



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 23 2018

Ms. Ashley Creek, LPN,
Administrator
Senior Care on Market St. LLC
914 West Market Street
York, Pennsylvania 17401

RE: Autumn House of York
License #: 332350

Dear Ms. Creek:

As a result of the Department of Human Services' annual licensing inspections on December 27, 28 and 29, 2017, March 30, 2018 and April 2, 2018 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summaries were found.

All violations specified on the enclosed License Inspection Summaries must be corrected by the dates specified on each License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosures
License Inspection Summary

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION
From August through November, 2017, Resident #1 initiated altercations with other residents. The home did not put in place any interventions to keep Resident #1 from physically harming others. The incidents occurred on the following dates:
On 8/8/17, Resident #1 shoved Resident #2 and held Resident #2's hands down.
On 11/3/17, Resident #1 hit Resident #4 in the face.
On 11/6/17, Resident #1 grabbed & held Resident #3's hands. Resident # 3 tried to free their hands, then was punched in the chest by Resident #1.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment, or disciplined in any way.
From August through November 2017, Resident #1 initiated altercations with other residents. The home did not put in place any interventions to keep Resident # 1 from Physically harming others. The incidents occurred on the following dates:
On 8/8/2017, Resident #1 shoved Resident #2 and held Resident #2's hands down.
On 11/3/17, Resident #1 hit Resident #4 in the face.
On 11/6/2017, Resident #1 grabbed and held Resident #3's hands. Resident #3 tried to free their hands, and then was punched in the chest by Resident #1.
A resident should always be safe and protected from abuse.
Resident #1 was seen by her PCP on 9/8/2017. After every incident both the PCP and POA were notified of the incident. Resident #1 was seen by med options psych nursing on 11/2/2017 with no new recommendations given. On 12/11/2017, Administration met with PCP of Resident #1. PCP reviewed her medications, put into place every hour toilet schedule, and a mid afternoon nap. Activities on Laurel Court (SDU) were also increased to involve the residents in more activities. On 1/29/2018, Resident #1 was started on every 15-minute location checks and Autumn House provided 1:1 to the resident during waking hours. On 2/5/2018 a meeting with Nursing, Administration, and family was held to discuss care options going forward for Resident #1. Resident #1's PCP was in-house and saw Resident #1 this day as well. PCP adjusted resident's routine dementia medications. It was reviewed with family that during this adjustment period they would need to provide 1:1 care for the resident during waking hours. Resident # 1 family is aware that even with the med adjustment and private duty a 30 day notice may be issued to ensure the safety of all residents. Resident #1 was relocated to Skilled Nursing on [redacted] 18/27

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) *Cashley Creek*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Cashley Creek* Date *4/2/2018*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-11-18 (Date)

Plan of correction implementation status as of 4-2-18 (Date)

The above plan of correction was approved by *BE* (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

On 12/23/17 and 12/24/17, the home was required to have a minimum of 130 staffing hours. The home only had 117.5 hours on 12/23/17 and 113.5 hours on 12/24/17.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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.

On 12/23/17 and 12/27/17, Autumn House was required to have a minimum of 130 staffing hours. Autumn House only had 117.5 hours on 12/23/17 and 113.5 hours on 12/24/2017.

Having proper staffing levels at all times is extremely important to ensure that the needs of our residents are being met. The Director of Wellness and the Resident Care Coordinator will work together to develop a schedule that meets the needs of our residents. The DOW and RCC will take into consideration the mobility needs of our residents and information on the resident RASPS. They will use that information to calculate the staffing hours needed and ensure we are scheduling the hours needed. On days when there are open shifts or call offs, the DOW and RCC are responsible for ensuring proper coverage is provided. Our DOW and RCC will be scheduled on an on-call rotation, rotating weeks, to ensure proper staffing coverage if needed. The DOW and RCC will work closely with human resources to ensure that we are proactive in interviewing, hiring, and training new employees to get open positions filled as quickly as possible.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Ashley Creek</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Ashley Creek</i>	<i>4/2/2018</i>

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The above plan of correction was approved by <u><i>AE</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
 2600.57(d) - At least 75% of the personal care service hours specified in § 2600.57(b) and § 2600.57(c) shall be available during waking hours.

