pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: September 18, 2018

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

RE: Autumn House of York
Certificate #: 332350

Dear Ms. Creek:

As a result of the Department's Bureau of Human Services Licensing inspection on June 27, 2018, June 28, 2018, June 29, 2018, July 13, 2018, August 16, 2018 and August 28, 2018 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

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

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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: 914 WEST MARKET STREET, YORK, PA 17401	

Certificate(s) of Occupancy

C-2 LP
04/27/2000
Labor and Industry

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 131 **Waking Staff:** 98

Type of Inspection: Partial **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)

Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site

06/27/2018: Heemer, Laura
06/28/2018: Heemer, Laura
06/29/2018: Heemer, Laura
07/13/2018: Heemer, Laura
08/16/2018: Heemer, Laura
08/28/2018: Heemer, Laura

Off-Site Inspection Dates and Inspectors, if Applicable

06/26/2018: Heemer, Laura
08/24/2018: Heemer, Laura

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 132

Number of Residents Served: 110

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: 17

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 21

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 110

Have Mental Illness: 0

Have an Intellectual Disabliity: 0

Have a Mobility Need: 21

Have a Physical Disability: 3

Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.25(c)(11) - The contract shall include a list of personal care services to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

2a. DESCRIPTION OF VIOLATION
The contract for Resident 1 does not include a list of the personal care services for which the home charged Resident 1, from November 2017 through April 2018, when the home determined the Resident required additional care.

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.

Regulation 2600.25 (c)(11) - The contract shall include a list of personal care services to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter, and services and how, when and by whom payment is to be made.

The contract for Resident 1 does not include a list of the personal care services for which the home charged Resident 1, from November 2017 through April 2018, when the home determined the Resident required additional care.

Nursing leadership / administration will communicate any changes in Level of Care to the Resident and or Responsible Party via phone call or in-person meeting. An addendum will be completed by the Business Office Manager and attached to the contract for any changes going forward.

*The home will perform an audit on all current resident contracts to assure that each contract is up-to-date and documents the charges each resident is receiving. This audit will be completed within 30 days from the reaipt of this plan.

BAS 9/17/18

Repeat Violation: No	**Date(s) of Previous Violation(s):**			
Signature of Legal Entity Representative (Required on EVERY Page)	Ashley Creek UPN PCHA			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Ashley Creek - Administrator	**Date**	9/14/2018	

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

The above plan of correction is approved as of 9/18/18 (Date)

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

Plan of correction implementation status as of 9/18/18 (Date)

- ☐ Fully Implemented
- ☒ XX Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION
On 7/12/2018, the Harford Duracool walk in refrigerator located in the kitchen of the home created a hazardous condition when Resident 2 was able walk in to it, unseen by staff. The resident was found inside the refrigerator by staff while completing a search for the resident. There were inadequate measures in place to limit the residents access to this walk-in refrigerator.

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.

Regulation 2600.95- Furniture and equipment must be in good repair, clean and free of hazards.

On 7/12/2018, the Harford Duracool walk in refrigerator located in the kitchen of home created a hazardous condition when Resident 2 was able walk in to it, unseen by staff. The resident was found inside the refrigerator by staff while completing a search for the resident. There were inadequate measures in place to limit the Residents access to this walk-in refrigerator.

Safety of our Resident's is of utmost importance. A double locking system is now in place. Dietary staff members now lock both the refrigerator and the freezer at the end of their evening shift. Dietary staff also lock all kitchen doors at the end of the evening shift to prevent any resident from entering the kitchen.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek - Administrator **Date** 9/14/2018

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Violation Report: 33235 - 06/26/2018 - Heemer, Laura
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 3 has a doctor's order for Torsemide 50 mg to be administered at 2pm if the Resident has a weight gain of three pounds overnight. On 6/7/2018 and 6/15/2018 the Medication Administration Record for Resident 3 records a three pound weight gain, but the home did not administer Torsemide 50 mg to the resident as ordered by the prescriber.

