary Staff Orientation

14. 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 Staff Member D, who was hired in [redacted] of 2025, did not have a general orientation to [redacted]r specific job functions.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

On any ancillary staff or permanent staff, they will be given a job function description. Administrator will put a copy in the staffs file immediately. Administrator completed audit on all current staff file to be sure that they have a copy of the job description. See attachment on newest employee's job description form. Completed on 01/15/2026 oon2/3/2026 administrator will start an audit on ancillary staff training, at present time we have no ancillary staff see audit attached

[Directed]
- In addition to the above steps, education to be provided to the Administrator regarding regulation 2600.65(c). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Per Administrator's plan of correction for 65(a), Staff Member D is no longer employed at the home.
- Beginning no later than 2/23/26, the administrator or designee will complete quarterly audits of all new ancillary staff records to ensure compliance. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented [redacted] - 06/18/2026)

88a - Surfaces

15. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 11/18/25, the permanently affixed ladder escape off of resident rooms 6, 8 and 12, has a tripping hazard before the step onto the platform and the platform itself is a tripping hazard. The step up has a pine branch, sticks and debris as well as a 4-5" waterspout/pipe placed directly in front of the platform of the ladder escape. The platform was comprised of 3 different pieces of wood, all at different heights. The difference in heights created a drop of about 2" right before the first step down, creating an unsafe environment to trip and then fall down the ladder escape metal steps. The platform itself also wobbled when stepped on.

Plan of Correction ***Directed █ - 02/06/2026)***

On 1/15/2025 The platform had three boards that were replaced by a contractor. The boards were to thick and made the platform uneven. They were replaced to make the platform sturdy and even. Making the height of the raised board is even with the rest of the platform avoided trip hazards. This area will be added to the monthly check sheet making sure facility clean and in good repair, free of hazards. on 1/15/2026 monthly check list was added to monthly duties administrator or designee will be responsible. see attachment

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to staff who will act as a designee for the Administrator with completing monthly audits regarding regulation 2600.88(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee will complete monthly audits, utilizing the home's monthly checklist. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented (█ - 06/18/2026)

89b - Hot Water Temperature

16. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 11/19/25 at 3:55 PM, the hot water temperature in the sink of the first-floor rear bathroom measured at 123.5 degrees Fahrenheit, and at approximately 4:00 PM, it was 122.5 degrees Fahrenheit.

Plan of Correction ***Directed █ - 02/06/2026)***

On 11/21/2025 the Administrator called UGI technician came and reduced the temp on the hot water heater. Water temps were taken and charted for December 2025 and were acceptable. Also, temps were taken January 2026 and were acceptable. Plan is to check water temps on a monthly basis. Please see attachment for schedule for different times of the day so water temp doesn't exceed 120 degrees. This was completed on 12/15/2025. administrator or designee is responsible for dec.2025, administrator will start checking water temps. twice a month see new chart start date will be 2/8/2026

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to staff who will act as a

89b - Hot Water Temperature (continued)

designee for the Administrator with completing monthly audits regarding regulation 2600.89(b). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee will complete monthly audits of water temperatures. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented (█ - 06/18/2026)

103f - Refrigerator/Freezer Temps

17. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the chest freezer and the standing freezer located in the basement.

Repeated Violation - 5/6/25, et al

Plan of Correction ***Directed █ - 02/06/2026)***

On 11/19/2025 thermometer was found in the chest freezer; it had fallen behind food. Freezers and refrigerators now have a log on each door. Temps are checked daily. Administrator or supervisor will continue to check the temps. The owner has bought freezer tape to ensure the security of the thermometers, for accurate reading. Completed on 1/15/2026 Please see attachment.
in addition all thermometers had been zip tied to keep them in place on 1/19/2026. Administrator or designate staff will continue to do monthly temp checks. See attachment of photo from 2/3/2026.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to staff who will act as a designee for the Administrator with completing monthly audits regarding regulation 2600.103(f). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all refrigerators and freezers in the home no later than 2/23/26. Documentation of this audit will be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee, will complete monthly audits, utilizing the monthly checklist. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented (█ - 06/18/2026)

105g - Lint Removal and Duct Cleaning

18. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 11/18/25 at 9:23 AM, there was an approximate 1/2-inch accumulation of lint in the lint trap of the dryer located

105g - Lint Removal and Duct Cleaning (continued)

in the basement. There were no clothes in the dryer at the time.