2a. DESCRIPTION OF VIOLATION
 On 12/23/17 and 12/24/17 the home was required to provide a minimum of 97.5 staffing hours during the waking hours. On 12/23/17 the home provided 92.5 hours and on 12/24/17 the home provided only 91 hours.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.57 (d) – At least 75% of the personal care services hours specified in 2600.57(b) and 2600.57(c) shall be available during waking hours.

On 12/23/17 and 12/24/17 the home was required to provide a minimum of 97.5 staffing hours during the waking hours. On 12/23/17 the home provided 92.5 hours and on 12/24/17 the home provided only 91 hours.

Having proper staffing levels at all times is extremely important to ensure that the needs of our residents are being met. The Director of Wellness and the Resident Care Coordinator will work together to develop a schedule that meets the needs of our residents. The DOW and RCC will take into consideration the mobility needs of our residents and information on the resident RASPS. They will use that information to calculate the staffing hours needed and ensure we are scheduling the hours needed. On days when there are open shifts or call offs, the DOW and RCC are responsible for ensuring proper coverage is provided. Our DOW and RCC will be scheduled on an on-call rotation, rotating weeks, to ensure proper staffing coverage if needed. The DOW and RCC will work closely with human resources to ensure that we are proactive in interviewing, hiring, and training new employees to get open positions filled as quickly as possible. When creating the schedule, the DOW and RC will use the formula provided by DHS to ensure that at least 75% of personal care services hours scheduled are available during waking hours.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ashley Creek*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Ashley Creek</i>	Date <i>4/2/2018</i>
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 (Initials)

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- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
 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.

2a. DESCRIPTION OF VIOLATION
 Ancillary Staff Member B, hired 3/20/17, did not receive a general orientation to their job functions.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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.

Ancillary staff member B, hired on 3/20/2017, did not receive a general orientation to their job functions.

Upon offer of a position within the company, the new team member will be required to attend an orientation day with human resources prior to their first day on the floor. At this orientation, specific job functions will be reviewed with the employee prior to their first day on the floor. Orientation days are held weekly to ensure that staff are orientated and able to start as soon as possible. New team members also receive on the floor training specific to their job duties by a current employee in that position. Orientation days are recorded in the ADP Payroll System as orientation to ensure that employees have this orientation.

Orientation records will be kept by the home. Autumn House West will keep records in house or have access to them electronically.

Administrator or designee will complete an audit of all staff records. Results will be included in the home's periodic Quality Management reviews. (65)

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) Ashley Creek

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <u>Ashley Creek</u>	Date <u>4/8 4/2/2018</u>
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Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

A record of training was not completed for training year January 1, 2016 to December 31, 2016.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

2600.65 (i) – A record of training including the staff persons trained, date, source, content, length of each course, and copies of any certificates received, shall be kept.

A record of training was not completed for the training year January 1, 2016 thru January 31, 2016.

Training records for 2016 were unable to be located at the time of survey. Training records for 2017 are documented and present in the home. Proper staff training is important to ensure staff are able to meet the needs of the residents that we serve. Attached (attachment #1) is the 2018 staff development calendar which includes dementia trainings and direct care trainings for all staff. Attached (attachment #2) is a sample staff training record that will be used to record staff training hours going forward. Human Resources will track training hours and keep record of training hours for each employee. There will be the paper sign in sheets for each training as well as the staff training record that will be stored on the company computer drive.

Building Administrator will review training records quarterly as a part of the quality management plan.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Copek

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Ashley Copek

Date

4/2/2018

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The above plan of correction was approved by

AC
(Initials)

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
 2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION
 On 12/28/17 in Bathroom #20, a purple lady's razor was found on the sink that was rusty and clogged with grime and hair. The razor was not labeled with the owner's name.
 A "House Glucometer" was used for Residents #11 and #12 during the month of November, 2017.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.85(a) – Sanitary conditions shall be maintained

On 12/28/2017 in bathroom #20, a purple lady's razor was found on the sink that was rusty and clogged with grime and hair. The razor was not labeled with the owner's name.

A "House Glucometer" was used for Resident's #11 and #12 during the month of November 2017.