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.

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

Resident 3 has a doctor's order for Torsemide 50 mg to be administered at 2pm if the Resident has a weight gain of three pounds overnight. On 6/7/2018 and 6/15/2018 the Medication Administration Record for Resident 3 records a three-pound weight gain, but the home did not administer Torsemide 50 mg to the resident as ordered by the prescriber.

It is very important to ensure that the resident receives their medication as prescribed. Staff educated on rights of medication administration and electronic documentation. Staff also educated on the importance of administering PRN medications as prescribed. All staff will be educated to PRN Meds and documentation of PRN meds at staff meetings in September.

*The administrator, and/or a desgnated staff person,will audit the Medication Administration Records on a weekly basis for a period of four weeks to ensure that the prescriber's orders for medication administration are being followed accurately. These audits will comence upon receipt of this plan. BAS 9/17/18

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature] LPN PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek; Administrator **Date** 9/14/2018

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Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:

(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

On 9/27/2017 Resident 1 experienced a fracture of the right clavicle. The home's most recent assessment, dated 4/27/2018, was not updated to include the Resident's use of a sling, or the Resident's need for additional assistance bathing, dressing and grooming. The home's most recent assessment of Resident 3, completed 9/25/2017, does not include the resident's need for T.E.D. hose to be worn bilaterally during the day and an assessment of Resident 3's dental needs.

The assessment for Resident 4 completed on 4/11/2018 documents that Resident 4 has no problem with aggression. Resident 4's record documents the resident becoming aggressive and combative while going into other resident rooms on 5/3/2018, pulling a staff member's hair on 5/6/2018 , pushing another resident to the ground on 5/23/2018, and becoming involved in a physical altercation with another resident on 6/6/2018. Resident 4 has not been reassessed to address Resident 4's behavioral and cognitive needs.

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.

Regulation 2600.225(c)- The resident shall have additional assessments as follows:

(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

On 9/27/2018 Resident 1 experienced a fracture of the right clavicle. The home's most recent assessment, dated 4/27/2018, was not updated to include the Resident's use of a sling, or the Resident's need for additional assistance bathing, dressing and grooming. The home's most recent assessment of Resident 3, completed 9/25/2017, does not include the resident's need for T.E.D. hose to be worn bilaterally during the day and an assessment of Resident 3's dental needs.

The assessment for Resident 4 completed on 4/11/2018 documents that Resident 4 has no problem with aggression. Resident 4's record documents the resident becoming aggressive and combative while going into other resident rooms on 5/3/2018, pulling a staff member's hair on 5/6/2018, pushing another resident to the ground on 5/23/2018, and becoming involved in a physical altercation with another resident on 6/6/2018. Resident 4 has not been reassessed to address Resident 4's behavioral and cognitive needs.

Autumn House West hired a new LPN Director of Wellness on 9/10/2018. DOW is familiar with DHS regulations in reference to DMEs, RASP, Support Plans, and Assessments. Direct Care Staff and Nursing Leadership Team Members that are responsible for completing and updating Assessments will be educated. Nursing Leadership will do an audit of all Assessments to ensure that all needs are documented and accurate by the end of October 2018. (Continued on Pg. 5A)

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

Signature of Legal Entity Representative (Required on EVERY Page) Ashley Greer VN PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Greer - Administrator. **Date** 9/14/2018

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Plan of correction implementation status as of 9/18/18 (Date)

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

2600.225(c)

Immediately: The home will complete a reassessment of the abilities and care needs of Residents #1 and #4.

On-going: The home will complete new assessments to address significant changes to the conditions and abilities of the residents.

BAS 9/17/18

Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.227(c) - The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION
The home's initial support plan developed for Resident 2 on 6/5/2017. The home;s records document Resident 2 falling down three steps at the home on 2/21/2018, the resident displaying exit seeking behaviors on 3/18/2018, the resident falling at the home on 7/10/2018 which required staples for a laceration to the head, and the resident walking into a walk-in refrigerator on 7/12/2018. The initial resident support plan was not updated to address the necessary increase of supervision due to Resident 2 having a diagnosis of dementia with exit seeking behavior and the increased risk of falls.

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.

Regulation 2600.227(c)- The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

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Autumn House West hired a new LPN Director of Wellness on 9/10/2018. DOW is familiar with DHS regulations in reference to DMEs, RASP, Support Plans, and Assessments. Direct Care Staff and Nursing Leadership Team Members that are responsible for completing and updating Support Plans will be educated. Nursing Leadership will do an audit of all Support Plans to ensure that all needs are documented and accurate by the end of October 2018.

(Continued on Page 6A)

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek, Administrator **Date** 9/14/2018

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- ☐ Not Implemented

2600.227(c)

Immediately: The home will update the support plan of Residents #2.

On-going: The home will update resident support plans to address significant changes to the conditions and abilities of the residents.

BAS 9/17/18

Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.227(i) - The support plan shall be accessible by direct care staff persons at all times.

2a. DESCRIPTION OF VIOLATION
On 6/28/2018 at 9am the resident support plans were located in the medication room. This room is locked and can only be accessed by staff responsible for medication adminiatration. The support plans were not accessible to direct care staff who were not nurses or medication technicians.

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.

Regulation 2600.227(i)- The support plan shall be accessible by direct care staff persons at all times.

On 6/28/2018 at 9am the resident support plans were located in the medication room. This room is locked and can only be accessed by staff responsible for medication administration. The support plans were not accessible to direct care staff who were not nurses or medication technicians.

Access of these records allow Direct Care staff to have the knowledge needed to provide care to our Residents. The Support Plan Books will be updated and moved to the linen closets of the house-side hallways. 100 / 1000 will be in 1000 linen closet. 200 / 2000 will be in 2000 linen closet. 300 / 3000 will be in 3000 linen closets. Laurel Court will be kept in the laundry room of Laurel Court. All Direct Care staff that provide care will have access to those areas to be able to read, review, and refer to the support plans as needed. This information will be communicated with all staff at the September staff meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Ashley Creet LPN PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creet; Administrative **Date** 9/14/2018

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Plan of correction implementation status as of 9/18/18 (Date)

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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 33235 - 06/26/2018 - Heemer, Laura
PCH Name: AUTUMN HOUSE OF YORK

1. REGULATION 55 Pa.Code §2600
2600.254(c) - Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

2a. DESCRIPTION OF VIOLATION
On 7/13/2018 in the 1000 hallway of the home, the following items wereobserved on a counter, unattended by staff and accessible to anyone who walked by :
- A Lab Binder containing dates of birth, social security numbers and medical information of residents, including Resident 5 and Resident 6
- A Binder labeled Coumadin containing the names and dates of birth of Resident 7 and Resident 8
- A Binder labeled 1000 containing medical information about diagnosis and care information of residents including Resident 9 and Resident 2

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.

Regulation 2600.254(c)- Resident records shall be stored in locked containers or a secured; enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

On 7/13/2018 in the 1000 hallway of the home, the following items were observed on a counter, unattended by staff and accessible to anyone who walked by:

* A Lab Binder containing dates of birth, social security numbers and medical information of residents, including Resident 5 and Resident 6

* A Binder labeled Coumadin containing the names and dates of birth of Resident 7 and Resident 8

* A Binder labeled 1000 containing medical information about diagnosis and care information of residents including Resident 9 and Resident 2

This confidential information will be stored in a locked cabinet at the nursing stations of each hallway. The cabinets are only accessible by nursing staff that need to know that information, as well as the administrator or designee, and will be made available upon request to the Department of representatives of the area agency on aging. This change was made immediately, and all staff were verbally told. All staff will be reminded again at the upcoming September staff meeting.

* The administrator will ensure that the confidential information is stored in a secure manner during daily walk-throughs of the facility. BAS 9/17/18

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ashley Creek, Administrator **Date** 9/14/2018

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