On 11/18/25, the home did not have documentation that the dryer ducts had been cleaned in 2024 or 2025.

Plan of Correction ***Directed ███ - 02/06/2026)***

The staff was retrained on lint trap cleaning on 12/17/2025. Administrator started a logbook for each staff to initial for their shift and initialing the fact that the trap was cleaned. The logbook was on the wall next to the dryers. See attached for training and dryer sheet checked.

Documentation that the dryer ducts were cleaned in 2024 and 2025. Paperwork was found and showed at the time of the inspection. Sending a copy of the chart. Will continue with documentation of importance of following procedures related to duct cleaning and lint to reduce risk of fire hazards. All procedures were completed on 1/15/2026.
In addition on 2/3/2026 staff was retrained on dryer vent cleaning. The start date for the daily logbook was 12/17,2025. The logbook is in place next to the dryer on the wall. The dryer vent ducts will continue to be done monthly. See attachment

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the administrator or designee will complete monthly audits of lint dryers, the lint dryer logbook and dryer vent cleanings. Documentation of these audits will be kept and available for review by the Department.

Not Implemented ███ - 6/22/26)

Directed Completion Date: *02/23/2026*

132d - Evacuation

19. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 6/28/25 at 2:50 PM, the evacuation time was 4 minutes and 30 seconds. The home's maximum safe evacuation time specified in writing within the past year by a fire safety expert is 2 minutes and 55 seconds.

Plan of Correction ***Directed (███ - 02/06/2026)***

Administrator repeated fire drill on 06/29/2025. Evacuation time was 2 min. 19 sec. Staff and residents were reeducated on the seriousness of evacuation and expectations of fire drills. We emphasize to staff and residents that fire drills are 2 min. and 55 secs. is the evacuation time that we must follow. Administrator will continue to monitor drills, review evacuation drills for any problems and that procedures are being met. See attachment for training.
in addition on 6/28/2025 we had a resident who refused to come downstairs he wanted to get dressed first. On 7/2/2025 administrator had a town meeting with residents about the fire drill administrator will continue to review fire drills monthly and will have meetings with staff quarterly. on 1/8/2026 the staff and residents were reeducated on expectations of a fire drill. Administrator and Lafayette Fire Chief.

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the administrator or designee will complete

132d - Evacuation (continued)

monthly audits of the fire drill logs as well as interview the staff who participated in the drills to confirm all residents were evacuated. Documentation of these audits and interviews will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

141a - Medical Evaluation

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted to the home on [redacted]/25. However, the resident's initial medical evaluation was completed on 3/12/25.

Plan of Correction ***Directed ([redacted] - 02/06/2026)***

Resident #1 was admitted on [redacted]/2025. The Medical Evaluation was taken to PCP by resident and signed and dated on June 1, 2025, by the PCP. Please see copies and the forms were emailed to the inspector. Administrator will continue to check all residents' files that all paperwork is completed before filing. This will be ongoing and completed in the correct amount of time to be in compliance. Administrator will initial bottom of form to ensure accuracy. Completed on 1/15/2026
In Addition, the Administrator put a note in resident #1 chart that this evaluation was cited on 11/18/2025. Starting on 2/5/2026 administrator will do audit of all medical evaluations to identify any issues. Medical Evaluations will be reviewed within 72 hours of receiving by administrator. The administrator and Administrator Assistant will monitor the charts monthly to ensure evaluations are current. The Administrator will place a paper in front of each chart with the due date for evaluations support plan. This will help ensure that this is completed in a timely manner. The Administrator and Administrator Assistant are responsible for this task. The charts will be monitored. There will be a resident roster created with a checkoff for each medical evaluation. This will be checked off after each evaluation is checked off in the resident's chart. At the end of each month the administrator assistant will check the created chart and check each medical evaluation to be sure they are in compliance.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and Administrative Assistant regarding regulation 2600.141(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all initial medical evaluations by later than 2/23/26. Any initial medical evaluations found to be out of compliance will have a note added to the record to state that this was found during an audit as a result of this violation and the date it was discovered. Documentation of this audit will be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee, will review an initial medical evaluation, including the date the evaluation was completed, within 72 hours of a resident moving into the home.