Sanitary conditions must be maintained to minimize the risk of resident illness and transmission of disease and blood borne pathogens. The razor was immediately disposed of by the maintenance director. Daily bathroom checks will be conducted by the housekeeping team to ensure sanitary conditions are maintained at all times (attachment #3). The importance of sanitary conditions will be reviewed with all staff at the monthly staff meeting.

The house glucometer was unable to be found at the time of inspection. Only glucometers of current resident's will be kept in the home. All other machines have been disposed of. All residents have their own machine. Their machines and cases are clearly labeled with their name and room number. All staff who do blood sugar checks have been educated on the importance of not sharing glucometers. At no time is it permissible for staff to use any other machine other than the resident's own machine and supplies. The DOW or RCC will do weekly checks on the glucometers to ensure that each machine is clearly marked with the resident name and room number, that the resident has their own strips, and lancets, and a battery supply (attachment #4). They will also ensure that the machine is correctly calibrated to the date and time.

Resident's # 11 and 12 were notified of the possibility that shared glucometers were used in 2017. Administrator will audit glucometer logs to ensure compliance with regulation. Administrator will check to ensure that each resident has their own machine, supplies, that it is correctly calibrated including the date and time. Administrator will audit glucometer log and documented results to ensure that they match. Administrator will initially audit them weekly for one month (April), bi-weekly the month after (May), and then monthly thereafter to ensure compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ashley Creek*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek	Date 4/2/2018
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Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.102(i) - A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

2a. DESCRIPTION OF VIOLATION

An unlabeled bar of soap was found on the second floor in Bathroom #20's shower.

Three unlabeled bars of soap were found in the showers of Bathroom #36.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.102 (i) – A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

An unlabeled bar of soap was found on the 2nd floor in bathroom # 20's shower.

Three unlabeled bars of soap were found in the shower of bathroom # 36.

To ensure proper hygiene, soap dispenser must be within reach of each bathroom sink. The unlabeled soap was immediately discarded. Soap dispensers will be ordered and installed so that bar soap can be eliminated. Currently any resident using bar soap has the soap dish clearly labeled with the resident name or room number. Housekeeping will do daily checks to ensure that the bar soap remains in the labeled soap dishes until the dispenser can be installed (attachment # 5).

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek

Date

4/2/2018

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Plan of correction implementation status as of

4-2-18
(Date)

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- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by

AS
(Initials)

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.132(c) - A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

2a. DESCRIPTION OF VIOLATION

The home's fire drill record does not indicate the number of staff participating in the drills on 7/19/17 and 7/20/17.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.132 (c) – A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered, and whether the fire alarm or smoke detector was operative.

The home's fire drill record does not indicate the number of staff participating in the drills on 7/19/2017 and 7/20/2017.

The fire drill log was revised to include all the required information of this regulation to meet compliance (attachment # 6). The facility administrator will complete the log after every fire drill to ensure that all information is completed with each drill.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ashley Creek*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Ashley Creek</i>	Date <i>4/2/2018</i>
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 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

The home's designated evacuation time from the fire safety expert is 7 minutes. The fire drill conducted on 8/30/17 had an evacuation time of 9 minutes and 45 seconds.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.132(d) – Resident 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 safety expert within the period of time specified in writing within the past year by a fire safety expert.

The home's designated evacuation time from the fire safety expert is 7 minutes. The fire drill conducted on 8/30/2017 had an evacuation time of 9 minutes and 45 seconds.

Ensuring that the home can evacuate in the designated amount of time ensures resident safety in the event of a fire related emergency. Autumn House is in contact with a fire safety expert to review the facility and determine a fire safe plan. At the permission of DHS, Autumn House conducted a practice fire drill for training purposes on 1/18/2018. Staff and residents participated in this drill to review evacuation zones, meeting locations, and evacuation times. The importance of fire safety and being ready when the alarm sounds was reviewed with all residents during the practice drill and at Resident Town Hall. Autumn House will continue to have unannounced monthly drills to ensure fire safety and awareness. All drills will be documented on the fire drill log.

