VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 8, 2023

Ms. L. Elise Haydon, Manager
The Yellow House Community
29 Seminary Street
Middlebury, VT 05753

Dear Ms. Haydon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 27, 2022.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 001	Initial Comments An unannounced, on-site re-licensure survey was conducted by staff from the Division of Licensing and Protection on 12/27/22 to determine compliance with the Vermont Therapeutic Community Residences (TCR) Licensing Regulations. The following regulatory violations were identified:	T 001	Please see attached plans of correction.	
T 037 SS=E	V.5.8.c Resident Care and Services 5.8 Medication Management 5.8.c Staff shall not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's or other licensed health care provider's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to obtain physician orders for over-the-counter medications for 3 applicable residents. (Residents #1, 2, 3) Findings include: 1. Per review of Resident #2's Medication Administration Record (MAR) and physician orders noted signed orders were received for prescription medications, however over-the-counter medications to include: Tylenol, Ibuprofen, antibiotic ointment, antifungal-cream, Benadryl and Aquaphor ointment lacked evidence of a physician's order to administer. Resident #2 received Ibuprofen 200 mgs on 10/11/22 & 10/13/22. In addition, there was also a lack of parameters for frequency for use or documenting	T 037		

T037 - T195 POCs accepted 2/3/23 JMcIntosh RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 037	Continued From page 1 of effectiveness for the use of the over-the-counter medications. This was confirmed by the Executive Director on the afternoon of 12/27/22 noting parents/guardians provide permission to administer the medications, however was unaware a physician's order was necessary. 2. Resident #1 does not take scheduled medications, however his/her MAR documents administration of PRN (as needed) medications to include Ibuprofen "1 cap" given on "8/8"; and Tylenol (acetaminophen) "1 cap" given on "11/14" and "11/18", and "1" given on 12/12. A Consent Form for Non-Prescriptive Medical Treatment indicates Resident #1's Primary Care Provider approved the use of Acetaminophen, Ibuprofen, Antibiotic Ointment, Anti-fungal cream or spray, Aquaphor (skin moisturizer), and Diphenhydramine, however the Consent Form is not signed and dated by a physician and lacks instructions for administration including the dose, route, frequency of administration, and the specific symptoms the medications are intended to address. Resident #1's MAR lacks instructions for administration and documentation of effectiveness when the medications were administered. This was confirmed by the Executive Director on the afternoon of 12/27/22 who noted parents/guardians provide permission to administer the medications, and s/he was unaware a physician's order was necessary. 3. Resident #3's MAR documents the administration of PRN medications to include 10 doses of Ibuprofen documented as "1 cap" or "1 tablet" between 11/11/21 and 12/14/22; "antihistamine 1 tablet 25 mg" on "12/12" and "12/12"; Benadryl "1 tab" on "12/11", "12/12", and	T 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 037	Continued From page 2 "12/17"; "Ricola cough drop" "1 drop" on 12/5; Thera Tears Eye Drops on 11/16/22; and Saline Eye Drops on 11/17/22. Resident #3 's MAR lacks instructions for administration, and documentation of effectiveness of administration with the exception of "didn't like" for the Ricola cough drop. A Consent Form for Non-Prescriptive Medical Treatment indicates Resident #3's Primary Care Provider approved the use of Acetaminophen, Ibuprofen, Antibiotic Ointment, Anti-fungal cream or spray, Aquaphor (skin moisturizer), and Diphenhydramine. Resident #3's physician signed and dated the Consent Form, however the form does not include specific orders for the medications including the dose, route, frequency of administration, and the symptoms the medications are intended to address. This was confirmed by the Executive Director on the afternoon of 12/27/22 who noted parents/guardians provide permission to administer the medications, and s/he was unaware a physician's order was necessary.	T 037		
T 054 SS=E	V.5.9.d Resident Care and Services 5.9 Staff Services 5.9.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the residence as	T 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 054	Continued From page 3 well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection and the Department for Children and Families in accordance with 33 V.S.A. §6911 and 33 V.S.A. §4919 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and personnel pre-employment background checks for 5 of 5 employees on 12/27/22 the TCR conducted national background checks on the employees but the screening did not include required checks for the Vermont Adult & Child Abuse registry and failed to conduct criminal background checks beyond a single county in Vermont. Findings include: Per review of the background checks on 12/27/22 noted the TCR utilizes a national background screening organization for part of their hiring process. However, the national screening fails to include the Vermont Adult & Child Abuse registry and only conducted criminal background checks for the county of Addison,VT failing to use the VCIC (Vermont Crime Information Center) which includes all counties within Vermont.	T 054		
T 127 SS=E	VII.7.2.b Nutrition and Food Services 7.2 Food Safety and Sanitation	T 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 127	Continued From page 4 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperature. Hot foods shall be kept hot at 135 degrees F and cold foods shall be kept at 41 degrees F or cooler. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there was a failure to label and date all perishable food and drink. Findings include: During a tour of the TCR on 12/27/22 at 10:40 AM accompanied by the Executive Director, food in the kitchen refrigerator included the following items without labels indicating the dates they were opened: feta cheese, yogurts, olives, hummus, Chobani Creamer, and various condiments. There was an unlabeled and undated Ziploc bag of tortellini in the kitchen freezer. Also noted in the basement refrigerator were unlabeled and undated perishable foods including frozen burritos loosely wrapped in paper, exposing them to freezer burn; a Ziploc bag of soup, and loaves of zucchini bread. The Manager confirmed the unlabeled and undated food items stored in the basement refrigerator during the facility tour on the morning of 12/27/22.	T 127		
T 146 SS=E	IX.9.1.a Physical Plant 9.1 Environment 9.1.a The residence must provide and maintain a safe, functional, sanitary, homelike and	T 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 146	Continued From page 5 comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there was a failure of the TCR to maintain a hazard free environment throughout the facility. Findings include: During a tour of the environment on 12/27/22 at 10:45 AM accompanied by the Executive Director noted a unlocked closet on the second floor where the resident's bedrooms are located. Within the closet were several bottles of hydrogen peroxide, cleaning supplies to include glass cleaner and a solution to remove the scent of urine. Due to the inquisitive nature of at least one resident who has a tendency to explore their environment, the unsecured solutions prevented a hazard free environment. The Executive Director confirmed the closet should be secured to protect residents from potential exposure to cleaning supplies. During a tour of the kitchen commencing at 10:40 AM on 12/27/22 an unlocked cabinet under the kitchen sink was noted to contain Bon Ami Powder Cleanser, dishwashing detergent pods, hydrogen peroxide, Clorox bleach, and various containers of Meyer's cleaning solutions. The Executive Director confirmed the use of a cabinet lock would prevent resident exposure to cleaning supplies during the course of the kitchen tour.	T 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 146	Continued From page 6 Additionally the basement door, which opens to a steep stairway with a low beam at the bottom of the stairs that pose risk for injury, was observed to be without a lock. The basement area serves as a storage area, utility room, and laundry area including the storage of laundry detergents. During the environmental tour on the morning of 12/27/22 the Executive Director acknowledged the hazards associated with the unlocked basement doorway, and confirmed a locked basement door would provide a safer environment for residents.	T 146		
T 187 SS=D	IX.9.11.c Physical Plant 9.11 Disaster and Emergency Preparedness 9.11.c Each residence shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure fire drills are conducted on at least a quarterly basis; at least one drill is completed during the morning, afternoon, evening, and night yearly; and the names of staff	T 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0663	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE YELLOW HOUSE COMMUNITY	29 SEMINARY STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 187	Continued From page 7 participating in drills is documented. Findings include: Per review of fire drill documentation a drill was not conducted in the evening during the previous year. This finding was confirmed by the Executive Director at 1:57 PM on 12/27/22.	T 187		
T 195 SS=B	XI.11.2 Resident Funds and Property 11.2 If the residence manages the resident's finances, the residence must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the residence or licensee's funds. This REQUIREMENT is not met as evidenced by: Based on staff interview there was a failure of the TCR administration who assist in the management of each resident's monthly spending accounts to provide a quarterly accounting to the residents' families/guardians of all costs of purchases made by the 4 applicable residents. (Residents #1, 2, 3, 4,) Findings include: Per interview on the afternoon of 12/27/22 the Executive Director confirmed the TCR manages monthly purchases made by each of the residents from specific accounts established for each individual resident. Accounting of the funds and purchases are only provided to families/guardians on a yearly basis. A quareterly accounting has not been provided.	T 195		