Directed Completion Date: *02/23/2026*

Implemented ([redacted] - 06/18/2026)

141b1 Annual Medical Evaluation

21. Requirements

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

Description of Violation

Resident #5's current medical evaluation, dated [redacted]/25, does not include health status or cognitive functioning.

Plan of Correction ***Directed [redacted] - 02/06/2026)***

Resident #5 medical evaluation dated 08/14/2025. Health status and cognitive functioning was sent on 9/3/2025. PCP signed and dated see attached forms. Administrator went over the importance of components of annual evaluations. Administrator will continue to check forms before filing to ensure completeness will initial forms when complete for compliance1/15/2026.
Starting on 2/5/2026 administrator will do audit of all medical evaluations to identify any issues. Medical Evaluations will be reviewed within 72 hours of receiving by administrator. The administrator and Administrator Assistant will monitor the charts monthly to ensure evaluations are current. The Administrator will place a paper in front of each chart with the due date for evaluations support plan. This will help ensure that this is completed in a timely manner. The Administrator and Administrator Assistant are responsible for this task. The charts will be monitored. There will be a resident roster created with a checkoff for each medical evaluation. This will be checked off after each evaluation is checked off in the resident's chart. At the end of each month the administrator assistant will check the created chart and check each medical evaluation to be sure they are in compliance.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and Administrative Assistant, regarding regulation 2600.141(b)1, including ensuring a medical evaluation is filled out entirely. Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all current annual medical evaluations by no later than 2/23/26 to ensure all current annual medical evaluations are filled out completely. Documentation of this audit will be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee will complete quarterly audits on all current annual medical evaluations to ensure all current annual medical evaluations are filled out completely. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented ([redacted] - 06/18/2026)

144c1 Smoking Area Guidelines

22. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 11/19/25 at 9:05 AM, the home's designated smoking area had 4 cloth seat cushions on chairs that did not have a tag or other indicator that the material was flame retardant. There were also 3 cigarette butts on the ground around

144c1 Smoking Area Guidelines (continued)

the gazebo.

Plan of Correction ***Accept █ - 02/09/2026)***

All cushions were immediately removed from the smoking area was cleaned of butts and discarded from property. The staff was reeducated on fire safety policy for smoking. Also, residents' meetings were held to ensure safety and go over policies. Administrator or designated person will monitor the smoking area daily to ensure rules are followed about non combustible furniture and the area is free of smoking debris. Will attach the policy and the daily check sheet.
in Addition, on 11/19/2025 Staff member C immediately removed the cushions and cleaned cigarette buts off the ground. Administrator created an audit on 1/13/2026 for first and second shift to do daily checks in the smoking area. On 1/15/2026 staff member C educated all staff on the importance of fire safety policy. Also, staff member C had a meeting with residents on fire safety and smoking.

Licensee's Proposed Overall Completion Date: *02/04/2026* **Not Implemented █ - 6/22/26)**

162c - Menus Posted

23. 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 11/18/25 at 9:02 AM, the home's menu for the week of 11/24/25 11/30/25 was not posted.

Repeated Violation 2/27/25

Plan of Correction ***Directed █ - 02/09/2026)***

On 11/18/2025 the menu was not posted. Menu was complete but not hung in a timely manner. Going forward the menu will be completed for 4 weeks when 1 week is complete a new menu will be posted immediately. This will allow 4 weeks to be posted at all times. The Administrator will check and initial the menu when posted. The staff was also be educated to look at the menu wall to ensure that there is 4 weeks posted. There will be a monthly checklist that will be checked for 3 months. Please see attached.
in addition, on 11/8/2025 staff person C immediately posted missing menus. Menu audit will be done by administrator starting on 1/1/2026 please see attached.