The maintenance director will oversee conducting the fire drills. The administrator will review every drill and document the drill on the fire drill log monthly.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
(Required on EVERY Page) Amley Creek

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Amley Creek Date 4/2/2018

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(Date)

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- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

1. REGULATION 55 Pa.Code §2600

2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION

The home held fire drills conducted during sleeping hours on 3/21/17 and 11/27/17; more than six months apart.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.132 (e) – A fire drill shall be held during sleeping hours once every 6 months.

The home held fire drills conducted during sleeping hours on 3/21/2017 and 11/37/2017, more than six months apart.

Because most fire related deaths occur during sleeping hours, it is crucial to practice fire drills during resident sleep hours. A 2018 fire drill schedule was created by the Administrator and Maintenance Director to ensure that a fire drill is scheduled during sleeping hours at least every 6 months. Sleep times (10:00pm to 6:30am) were also added to the new fire drill log.

The maintenance director or Administrator will oversee every drill to ensure that drills are conducted as scheduled to include at least one drill every 6 months.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Green

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Ashley Green

Date 4/2/2018

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Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.141(a)(1) - 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.

2a. DESCRIPTION OF VIOLATION

Resident #5 was admitted on [redacted] 16. The resident's medical evaluation was completed on 9/27/16, more than 60 days prior to admission.

Resident #6 was admitted on [redacted] 16. A medical evaluation has not been completed for this resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.141 (a)(1) – A resident shall have a medical evaluation by a physician, a 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.

Resident #5 was admitted on [redacted] 2016. The resident’s medical evaluation was completed on 9/27/2016, more than 60 days prior to admission.

Resident #6 was admitted on [redacted] 2016. A medical evaluation has not been completed for this resident.

Medical evaluations are important because accurate medical information helps the home decide whether a resident’s needs can be met at the home. Medical evaluations also assist in the development of the assessments and support plans and ensure that the resident’s medical needs will be met in the home. If a medical evaluation is not completed before admission we can not be sure that we can meet the needs of the residents. Staff responsible for completion of medical evaluations educated on timeframes to ensure compliance (Community Liaison for initial and DOW/RCC for annual and significant changes).

A complete audit of all resident files will be completed by 3/15/2018 by the administrator to determine if there are any other residents that are out of compliance with this regulation. A record will be kept of any missing documents.

Ongoing, an audit of all medical evaluations due will be conducted quarterly by the Administrator or designee and reported during the home’s Quality Management reviews. (LE)

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Ashley Creek*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Ashley Creek* Date *4/2/2018*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>4-11-18</u> (Date)	Plan of correction implementation status as of <u>4-2-18</u> (Date)
The above plan of correction was approved by <u>Be</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
On 12/29/17, Risperidone 0.25mg, prescribed for Resident #7, was present in the medication cart. This medication was discontinued on 11/5/17.
On 12/29/17, Haloperidol 2mg/ml Solution, prescribed for Resident #7, was present in the medication cart. This medication was discontinued on 11/22/17.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.183(d) – Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

On 12/29/2017, Risperidone 0.25mg, prescribed for Resident #7, was present in the medication cart. This medication was discontinued on 11/5/2017.

On 12/29/2017, Haloperidol 2mg/ml Solution, prescribed for Resident #7, was present in the medication cart. This medication was discontinued on 11/22/2017.

Medications that are discontinued should not be kept in the home. All med passers educated on checking med cart for discontinued or expired medication with each med pass. If a medication is discontinued, that medication will be immediately removed from the cart and destroyed. DOW/RCC will do monthly cart audits to ensure compliance with this regulation. Also, Brockie Pharmacy will do cart audits throughout the year to ensure compliance with this regulation.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) Ashley Creek

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek Date 4/2/2018

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-1-18 (Date)

The above plan of correction was approved by AE (Initials)

Plan of correction implementation status as of 4-2-18 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
 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.

2a. DESCRIPTION OF VIOLATION
 Resident #10 is prescribed Morphine sulfate 100mg per 5ml Solution. The medication was not available in the home. Also, the home did not have a narcotic count sheet to account for the medication, which is required under the home's medication policy.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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:

Resident #10 is prescribed Morphine Sulfate 100mg per 5ml solution. The medication was not available in the home. Also, the home did not have a narcotic count sheet to account for the medication, which is required under the home's medication policy.

