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

June 12, 2023

[redacted], ADMINISTRATOR
COUNTRY MEADOWS OF YORK LLC
[redacted]

RE: COUNTRY MEADOWS OF YORK
1920 TROLLEY ROAD
YORK, PA, 17408
LICENSE/COC#: 33354

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/16/2023, 05/17/2023, 05/18/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *COUNTRY MEADOWS OF YORK* **License #**: *33354* **License Expiration**: *08/31/2023*

Address: *1920 TROLLEY ROAD, YORK, PA 17408*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *COUNTRY MEADOWS OF YORK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP*	**Date**: *05/01/1996*	**Issued By**: *Labor and Industry*
Type: *C-2 LP*	**Date**: *06/14/1999*	**Issued By**: *Labor and Industry*
Type: *I-2*	**Date**: *08/15/2012*	**Issued By**: *West Manchester Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *173* **Waking Staff**: *130*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *05/17/2023*

Inspection Dates and Department Representative

05/16/2023 - On-Site: [redacted]
05/17/2023 - On-Site:
05/18/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *215* **Residents Served**: *116*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *48* **Residents Served**: *34*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *116*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *57* **Have Physical Disability**: *1*

Inspections / Reviews

05/16/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2023*

05/30/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/13/2023*

06/05/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/12/2023*

06/09/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/12/2023*

06/12/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

187b - Date/Time of Medication Admin.

1. Requirements

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

Description of Violation

Resident 1 is prescribed several medications to be given at [redacted] including, [redacted]. On [redacted], none of the morning medications were administered until after [redacted] AM, however, the medication administration record was marked indicating that all morning medications had been given at the prescribed time.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

o A miscommunication between off going Medication Associate and two on coming LPNs occurred at the change of shift on morning of March 19, 2023. This miscommunication resulted in documenting that medications were given at prescribed time. In morning huddle the two LPNs realized the miscommunication was interpreted as medications given when they were not. The LPN proceeded to check the med cart to find the medications still in cart and proceeded to administer but were late. At the same time, the resident made the LPNs aware she did not receive her medications. LPN notified PCP on March 19, 2023 via fax and discussed with resident.
o On March 20, 2023, Director of Nursing made aware by LPN and completed and faxed reportable to state. Director of Nursing met with those involved on March 22, 2023 and issued a formal co-worker first and last warning for both LPNs for not following proper medication administration and documentation.
o Medication Associate and LPNs will administer medications as ordered or document the why not given. Director of Nursing will re-educate at next Medication Associate and LPN meeting on June 1, 2023.
o Campus Executive Director to be on site by 7:00 am on Sunday May 28, 2023 to observe proper medication administration and documentation at shift hand off to ensure all medications administered and documented by off going Medication Associate and proper medication administration and documentation by on coming LPN. Director of Nursing to be on site by 7:00 am on June 17, 2023 to review same.
o Twice a week for three weeks starting July 2, 2023, Director of Nursing will observe medication administration and documentation for two residents at a shift change, varying times of observation to ensure monitoring of all shift changes.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented [redacted] - 06/09/2023)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident 1 is prescribed several medications to be given at [redacted], including, [redacted]. On [redacted], none of the morning medications were administered until after [redacted] AM.

Resident 1 is prescribed [redacted] to be administered upon awakening and before bed. On

187d - Follow Prescriber's Orders (continued)

[redacted] *this medication was not administered at bedtime.*

Repeated Violation - 5/3/22, et al

Plan of Correction ***Accept ([redacted] - 06/05/2023)***

o Medication Associates and LPNs will document a medication error correctly in the Medication Administration Record. Director of Nursing will re-educate Medication Associate and LPNs on proper documentation of a medication error at next Mediation Associate and LPN meeting on June 1, 2023.
o Starting May 31, 2023 and completing by June 9, 2023 Director of Nursing will review all reportable medication errors that were reported to the Department of Human Services to ensure there is proper documentation in Medication Administration Record. If any discrepancies are found, Director of Nursing will write progress note.
o Starting June 4, 2023 Campus Executive Director or Director of Nursing will do a weekly audit of all missed medications to ensure proper documentation is in the medication administration record for 4 weeks.
o Twice a week for three weeks starting July 2, 2023, Director of Nursing will observe medication administration and documentation for two residents at a shift change, varying times of observation to ensure monitoring of all shift changes

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented ([redacted] - 06/12/2023)