[Directed]
In addition to the above steps, education to be provided to all staff, including the Administrator, regarding regulation 2600.162(c). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented █ - 06/18/2026)

183b - Meds and Syringes Locked

24. 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 11/18/25 at 9:04 AM, Resident #12's Arformoterol 15 mcg/2ml was unlocked, unattended, and accessible in the small refrigerator in the medication area located in the entryway of the home.

Repeated Violation - 5/6/25, et al and 2/27/25

Plan of Correction ***Directed [redacted] 02/09/2026)***

Immediately the med was determined that the medication did not have to be refrigerated per Lititz Apothecary. It was removed from refrigerator and put in locked med cart on 1/15/2026 all staff have been reeducated on medication storage. The administrator will conduct routine checks to ensure ongoing compliance. Compliance was achieved on 1/16/2026 and will be monitored on an ongoing basis.
on 1/15/2026 the administrator moved item from refrigerator to locked med cart, also called pharmacy to see if it needed to be refrigerated. On 2/5/2026 an audit will be started for locked prescription medications see attachment.

[Directed]
- In addition to the above steps, beginning no later than 2/23/26, the administrator or designee will complete monthly audits to ensure medications stored in the home are secured, including any medications located in the refrigerator. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented [redacted] - 6/22/26)**

185a Implement Storage Procedures

25. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #10 is prescribed routine blood glucose readings before meals and at bedtime utilizing a Dexcom glucometer. The Dexcom does not retain routine readings. Between 11/1/25 and 11/19/25, there were only 5 readings that could be verified for accuracy. Resident #10 is prescribed Humalog 100 u Kwikpen: inject 11 units subcutaneously with breakfast, 7 units with lunch, 11 units with dinner (3 times daily with meals). In addition to routine, a sliding scale is prescribed for additional units: 150-200=1; 201-250=2; 251-300=3; 301-350=4. Greater than 350- give 5 unites for a maximum does of 45 units. Because the readings are not retained in the glucometer, the documented sugar readings cannot verify that the additional units prescribed for the sliding scale were administered without error.

Plan of Correction ***Accept [redacted] 02/09/2026)***

on 1/14/2026 the pharmacy owner came to the facility to educate on how to get the accu check readings from Dexcom. [redacted] also educated staff on the Dexcom. The Administrator will educate all the staff on the retrieval of the readings. Starting immediately these numbers will be printed monthly and put in the chart with the MARS sheet. The Administrator will check the chart monthly to ensure the Dexcom readings are in the chart with MARS. A check off sheet will be implemented monthly dated and signed to ensure accuracy this will continue ongoing for 3 months. See attached forms.
The administrator will conduct an educational session for all med tech staff on 2/3/2026 focusing on the proper

185a - Implement Storage Procedures (continued)

method for retrieving blood sugar results. Beginning on 2/7/2026 med tech staff are required to print recorded blood sugar results and file them in the designated chart. In addition, monthly audit of this process will commence on 2/7/2026 to ensure compliance and accuracy. The administrator will also create a checkoff sheet which staff must complete each time they document blood sugars. This procedure will be maintained on a monthly basis.

Licensee's Proposed Overall Completion Date: *02/04/2026* **Not Implemented ([redacted] - 6/22/26)**

187a - Medication Record

26. 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.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed Lizness 145 mcg capsule with orders take 1 capsule by mouth daily in the morning for IS-C. However, this medication is not included on Resident's #1's medication administration record.

Resident #10 is prescribed Flonase .05% nasal spray Fluticasone PROP 50 MCG NS: one spray into each nostril daily as directed for allergies. However, this medication is not included on Resident's #10's medication administration record.

Repeated Violation - 2/27/25

Plan of Correction ***Directed [redacted] - 02/09/2026)***

Starting immediately, the Administrator and Supervisor will review all residents' medications and update the MARS to ensure all prescribed medications are accurate. Resident #1 and Resident #10 are missing documentation for medications were added to the MARS upon discovery. The staff responsible for medication administration will be reeducated on the requirements to verify that all medications are documented on the MARS prior to administration. The Administrator will conduct monthly MARS Audits prior to the MARS going into the MAR book for the beginning month to ensure compliance. Any medication that come in after MAR is placed will be entered immediately. All Med Tech staff will be educated on how to dispense med against med to maintain accuracy on medication. Also, adding new mediation to the mars to achieve accuracy. See attached training also reviewed with staff at the meeting 0n 1/15/2026.

Effective immediately a dedicated notebook will be placed in the med cart for med techs to record all medications prescribed to residents following their medical appointments. In addition to documenting the medications in the medication administration record med techs must ensure every new entry is clearly noted in the notebook for reference. When medication recaps arrive at the facility two med techs will work together to verify that all new medications are accurately documented in both notebook and the MAR. This verification process helps maintain accuracy and accountability. Once the recaps are completed and the updated MARS are updated in the med cart

187a Medication Record (continued)

the administrator will review documentation to confirm all entries are correct and complete. Weekly the med trainer will audit both the notebook and the MAR that all new medication has been documented in the MARS this procedure will remain in effect for 90 days after which the process will be reviewed for effectiveness and any necessary adjustments. starting 2/3/2026

[Directed]
In addition to the above steps, education to be provided to the staff who administer medications regarding regulation 2600.187(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
The Administrator or designee will complete an initial audit of all current resident medication administration records to ensure all current medication administration records are up to date. This will be completed no later than 2/23/26. Documentation of this audit will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented ██ - 06/18/2026)

190a - Completion Medication Course

27. 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 A, who has not successfully completed the Department approved medications administration course, administered medication on the following dates and times:

- *On 11/2/25, 11/4/25, 11/6/25 11/10/25 and 11/15/25 at 8:00 AM to Resident #1.*
- *On 11/1/25, 11/2/25, 11/4/25 and 11/7/25 at 8:00 AM, to Resident #3.*
- *On 11/2/25, 11/7/25, 11/10/25 and 11/11/25 at 8:00 AM, to Resident #5.*
- *On 11/1/25, 11/5/25, 11/16/25 and 11/18/25 at 8:00 AM, to Resident #9.*
- *On 11/2/2/25, 11/4/25, 11/10/25 and 11/15/25 at 8:00 AM to Resident #18.*

Staff Member I, who has not successfully completed the Department approved medications administration course, administered medication on the following dates and times:

- *On 11/1/25, 11/2/25, 11/3/25, 11/5/25, 11/6/25, 11/12/25, 11/15/25 and 11/17/25 at 8:00 PM to Resident #1.*
- *On 11/1/25, 11/2/25, 11/3/25, 11/5/25, 11/6/25, 11/12/25, 11/15/25 and 11/17/25 at 8:00 PM to Resident #3*
- *On 11/1/25, 11/2/25, 11/3/25, 11/5/24, 11/6/25, 11/11/25, 11/13/25 and 11/17/25 at 8:00 PM to Resident #5.*
- *On 11/12/25, 11/13/25, 11/15/25 and 11/16/25 at 8:00 PM to Resident #9.*
- *On 11/1/25, 11/2/25, 11/3/15, 11/5/25, 11/6/25, 11/7/25, 11/12/15, 11/13/15, 11/15/25, 11/16/25 and 11/17/25 at 8:00 PM to Resident #18.*

Repeated Violation 5/6/25, et al

Plan of Correction ***Directed ██ - 02/09/2026)***

Immediately the Med tech trainer entered a Staff Member A, and Staff Member I, into a training class. Both staff members were taken off the medication cart until class was complete and they had their grade report and

190a - Completion Medication Course (continued)

certificate. Certified Med Techs were put in place until certificates were completed. Staff member E will make sure all new staff are up to date on med tech and the seasoned med techs are keped in compliance with regulations to ensure accuracy and no repeat violations. See attached. Both are certified and have certificates for Med Techs 1/15/2026.
Staff member I was certified on 11/26/2025, Staff member A was certified on 1/9/2026. Staff member E completed an audit on 2/3/2026 See attachment

[Directed]
- In addition to the above steps, education to be provided to the Administrator and the Administrative Assistant regarding regulation 2600.190(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee, will complete quarterly audits of all medication technicians' records to ensure compliance. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented [redacted] - 06/18/2026)

225a - Assessment 15 Days

28. 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.