This regulation is necessary to ensure that the home has the medication that is prescribed to the resident and to reduce the risk of medication being lost, misplaced, or misused. Pharmacy was contacted about the medication availability. Nursing staff will ensure that if we have an order for the medication, that we have the medication available. If the medication is not available, staff will call Brockie Pharmacy to have them supply the resident medication. Brockie pharmacy also supplies the facility with the narcotic count sheets. All controlled substances now have count sheets to ensure correct accountability of resident medication. Facility staff and Brockie pharmacy staff will do routine audits of med carts to ensure that we are in compliance with this regulation.

The medication was order and is available to the resident. Brockie pharmacy is supplying narcotic count sheets for medications that they supply.

The DOW / RCC will audit the med carts weekly to ensure that we have the medication as ordered and any supplies / narcotics sheets that are required to go along with the medication.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ashley Creech*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Ashley Creech</i>	Date <i>4/2/2018</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 7-11-18
 (Date)

The above plan of correction was approved by BE
 (Initials)

Plan of correction implementation status as of 7-2-18
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
PCH Name: AUTUMN HOUSE OF YORK

- 1. REGULATION 55 Pa.Code §2600**
2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:
- (1) Resident's name.
 - (2) Drug allergies.
 - (3) Name of medication.
 - (4) Strength.
 - (5) Dosage form.
 - (6) Dose.
 - (7) Route of administration.
 - (8) Frequency of administration.
 - (9) Administration times.
 - (10) Duration of therapy, if applicable.
 - (11) Special precautions, if applicable.
 - (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
 - (13) Date and time of medication administration.
 - (14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION
The medication administration record (MAR) for Resident #1 did not include the initials of the person administering Levothyroxine 88mcg, or an indication that the medication was given on 12/14/17.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The medication administration record (MAR) for Resident #1 did not include the initials of the person administrating Levothyroxine 88MCG, or an indication that the medication was given on 12/14/2017.

This regulation is important to ensure that residents are receiving medications as prescribed. Staff educated on the importance of signing off on all medications administered. The RCC/DOW will do random med sheet audits monthly to ensure that staff are initialing medications as they are administered. The administrator is a trainer for the medication administration course and routinely audits medication sheets for accuracy on all Certified Medication Techs.

The DOW or RCC will do weekly med sheets audits to ensure that they are be completed as required. On a weekly basis, the DOW or RCC will audit at least 10% of the Resident's MAR's to ensure compliance with this regulation requirement.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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Ashley Creek

4/2/2018

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-11-18
(Date)

The above plan of correction was approved by BE
(Initials)

Plan of correction implementation status as of 4-2-18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #10 was prescribed Cephalexin 500 mg from 11/27/17 to 12/4/17. The medication was administered from 12/5/17 to 12/11/17, without an additional prescriber's order in place.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.187 (d) – The home shall follow the directions of the prescriber.

Resident #10 was prescribed Cephalexin 500mg from 11/27/17 to 12/4/17. The medication was administered from 12/5/17 to 12/11/17, without additional prescriber's order in place.

It is very important to ensure that the resident receives their medication as prescribed. Resident #10 only received the medication as ordered from 11/27/17 thru 12/4/2017. Because this is a time-limited medication, the pharmacy only sent enough medication to last through the prescribed time frame. Staff and pharmacy did not put an end date on the MAR for this, therefore, it was initiated, but not given as the medication was already completed. Staff educated on rights of medication administration and electronic documentation. Staff also educated on the importance of adding in end dates for time-limited medications.

Ongoing, the Administrator or designee will complete monthly audits of all medication administration records and physicians' orders. Results will be included in the home's periodic Quality Management reviews. (BE)

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Oshtley Creek

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Oshtley Creek

Date

4/2/2018

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-11-18
(Date)

Plan of correction implementation status as of 4-2-18
(Date)

The above plan of correction was approved by BE
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
 PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

There was no preadmission screening form completed for Resident #6, admitted on [REDACTED] 16.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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.

There was no preadmission screening form completed for Resident #6, admitted on [REDACTED] 16.

Preadmission Screenings are important because accurate medical information helps the home decide whether a resident’s needs can be met at the home. If a preadmission screen is not completed before admission we cannot be sure that we can meet the needs of the residents. Nursing leaders and the Community Liaison are responsible to ensure that a pre-admission screen is completed before admission to facility.