ATTACHMENT A:
Plan of Correction for Yellow House Community Services, Inc. in response to DLP Site Visit on 12/27/22.
Submitted by L. Elise Haydon, House Manager/Executive Director, on 1/30/23.

ID Prefix Tag: T 037

Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:

YHCS will discontinue use of the current "Consent Form for Non-Prescription Medical Treatment". Instead, YHCS will have parents/guardians request "Standing Orders" from their child's Primary Care Provider to address any and all PRN (as needed) medications. These physician's orders will include dose, route, frequency of administration, and the specific symptoms the medications are intended to address.

In addition, YHCS staff will be re-trained on filling out the Medication Administration Records for PRNs. Areas of focus will include reviewing the Doctor's Standing Orders and documenting the effectiveness of the administration.

How the corrective action(s) will be monitored:

The YHCS Nurse Affiliate reviews MARs for each resident on a monthly basis. She will review and check off on MARs for PRNs and communicate any areas for improvement to the staff. She will confirm that a Standing Order exists for each PRN, and consult the ordering PCP as needed.

Date(s) corrective action will be completed:

Parents will be contacted about requesting Standing Orders on 2/3/23. Training for the staff on Standing Orders and improved MAR documentation will be provided by the Nurse Affiliate on 2/20/23 (ideally all orders will have been provided by the PCPs by that date). Staff will implement changes following the 2/20/23 training.

A note on this change: The current list of PRNs is comprehensive and includes most items that residents had in their home medicine cabinets prior to living at Yellow House (acetaminophen, ibuprofen, antibiotic ointment, anti-fungal cream or spray, Aquaphor, diphenhydramine, Miralax, calamine lotion, saline solution (eye drops), cough drops, and cough syrup). It is our hope that PCPs will be willing to provide, on an annual basis, Standing Orders for all of these PNRs that have been approved for a resident by his/her parent/guardian. We may request guidance from the DLP as to how to obtain all of these orders if PCPs are unfamiliar or unwilling to comply with such requests.

ID Prefix Tag: T 054

Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:

All current YHCS staff, including the manager, will be retroactively screened via the Vermont Adult and Child Abuse registry, as well as through the Vermont Crime Information Center

(VCIC). All future YHCS employees will be screened for the above, in addition to the national background checks that they undergo as part of the established pre-employment screening.

How the corrective action(s) will be monitored:
Pre-employment screenings and onboarding tasks are tracked for each employee via an online checklist. Screenings for: 1) Vermont Child Abuse Registry; 2) Vermont Adult Abuse Registry; and 3) VCIC will be added to the new employee checklist. The checklists are overseen and monitored by the Executive Director and Program Director.

Date(s) corrective action will be completed:
The Executive Director requested registration packets from the VCIC and Vermont Adult & Child Abuse registry on 1/18/23. She received screening consent forms from AHS on 1/25/23 and has begun collecting consent signatures from employees for the Adult & Child Abuse registries. The ED has not received a follow up from VCIC; she will call this week to inquire so that she can initiate these checks. All three retroactive screenings for 21 YHCS employees will be submitted by 2/28/23 (barring any issues with VCIC), with a goal of completion by 3/15/23.

ID Prefix Tag: T 127
Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:
All perishable food and drink, as well as opened or homemade freezer items, will be properly labeled with type of food (if not identified on brand label) and date opened. All freezer food items will be properly packaged in a container or plastic bag so as to avoid exposure to freezer burn. Adhesive labels have been purchased for use on all products. Staff will be educated as to the new labeling policy at the 2/6/23 all staff meeting.

How the corrective action(s) will be monitored:
Refrigerators and freezers are cleaned out weekly by the Household Support staff member. Her updated task list will include verifying that all food items are properly labeled and discarding items that do not meet this labeling requirement. Food labeling practices will be added to the new staff training agenda.

Date(s) corrective action will be completed:
This action will be completed by 2/15/23.

ID Prefix Tag: T 146
Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:
Locks will be added to the following doors: 1) Second floor "cleaning supplies" closet; 2) basement door; 3) kitchen sink cabinet. The Executive Director will research, in combination with the owners and local locksmith, the most appropriate style of locks for the desired

protection. Combination locks were recommended, as were keyed locks that only staff have access to. Some hazardous supplies, such as hydrogen peroxide, will be permanently moved to the locked staff office.

How the corrective action(s) will be monitored:
The YHCS staff will monitor the efficacy of the locks through regular use and observation of resident's engagement (or lack thereof) with the locked spaces.

Date(s) corrective action will be completed:
The corrective action is anticipated to be completed by 3/15/23. If the product lead time or locksmith availability necessitates a longer completion time, the ED will communicate with the DLP.

ID Prefix Tag: T 187
Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:
The Executive Director and Program Director will schedule quarterly fire drills that rotate between the four different times of day: morning (7am – 12pm), afternoon (12pm – 5pm), evening (5pm – 9pm), and night (9pm – 7am). These have been set for 2023: Quarter 1 – "evening"; Quarter 2 – "afternoon"; Quarter 3 – "night"; Quarter 4 – "morning".

How the corrective action(s) will be monitored:
The Administrative Assistant will review logs at the end of each month as part of her monthly facilities log review. She will communicate any questions or issues with completion with the ED.

Date(s) corrective action will be completed:
The fire drill schedule was amended by the ED on 1/18/22, upon receipt of the survey report. The Quarter 1 evening drill is scheduled for 2/22/23.

ID Prefix Tag: T 195
Action that will be taken to correct the deficiency and measures/systemic changes YHCS will make to ensure deficient practice does not reoccur:
The ED will provide a quarterly accounting of each resident's monthly spending accounts to the residents' families/guardians. This report will be created using QuickBooks and provided to the parents/guardians electronically within 20 days of the completion of the quarter (e.g. April 20th for Quarter 1) to allow for reconciling of the previous month's expenses.

How the corrective action(s) will be monitored:
Quarterly accounting of resident spending will be added to the bookkeeper's quarterly responsibilities. The ED will request the summary for each resident upon completion of the quarter and email the statement to the parent/guardian. Parents/guardians will be informed of this change.

Date(s) corrective action will be completed:
The first quarterly accounting of 2023 will be provided to parents by 4/20/23. They will receive an email explaining the change prior to the first quarterly statement. The YHCS bookkeeper will be informed of this change on 2/15/23 during the monthly check-in meeting.