Description of Violation

Resident #1's current and initial assessment, dated [redacted]/25, does not include the toileting, personal hygiene, dental, dietary, sensory, judgment, the resident's interests and hobbies, solitary activities and group activities.

Plan of Correction ***Directed [redacted] - 02/09/2026)***

Resident #1 assessment dated [redacted]/2025 was corrected by Administrator on 11/19/2025. Administrator will go through all residents' files to assure assessments are complete will do audit for 3 months starting in January 2026. Will send attachment of completed assessment.
Additional audit will be completed for 100 % of current residents support plans by the administrator within 10 business days of this plan of correction administrator assistant will review these initial audits to ensure accuracy and compliance and proceed to conduct quarterly audits for the following 6 months to maintain ongoing oversite and quality assurance. See attached.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to the Administrative Assistant regarding regulation 2600.225(a). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of current assessments no later than 2/23/26. Documentation of this audit will be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee will complete quarterly audits of current assessments. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026* **Not Implemented ([redacted] - 6/22/26)**

225a - Assessment 15 Days *(continued)*

Implemented █ - 06/18/2026)

227d - Support Plan Medical/Dental

29. 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

Resident #1's current support plan, dated █/25, does not include the description of service need and how the home plans to meet the service need for the following areas: managing healthcare, securing healthcare, securing and using transportation and managing and keeping appointments.

Plan of Correction ***Directed █ - 02/09/2026)***

Resident 1 support plan was corrected on 11/19/2025 by administrator. Administrator will check all resident charts to assure support plans MA51 and DME's are correct. Monitor with a chart audit and this will be done for a 3-month period. See attachment of support plan that has been completed.
Additional audit will be completed for 100 % of current residents support plans by the administrator within 10 business days of this plan of correction administrator assistant will review these initial audits to ensure accuracy and compliance and proceed to conduct quarterly audits for the following 6 months to maintain ongoing oversite and quality assurance. See attached.

[Directed]
- In addition to the above steps, education to be provided to the Administrator and to the Administrative Assistant, regarding regulation 2600.227(d). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of current support plans no later than 2/23/26. Documentation of this audit will be kept and available for review by the Department.
- Beginning no later than 2/23/26, the administrator or designee, will complete quarterly audits of current support plans. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented █ - 06/18/2026)

227j - Support Plan Copy

30. Requirements

2600.
227.j. The home shall give a copy of the support plan to the resident and the resident's designated person upon request.

227j Support Plan Copy *(continued)*

Description of Violation

Resident #3's current resident assessment and support plan (RASP), dated [redacted]/25, did not indicate if the resident requested a copy of the RASP or if the resident was provided a copy of the RASP.

Resident #7's current RASP, dated [redacted]/25, did not indicate if the resident requested a copy of the RASP or if the resident was provided a copy of the RASP.

Plan of Correction ***Directed [redacted] - 02/09/2026)***

Resident #7 and Resident #3 support plans were corrected by administrator on 11/18/2025. Administrator will do 3 month audit to monitor that support plans are done properly. See attached support plans for Resident #3 and Resident #7.
Additional audit will be completed for 100 % of current residents support plans by the administrator within 10 business days of this plan of correction administrator assistant will review these initial audits to ensure accuracy and compliance and proceed to conduct quarterly audits for the following 6 months to maintain ongoing oversite and quality assurance. See attached.

[Directed]
In addition to the above steps, education to be provided to the Administrator and to the Administrative Assistant, regarding regulation 2600.227(j). Education to be provided by 2/23/26. Documentation of education to be kept and available for review by the Department.
The Administrator or designee will complete an initial audit of current support plans regarding if the support plan indicates the resident requested a copy of the RASP or if the resident was provided a copy of the RASP no later than 2/23/26. Documentation of this audit will be kept and available for review by the Department.
Beginning no later than 2/23/26, the administrator or designee, will complete quarterly audits of current support plans. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: *02/23/2026*

Implemented [redacted] - 06/18/2026)