A complete audit of all resident files will be completed by 3/15/2018 by the administrator to determine if there are any other residents that are out of compliance with this regulation. A record will be kept of any missing documents.

Ongoing, the Administrator or designee will complete bi-annual audits of resident records. Results will be included in the home’s periodic Quality Management reviews. (LSE)

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Amberlynn

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page)

Ashley Creek

Date

4/2/2018

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of

4-11-18
 (Date)

Plan of correction implementation status as of

4-2-18
 (Date)

The above plan of correction was approved by

LSE
 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 33235 - 12/27/2017 - Gillespie, Denise
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
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.

2a. DESCRIPTION OF VIOLATION
The home has not completed an initial assessment for Resident #6, admitted on [redacted] 2016.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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.

The home has not completed an initial assessment for Resident #6, admitted on [redacted] 2016.

Completion of an initial assessments allows the home to create a comprehensive profile of a resident’s needs and serves as the basis for the plan to meet those needs.

The DOW or designee is responsible for completion of the initial assessment. Required initial paperwork reviewed with the nursing leaders and admissions team.

A complete audit of all resident files will be completed by 3/15/2018 by the administrator to determine if there are any other residents that are out of compliance with this regulation. A record will be kept of any missing documents.

The complete chart audit was completed by 3/15/2018. Nursing is aware of documents that need to be completed and will work on getting them all completed in the month of April, with a goal of having anything that can be completed done by 5/1/2018.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page) Ashley Creech

Printed Name and Title of Legal Entity Representative Ashley Creech Date 4/2/2018
(Required on EVERY Page)

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-11-18
(Date)

The above plan of correction was approved by SC
(Initials)

Plan of correction implementation status as of 4-2-18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

**VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: AUTUMN HOUSE OF YORK		License Number: 33235
Address: 914 WEST MARKET STREET, YORK, PA 17401		County: York
Administrator: Ashley Creek		Region: CENTRAL
Legal Entity Name: SENIOR CARE ON MARKET ST LLC		
Legal Entity Address: 6119 28TH STREET SE SUITE 1D, GRAND RAPIDS, MI 49546		
Certificate(s) of Occupancy C-2 LP 04/27/2000 L & I		
Staffing Hours Resident Support: 0 Total Daily Staff: 124 Working Staff: 93		
Type of Inspection: Partial BHA Docket Number: Notice: Unannounced		
Reason(s) for Inspection(s) Interim, Complaint		
On-Site Inspections Dates and Department Representatives On-Site 03/30/2018: Gillespie, Denise 04/02/2018: Gillespie, Denise		
Off-Site Inspection Dates and Inspectors, if Applicable		
<div style="font-size: 2em; font-weight: bold; margin: 0;">RECEIVED</div> <div style="font-size: 1.2em; margin: 5px 0;">APR 13 2018</div> <div style="font-size: 1.1em; margin: 0;">Human Services Licensing</div>		
Other Details Partial or Full Triggers: N/A Random Indicators: N/A		
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 132 Number of Residents Served: 105 Secured Dementia Care Unit In Home: Yes Area: Laurel Court Secured Dementia Unit Capacity, if Applicable: 18 Number of Residents Served in Secured Dementia Care Unit, if applicable: 16 Number of Current Hospice Residents: 3 Number of Hospice Residents in past year: 20	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 105 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 19 Have a Physical Disability: 2	

Violation Report: 33235 - 03/30/2018 - Gillespie, Denise

FCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

Resident #1 has a physician's order requiring blood sugar readings four times daily. On 3/31/18 at 11:30 am, the MAR indicated a blood sugar reading of 201, but there was no corresponding reading on the glucometer. On 3/31/18 at 4:00 pm, the blood sugar recorded on the glucometer was 266; the MAR had a reading of 256. On 3/31/18 at 7:00 pm, the blood sugar reading on the resident's glucometer was 199; the reading on the medication administration record (MAR) was 258.

Resident #2's physician's order requires blood sugar readings once daily. On 3/5/18, the MAR included a blood sugar reading of 113; there was no corresponding reading on the resident's glucometer. On 3/7/18, the blood sugar reading on the glucometer was 184; the MAR recorded 189. On 3/9/18, the MAR had a blood sugar reading of 120; there was no corresponding reading on the glucometer.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

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.

Resident #1 has a physician's order requiring blood sugars readings four times a daily.

On 3/31/2018 at 11:30am, the MAR indicated a blood sugar reading on 201, but there was no corresponding reading on the glucometers.

On 3/31/2018 at 4:00pm, the blood sugar recorded on the glucometer was 266; the MAR had a reading of 256.

On 3/31/2018 at 7:00pm, the blood sugar reading on the resident's glucometer was 199; the reading on the medication administration record (MAR) was 256.

Resident #2's physician's order required blood sugar readings once daily. On 3/5/2018, the MAR included a blood sugar reading of 113; there was no corresponding reading on the resident's glucometer. On 3/7/2018, the blood sugar reading in the glucometer was 184; the MAR recorded was 189. On 3/9/2018 the MAR had a blood sugar reading of 120; there was no corresponding reading on the glucometer.

This regulation is necessary to ensure that we are properly and accurately recording and documenting blood sugar results. The physician uses these results to monitor and make changes in medication as needed. Starting this week, the DOW or RCC will audit the blood sugar results that are documented on the MAR and compare them against the actual glucometer to ensure that the results on the MAR match the results on the glucometer. Every resident that gets their blood sugar checked will be audited. Audits will be done weekly for a month, then bi-weekly for a month, and then monthly after that. The administrator will audit the audits to ensure that the DOW/RCC are doing the audits and that they match up according to the schedule above. Please see attachment #1. There will be a mandatory staff meeting on 4/17/2018 for all med passers. At this meeting, time will be spent with each glucometer to ensure that staff correctly and accurately know how to use them, can calibrate them to ensure the correct date and time, as well as show them how to review the results. All new med passers going forward will have a training specific to glucometers with the RCC or DOW as part of their on the floor orientation.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek APRN PCH#2

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek, Administrator

Date 4/13/2018

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-15-18
(Date)

Plan of correction implementation status as of 4-15-18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *SC*
(Initials)

Violation Report: 33235 - 03/30/2018 - Gillespie, Denise

PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #1 did not receive Digoxin, 125 mcg, Sertraline, 100 mg, or Lisinopril, 5 mg, from 3/1/18 to 3/31/18 as the medications were not available in the home .

Resident #3 did not receive Senna LAX, 8.5 mg, from 3/1/18 to 3/10/18 due to the medication not being available in the home.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.187 (d) – The home shall follow the directions of the prescriber.

Resident #1 did not receive Digoxin 125mcg, Sertraline 100mg, or Lisinopril 5mg from 3/1/2018 thru 3/31/2018 as the medications were not available in the home.

Resident #3 did not receive Senna LAX 8.5 from 3/1/2018 to 3/10/2018 due to the medication not being available in the home.

This regulation is necessary to ensure that the resident receives their medication as prescribed. Resident #1 receives her medication via mail order. The physician and family were notified. Her physician did discontinue the Digoxin. The other two medications were supplied and are available for the resident. Resident #3 receives her medication through our house pharmacy. That medication was supplied and is now available for the resident.

Autumn House West will be updating their contract to include a medication addendum. All current residents will receive the attached (see attachment #2) contract addendum in reference to medications and medication availability. This new policy will allow us to ensure that all residents are always receiving their medications as prescribed by a physician. There will be a med passer meeting on 4/17/2018, at which time, the new policy will be reviewed with staff. Audit forms have been created / revised to ensure compliance with this regulation. Please see attachments # 3 and # 4. The med cart and med sheet audit forms will be completed for at least 10% of the resident population by the DOW / RCC on a weekly basis for the next month. After that, they will be completed bi-weekly for a month, and then monthly after that. The administrator will audit the audit tools per the schedule above to ensure that it is getting completed and we are remaining compliant with this regulation.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek LPN PCHM

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Ashley Creek; Administrator

Date *4/13/2018*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 4-16-18
(Date)

Plan of correction implementation status as of 4-16-18
(Date)

The above plan of correction was approved by *SA*
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented