pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **914 W MARKET STREET OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **AUTUMN HOUSE OF YORK**
NAME OF FACILITY OR AGENCY

Located at **914 WEST MARKET STREET, YORK, PA 17401**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **132**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 20**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 26, 2024** until **June 26, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338220**

ISSUING OFFICER

Juliet Marsala
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: JUNE 26, 2024

914 W. Market Street Operating Company, LLC

RE: Autumn House of York
914 West Market Street
York, Pennsylvania 17401
License #: 338220

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 27, 2024, and May 7, 2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

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

June 12, 2024

914 W MARKET STREET OPERATING COMPANY LLC

RE: AUTUMN HOUSE OF YORK
914 WEST MARKET STREET
YORK, PA, 17401
LICENSE/COC#: 33822

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/27/2024, 02/28/2024, 02/29/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #**: *33822* **License Expiration**: *05/21/2024*

Address: *914 WEST MARKET STREET, YORK, PA 17401*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2000* **Issued By**: *Labor and Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *02/29/2024*

Inspection Dates and Department Representative

02/27/2024 - On-Site:
02/28/2024 - On-Site:
02/29/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *97*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *20* **Residents Served**: *15*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*
Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *34* **Have Physical Disability**: *1*

Inspections / Reviews

02/27/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2024*

Inspections / Reviews *(continued)*

03/25/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/19/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *04/01/2024*

04/02/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/19/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *04/19/2024*

06/12/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/19/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/27/24, copies of this chapter and the home's current licensing inspection summary, dated 9/12/23, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 03/25/2024)***

On 2/27/2024, Administrator added the most recent inspection summary dated 9/12/2024 to the inspection report binder brining the binder up to date.
Administrator will audit inspection summary binder on a weekly basis for four weeks, bi-weekly for four weeks and monthly for three months to ensure the most updated inspection summaries are present in the binder.
Administrator will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented - 05/17/2024)

23b - Instrumental Activities of Daily Living Assistance

2. Requirements

2600.
23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for Resident 1, dated 7/23, indicates the resident requires 24-hour direct supervision. On /24, the resident eloped from the secured dementia care unit (SDCU) and was found several blocks away by police. According to staff, the resident was outside for approximately 60 to 90 minutes.

Plan of Correction ***Accept 03/25/2024)***

On /2024 when resident #1 arrived back at Autumn House West, was placed on 15 min checks to ensure staff always know resident #1's whereabouts. The 15 min checks will continue until April 30, 2024 when they will revert back to 30 min checks. In early February 2024, Resident #1 was fitted with a locator bracelet with York County Sheriff's Department. If resident #1 leaves the SDCU the bracelet will be enabled and the location will immediately be known to the York County Sheriff's Department.
An education will be held by Administrator on 3/20/2024 an all staff meeting regarding the regulation and correlation to the violation.
Staff will be instructed to monitor the SDCU doors when family and other staff enter and leave to ensure no resident is following. Staff were also educated on ensuring the door to the SDCU is completely closed prior to them leaving the area on 3/20/2024. This will ensure a resident is not following. There are signs on the main entry door for staff and visitors regarding the safety measures.
Autumn House West will be adding a FT LPN to the SDCU prior to April 1, 2024 which will assist staffing and added resident oversight of the unit.
Memory Care Coordinator will ensure ongoing compliance.

23b - Instrumental Activities of Daily Living Assistance (continued)

This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/19/2024*

Implemented - 05/17/2024)

42b - Abuse

3. Requirements

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

Description of Violation

On /24 around 6:45 PM, Resident 1 entered Resident 8's bedroom and the two residents began shoving each other, Resident 8 admitted to striking Resident 1 in the face leaving Resident 1 with a bloody nose.

On /24 at 6:00 AM, Resident 9 pushed walker into Resident 1. Resident 1 pushed Resident 9, knocking to the floor.

On 1 /24 at 6:40 AM, Resident 10 was yelling at Resident 11 to get up out of a chair. Resident 11 stood up, grabbed Resident 10, and bit right ear causing a part of it to come off. Resident 10 was knocked to the floor during this incident and Resident 11 kicked in the chest threatening, "Bye-Bye, you're lucky, your eyes were next."

On /24 at 8:45 AM, Resident 1 entered Resident 9's bedroom. Resident 9 was yelling for to get out. A staff person was attempting to redirect Resident 1 when reached over and smacked Resident 9 in the face.

On /23 at 6:00 AM, Resident 12 entered Resident 9's bedroom, Resident 9 screamed for to leave, then Resident 12 hit Resident 9 twice on the left arm.

On 23 at 10:55 PM, Resident 13 was found in bed by staff, holding onto cane stating would "hit us all and kill us." Resident 2 was on the floor and stated that Resident 13 should not have hit like that. Resident 2 was found to have a large, red, long, diagonal mark extending from the right middle of back to the right side of back.

On /23 at 6:20 AM, Resident 13 pushed Resident 9 out of a chair and onto the floor. Resident 13 then stood over Resident 9 and told to "shut mouth."

On /23 at 7:30 PM, Resident 14 struck Resident 15 in the mouth with a closed fist knocking out one of Resident 15's front teeth.

Repeated Violation - 9/12/23, 7/18/23

Plan of Correction ***Directed - 04/02/2024)***

An in-service has been scheduled for April 17, 2024 (staff meeting) with Ascend Hospice Nurse to review positive interventions and resident re-direction.
An in-service has been scheduled for April 17, 2024 with (ombudsman) to review resident rights, and Protective Services will present Abuse, Neglect, Dignity and Respect.
Autumn House West will also be adding a FT LPN to the SDCU prior to April 1, 2024 which will improve staffing

42b - Abuse (continued)

and added resident oversight of the unit.
On 1/31/2024 resident #1 was placed on 15 min checks by Administrator so staff know the whereabouts 4 times per hours.
An F/T LPN is assigned to our SDCU to better support the staff and improve resident oversight on the unit. If resident #1 is witnessed attempting to enter other resident rooms resident #1 will immediately be re-directed to avoid a possible altercation with another resident. If resident #1 is seen in close to other residents staff will immediately re-direct to avoid incidents.
Memory Care Coordinator started working one-on-one activities with resident #1 since 3/18/2024 to engage as often as possible.
This POC will be discussed at our next quality meeting on 5/8/2024.

Proposed Overall Completion Date: 03/26/2024

(Directed)
An in-service has been scheduled for April 17, 2024 (staff meeting) with Ascend Hospice Nurse to review positive interventions and resident re-direction.
An in-service has been scheduled for April 17, 2024 with [redacted] (ombudsman) to review resident rights, and Protective Services will present Abuse, Neglect, Dignity and Respect.
Autumn House West will also be adding a FT LPN to the SDCU prior to April 1, 2024 which will improve staffing and added resident oversight of the unit.
On 1/31/2024 resident #1 was placed on 15 min checks by Administrator so staff know the whereabouts 4 times per hours.
The administrator will conduct reassessments of all residents identified in this violation and update the support plans in order to identify and plan services related to mental health, dementia, aggression, wandering and other behaviors.
An F/T LPN is assigned to our SDCU to better support the staff and improve resident oversight on the unit. If resident #1 is witnessed attempting to enter other resident rooms resident #1 will immediately be re-directed to avoid a possible altercation with another resident. If resident #1 is seen in close to other residents staff will immediately re-direct to avoid incidents.
Memory Care Coordinator started working one-on-one activities with resident #1 since 3/18/2024 to engage as often as possible.
This POC will be discussed at our next quality meeting on 5/8/2024.

Directed Completion Date: *04/15/2024*

Implemented ([redacted] - 05/17/2024)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 2/12/24 and 02/17/24 during the 10:45 PM to 7:15 AM shift, there were approximately 96 residents present in the home. However, there were no staff members certified in CPR/FA.

63a - First Aid/CPR Training (continued)

On 2/21/24 during the 10:45 PM to 7:15 AM shift, there were approximately 96 residents present in the home. However, there was only one staff member certified in CPR/FA.

Plan of Correction ***Directed ███ - 04/01/2024)***

On 2/28/2024 Director of Wellness (DOW) made changes to the schedule to reflect at least two staff on all shifts with a valid CPR certification.
The dates 2/12/2024, 2/17/2024 and 2/21/2024 did in fact have two or more staff working who possesses a valid CPR certification. The certification for these staff were misplaced, however, located and placed in the current CPR binder which has been placed in the Administrators office and will be updated accordingly.
A CPR class for staff has been scheduled for 3/27/2024 to recertify select staff. Another class will be held in the fall to ensure there are no lapses in certification.
This list will be used when the schedule is being built to ensure at least two staff with CPR certification are scheduled on each shift.
On 3/4/2024 DOW audited all staff CPR records and compiled a list of all staff who will need re-certification as well as the dates due. All future schedules will include the the appropriate number of CPR certified staff to the number of in-house residents.
Director of Wellness will ensure ongoing compliance.

Proposed Overall Completion Date: 03/27/2024

(Directed)
On 2/28/2024 Director of Wellness (DOW) made changes to the schedule to reflect at least two staff on all shifts with a valid CPR certification.
The dates 2/12/2024, 2/17/2024 and 2/21/2024 did in fact have two or more staff working who possesses a valid CPR certification. The certification for these staff were misplaced, however, located and placed in the current CPR binder which has been placed in the Administrators office and will be updated accordingly.
A CPR class for staff has been scheduled for 3/27/2024 to recertify select staff. Another class will be held in the fall to ensure there are no lapses in certification.
This list will be used when the schedule is being built to ensure at least two staff with CPR certification are scheduled on each shift.
On 3/4/2024 DOW audited all staff CPR records and compiled a list of all staff who will need re-certification as well as the dates due. All future schedules will include the the appropriate number of CPR certified staff to the number of in-house residents.
Director of Wellness will ensure ongoing compliance.

Proposed Overall Completion Date: 03/27/2024

Beginning 4/5/24, the administer or designee will audit upcoming upcoming work schedules to ensure that at least one staff with current CPR and first aid certification is working for every 50 residents in the home. This audits will be documented, will include the current census information, and will include a list of staff working with current certification on each shift. These audits will continue, weekly, for no less than four weeks from the date that they start.

Directed Completion Date: *04/05/2024*

63a - First Aid/CPR Training *(continued)*

Implemented [redacted] - 05/17/2024)

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff A, hired [redacted]/23, and Staff B, hired [redacted]24, did not receive training on the topics required by this regulation.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 3/4/2024 Human Resources Manager performed an audit on all staff to ensure all orientations from 2022, 2023, and 2024 have been completed.
If the trainings are not current, Human Resources Manager will immediately schedule trainings for the individual to complete.
On 3/11/2024 Administrator educated Human Resources Manager on the regulation and the correlation to the violation.
On 3/12/2024 Human Resources Manager performed an orientation on staff A and staff B covering topics, evacuation procedures, staff duties during fire drills, smoking, fire training, telephone use, resident rights and mandatory abuse reporting.
Human Resources Manager will develop a checklist of all orientation trainings required for staff to ensure all topics will be covered during an initial orientation or onboarding. This list will be developed by 3/28/2024.
Human Resources Manager will be responsible for ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/13/2024*

Implemented ([redacted] - 05/17/2024)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101—10225.5102).

65b - Rights/Abuse 40 Hours *(continued)*

4. Reporting of reportable incidents and conditions.

Description of Violation

Staff A, hired [redacted]/23, and Staff B, hired [redacted]/24, did not receive training on the topics required by this regulation.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 3/4/2024, Human Resources Manager audited employee files to ensure trainings were current on all current staff including 2022 and 2023 and 2024.
If the trainings are not current, Human Resources Manager will immediately schedule trainings for the individual to complete asap.
On 3/11/2024 Administrator educated Human Resources Manager on the regulation and the correlation to the violation.
On 3/12/2024 Human Resources Manager held a training session for staff A and Staff B which covered Resident Rights, Mandatory reporting of abuse and neglect, and reporting of reportable incidents.
Human Resources Manager will develop a checklist for new hires as well as annual trainings by 3/31/2024 to track employee trainings on a month to month basis.
Administrator will audit the monthly checklists for the trainings to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Implemented [redacted] - 05/17/2024)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care Staff C did not receive training in the following topics during training calendar year 2023:
- Instruction on meeting the needs (DME & RASP)
- Infection control/cleanliness/immobility

Direct care Staff C did not receive training in the following topics during training calendar year 2022:
- Medication self-administration
- Instruction on meeting the needs (DME & RASP)
- Infection control/cleanliness/immobility concerns
- Personal care service needs of the resident

Direct care Staff E did not receive training in the following topics during training calendar year 2023:
- Instruction on meeting the needs (DME & RASP)
- Infection control/cleanliness/immobility concerns

65f - Training Topics (continued)

- Safe management techniques

Plan of Correction ***Accept █ - 03/25/2024)***

On 3/4/2024 Human Resources Manager performed an audit on all staff trainings in 2022 and 2023 to ensure they are current. If the trainings are not current, Human Resources Manager will immediately schedule trainings for the individual to complete.
On 3/11/2024 Administrator educated Human Resources Manager on the regulation and the correlation to the violation.
Human resources Manager has scheduled a training for staff C and staff E for 3/19/2024. At this training, Human Resources Manager will train both staff C and E to bring them current with all missing trainings.
Human Resources Manager will develop a checklist for new hires as well as annual trainings by 3/31/2024 to track employee trainings on a month to month basis.
Administrator will audit the monthly checklists for these trainings to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented █ - 05/17/2024)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff C did not receive training in the following topics during the 2023 training calendar year:
- Fire safety by a fire safety expert or staff trained by a fire safety expert.
- Resident rights
- Older Adult Protective Services Act (OAPSA)

65g - Annual Training Content (continued)

Staff C did not receive training in the following topics during the 2022 training calendar year:
- Fire safety by a fire safety expert or staff trained by a fire safety expert
- Emergency preparedness procedures
- Older Adult Protective Services Act (OAPSA)

Staff D did not receive training in the following topics during the 2023 training calendar year:
- Fire safety by a fire safety expert or staff trained by a fire safety expert

Staff D did not receive training in the following topics during the 2022 training calendar year:
- Fire safety by a fire safety expert or staff trained by a fire safety expert
- Emergency preparedness procedures

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 3/4/2024 Human Resources Manager performed an audit on all staff trainings in 2022 and 2023 to ensure they are all current. If the trainings are not current, Human Resources Manager will immediately schedule trainings for the individual to complete asap.
On 3/11/2024 Administrator educated Human Resources Manager on the regulation and the correlation to the violation.
Human Resources Manager scheduled a training for staff C which will cover fire safety, resident rights, older adult protective services act for 2023. For 2022, Fire safety, Emergency procedures, and older adult protective services act. which will be held on 3/19/2024.
Staff D will be trained on 2023 Fire safety, 2022 fire safety and emergency preparedness which was scheduled for 3/19/2024.
Human Resources Manager will develop a checklist for new hires as well as annual trainings by 3/31/2024 to track employee trainings on a month to month basis.
Administrator will audit the monthly checklists for these trainings to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented [redacted] - 05/17/2024)

82a - Poisonous Materials

9. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

An unlabeled spray bottle containing a pink liquid was in the storage cabinet in the unlocked secured dementia care unit office.

Repeated Violation - 9/12/23, 7/18/23

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 2/27/2024 Administrator removed spray bottle from the SDCU and discarded in the dumpster outside the community.

82a - Poisonous Materials (continued)

Administrator held a staff education for housekeeping on 3/14/2023 regarding regulation 82 a and the correlation of the violation, also the proper labeling and storage of all cleaners and chemicals.
Housekeeping manager will audit all cleaning bottles to ensure all are appropriately labeled by 3/15/2024.
Housekeeping Manager will be conducting weekly checks to ensure all bottles are labeled which will commence on 3/15/2024. If a bottle is located without a label, Housekeeping Manager will immediately label with appropriate label. If substance in the bottle is unknown, the bottle will be discarded immediately.
Housekeeping Manager will ensure ongoing compliance.
This will be discussed at the next quality assurance meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented (- 05/17/2024)

82c - Locking Poisonous Materials

10. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Spray bottles of Spic 'n Span All Purpose Spray, Glass Cleaner and Comet Disinfectant Sanitizing Bathroom Cleaner with labels stating to call a poison control center for treatment advice if in contact, where unlocked, unattended, and accessible to residents in the storage cabinet in the unlocked secured dementia care unit office. None of the residents in the SDCU have been assessed to be capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 03/25/2024)***

The Spic 'n Span, Glass Cleaner and Comet were removed from the SDCU Unit on 2/27/2024 and brought to the Housekeeping Manager.
Administrator will hold an education for all staff on 3/20/2024 on regulations 82c and the correlation to the violation, also importance of locking all poisonous materials when not in use and unsupervised.
SDCU Manager will ensure floor staff conduct sweeps of the SDCU once at the beginning and the conclusions of their shift to ensure all office doors are secure and all poisonous materials are secure. These sweeps will commence on 3/11/2024 and will be for an indefinite period of time. These checks will include all problems identified and steps taken to address.
SDCU Manager will be responsible for ongoing compliance.
This will be discussed at the next QA meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented 05/17/2024)

86b - Bathroom

11. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

86b - Bathroom *(continued)*

Description of Violation

The bathroom shared by bedrooms [redacted] does not have an operable window and the ventilation fan doesn't work.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 2/29/2024 Maintenance Manager repaired the fan motor in the shared bathroom.
Administrator educated Maintenance staff to regulation 86b and the correlation to the violation on 3/12/2024.
Maintenance Manager will be responsible to inspect 5 resident rooms and bathrooms per week to ensure all lights, fans, showers, and toilets to ensure they are working and in good repair. These checks will commence on 3/15/2024. These checks will include all problems identified and steps taken to address. Also a Maintenance TELS system is used at Autumn House West where staff will submit a work order if they or a resident notices any items in need of repair. Maintenance will see the report, repair and clear the report within 24-48 hours.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented [redacted] - 05/17/2024)

88a - Surfaces

12. Requirements

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

Description of Violation

There is a hole in the wall measuring 7 inches wide by 5 inches in length in the 100B hall near bedroom [redacted]

Plan of Correction ***Accept [redacted] - 03/25/2024)***

The hole in said wall was repaired on 2/29/2024 by Maintenance.
Administrator provided education to Maintenance staff on 3/12/2024 regarding regulation 88a and the correlation to the violation.
Staring 3/18/2024 Maintenance will conduct weekly walkarounds of the interior of the building ensuring floors, ceiling and walls are in good repair.
These checks will include all problems identified and steps taken to address.
Maintenance Manager will ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented ([redacted] - 05/17/2024)

95 - Furniture and Equipment

13. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The bench outside of the main entrance had a damaged seating surface with a screw protruding from the wood.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept █ - 03/25/2024)***

On 2/29/2024 the bench was removed by Maintenance staff from the property, disposed of and a new bench installed.
Administrator will provide education to all Maintenance staff regarding regulation 95 and the correlation to the violation on 3/12/2024.
Administrator has created a weekly checklist of items including all interior and exterior furniture to be reviewed by the Maintenance Director. This will commence on 3/18/2024.
These checks will include all problems identified and steps taken to address.
Administrator will audit checks on a weekly basis.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Implemented █ - 05/17/2024)

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 2/28/24 at 10:15 AM, Resident 3 was lying in bed and there were no bedsheets on the mattress.

Plan of Correction ***Accept █ - 03/25/2024)***

On 2/28/2024 Resident 3 bed was made by Housekeeping Manager.
On 3/14/2024 Housekeeping Manager met with staff to educate on regulation 101j3 and the correlation to the violation.
A daily audit sheet was developed on 3/14/2023 to ensure all resident beds have clean linens and blankets. If a resident bed does not contain these items during an audit, staff will immediately place lines and blankets on said bed. The daily audits will be ongoing for a period of four weeks, then three times a week for a period of four weeks then once a week for a period of four weeks.
Housekeeping Manager will audit the daily audit sheets on a weekly basis to ensure compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Implemented █ - 05/17/2024)

101j7 - Lighting/Operable Lamp

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

There was no bedside lamp present in bedroom 1100.

101j7 - Lighting/Operable Lamp *(continued)*

Plan of Correction ***Accept ███ - 03/25/2024)***

On 2/29/2024 a lamp was placed at bedside in room 1100 by Maintenance Manager.
An education regarding regulation 101j7 and the correlation to the violation was given to the Maintenance team by the Administrator on 3/12/2023.
A resident room checklist was created, Maintenance will conduct a comprehensive inspection of 5 resident rooms per week to ensure they include all items listed in regulation 101j1-101j7.
These inspections will commence on 3/18/2024 and will run indefinitely.
If any item is missing or inoperable Maintenance will replace asap.
Maintenance Manager will be responsible for ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented ███ - 05/17/2024)

105g - Lint Removal and Duct Cleaning

17. Requirements

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

Description of Violation

On 2/28/24, there was a heavy accumulation of lint in the lint trap of dryer #1 in the main laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ███ - 03/25/2024)***

On 2/28/2024 Housekeeping Manager checked all dryers in the building to ensure no lint was trapped inside the lint catches.
On 3/12/2024 an education was provided by Housekeeping Manager to staff regarding regulation 105g and the correlation to the violation.
A lint trap audit sheet was developed and implemented on 3/12/2024 for staff to sign and date the lint trap was cleaned after each use in the laundry room.
This will be documented after every use for a period of three months.
Housekeeping Manager will audit the lint trap documents daily to ensure compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Implemented ███ - 05/17/2024)

132a - Monthly Fire Drill

18. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

132a - Monthly Fire Drill *(continued)*

Description of Violation

An unannounced fire drill was not held during the month of December 2023.

Plan of Correction ***Accept █ - 03/25/2024)***

An education was conducted on 3/6/2024 by Administrator to the Maintenance team regarding regulation 132a and the correlation to the violation.
An audit was completed by Administrator on 3/8/2024 to ensure all fire drills prior to December 2023 were completed.
Administrator has developed a fire drill schedule for the remainder of 2024 to ensure all unannounced drills will be conducted and given the schedule to the Maintenance Manager.
Maintenance Manager will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented █ - 05/17/2024)

132c - Fire Drill Records

19. Requirements

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.

Description of Violation

The fire drill records for the drills conducted on 2/28/23, 4/26/23, and 11/30/23, do not include an exit route.

The fire drill records for the drills conducted on 5/19/23, 6/27/23, and 8/30/23 do not indicate if the alarm was operative and do not include an exit route.

The fire drill record for the drill conducted on 9/27/23 does not include the number of residents who evacuated, if the alarm was operative, and does not include an exit route.

The fire drill record for the drill conducted on 10/31/23 does not include the number of residents who evacuated the home.

Plan of Correction ***Accept █ - 03/25/2024)***

Administrator held an education with the Maintenance team on 3/6/2024 on regulation 132c the correlation to the violation and the importance of the elements needed on the fire drill document.
Administrator built a new fire drill document on 2/19/2024 which addressed all missing elements contained in regulation 132c.
Commencing March 2024, Administrator will audit all future completed fire drill documents to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented █ - 05/17/2024)

132h - Designated Meeting Place

20. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 2/28/23 at 1:00 PM, one resident did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill on 10/31/23 at 6:15 AM, five residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 3/20/2024 (all staff meeting) Administrator held an education on regulation 132h and the correlation of the violation to all staff explaining the importance of all residents being evacuated to a safe meeting location during a fire drill.
Autumn House West uses a fire hall document where every hall in the building has a list of residents and corresponding room number. This list is used to ensure the evacuation of all residents via one staff checking all rooms and noting on the document when a resident has evacuated.
During drills, Maintenance Manager will ensure staff adhere to their fire chart responsibilities during a drill.
Administrator will audit all future fire drills starting March 2024 on a monthly basis to ensure all residents were evacuated, If a resident does not evacuate, another drill will be conducted during that month until all residents safely evacuate.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Implemented [redacted] - 05/17/2024)

141a 1-10 Medical Evaluation Information

21. Requirements

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 2's medical evaluation, completed [redacted]/22, does not include body positioning and movement or health status and cognitive functioning.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept (- 04/02/2024)***

The DME for resident #2 was rectified on 2/29/2024 by to include all missing content.
All current Memory Care residents DME's were audited by to ensure all content is accurate on 3/11/2024.
An education was held by Administrator on March 15, 2023 regarding the regulation and the correlation with the violation.
When resident DME's are updated RCC will ensure document complete and accurate.
Administrator will review each completed DME to ensure all information is compete and accurate.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/26/2024*

Implemented (- 05/17/2024)

141b1 - Annual Medical Evaluation

22. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on /23. The resident's previous medical evaluation was completed on 10/31/22.

Resident 3's most recent medical evaluation was completed o 23. The resident's previous medical evaluation was completed on 9/9/22.

Plan of Correction ***Accept (- 03/25/2024)***

On 3/4/2024 Director of Nursing conducted an audit on residents to ensure no other resident annual medical evaluation exceeded more than the time allotted.
Administrator educated Director of Nursing and RCC on 3/17/2024 regarding the regulation and the correlation to the violation.
An audit document has been developed and will commence on 3/20/2024. This document is a monthly audit for residents who are due for their annual medical evaluation within the next 60 days.
Director of Nursing will ensure appointments are made at least 60 days prior to their annual review date.
Director of nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented (- 05/17/2024)

144c1 - Smoking Area Guidelines

23. Requirements

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

144c1 - Smoking Area Guidelines *(continued)*

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

Description of Violation

The home has two designated smoking areas: one on the bench next to the ramp into the building and another in the corner of the main parking lot.

- the bench in the smoking area had an upholstered seat cushion that did not have a label indicating that it was resistant to fire.
- there were approximately 22 cigarette butts in the wood mulch at the end of the home's exit walkway rounding the corner of the building toward the main parking lot.
- on 2/28/24 at approximately 11:00 AM, Resident 7 was smoking on the third-floor balcony. Resident 7 was aware of the location of the smoking area and understands the balcony is not a smoking area but stated that she did not want to go down to the smoking area because it is raining and said, "I come here when it's bad weather."

Plan of Correction ***Accept (- 04/02/2024)***

On 2/27/2024 the cushion on the smoking bench was removed by . On 2/29/2024 all discarded cigarette butts were collected and removed from the end of the building. A no smoking sign was placed in that location and on the third floor balcony door on 3/12/2024.
On 3/20/2024 Administrator will hold an all staff education regarding regulation 144c1 and the correlation with the violations.
Resident #7 was reminded of the the homes smoking policy and was subsequently given a 30 day notice for violating Autumn House West's smoking policy which resident #7 was given when they were admitted to the home. The notice will expire on 3/31/2024.
Resident #7 was asked by Administrator to cease smoking on the balcony and start smoking only in designated areas.
If resident #7 continues to smoke on the balcony, they will be able to access cigarettes only at the reception desk.
Maintenance Manager will monitor ongoing compliance by walking around the building daily to ensure all smoking polies are being followed including residents and staff. Maintenance Manager will conduct weekly audits of the resident smoking area to ensure the bench has no cushions present. This will be documented on a weekly audit sheet.
The smoking bench is near the building front entrance way which is observed by most staff on a daily basis. Staff are aware the bench should not have a cushion.
These sheets will be turned into the Administrator on a weekly basis to ensure audits are being completed.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/26/2024*

Implemented - 06/12/2024)

183b - Meds and Syringes Locked

24. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

183b - Meds and Syringes Locked *(continued)*

Description of Violation

On 2/27/24, at 9:45 AM, a 4-ounce tube of Medline Remedy Clinical Zink Oxide Paste Skin Protection cream was unlocked, unattended, and accessible in the cabinet opposite the 2000 hallway medication cart.

On 2/28/24 at 10:45 AM, a small peach tablet, a large yellow tablet, and a large pink tablet were unlocked, unattended, and accessible on the floor, where the 2000 hallway medication cart is stored.

Plan of Correction ***Accept [redacted] - 03/25/2024)***

On 2/27/2024 Administrator discarded the 4 ounce tube of skin paste.
On 2/27/2024 Med-Tech discarded the three tablets which were found on the 2000 hallway.
Director of Wellness held a staff education regarding regulation 183b which was held on 3/6/2023 explaining the correlation between the regulation and the violation.
A daily area audit document was created on 3/12/2024. The daily area checks will commence on 3/18/2024. Med-Techs will perform a daily area check when coming on shift to ensure all medications are secure in the medication cart.
To ensure compliance the Director of Wellness or designee will audit the daily area checks on a weekly basis.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Implemented [redacted] - 06/12/2024)

183e - Storing Medications

25. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/28/24, there was an oval, gray tablet loose inside of the 1000 hallway medication cart. There was a small, white tablet and a large, orange tablet loose inside of the 2000 hallway medication cart.

Plan of Correction ***Accept ([redacted] - 03/25/2024)***

On 2/28/2024 Med-Tech discarded all loose medication on the 1000 and 2000 halls.
On 3/6/2024 and education was conducted by Director of Wellness (DOW) regarding regulation 183e and the correlation to the current violation.
Daily audit sheets were initiated on 3/7/2024 to ensure Med-Techs will inspect the carts daily for any loose medication. If loose medication is located, it will be documented and destroyed.
DOW will be auditing all daily sheets on a weekly basis to ensure compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Implemented [redacted] - 05/17/2024)

184a - Resident's Meds Labeled

26. Requirements

2600.

184a - Resident's Meds Labeled *(continued)*

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident 1's Senexon tablet, 8.6 – 50 mg, states to take 2 tablets by mouth every 12 hours as needed. The medication administration record (MAR) states to take 2 tablets at bedtime.

Plan of Correction ***Accept ██ - 03/25/2024)***

On 2/28/2024 Resident Care Coordinator (RCC) labeled residents #1's medication to ensure compliance.
An education was held by RCC with Med-Techs on 3/6/2024 regarding regulation 184a and the correlation with the violation.
A monthly med cart audit will be performed and documented to ensure all medications are properly labeled.
If a medication is found with no label, Med Tech will complete a pharmacy sticker and attach it to the particular medication prior to administering.
RCC will be responsible for ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/13/2024*

Implemented ██ - 05/17/2024)

185a - Implement Storage Procedures

27. Requirements

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

Description of Violation

Resident 4's Tramadol 50 mg, 0.5 mg tablet by mouth twice daily, was given the morning of 2/28/24 by Staff F but not marked as administered, as a result, the count sheet indicated that there were 20 tablets remaining, however, there were only 19. In addition, the count sheet is not accurate as evidenced by various strikeouts and no accounting for tablets 27 and 25 because the count jumps from 28 tablets on 2/23/24 at 5:00 PM to 26 tablets on 2/24/24 at 5:00 PM.

Plan of Correction ***Accept ██ - 03/25/2024)***

On 2/28/2024 Med-Tech rectified the narcotic count regarding resident #4's Tramadol.
On 3/6/2024 Director of Wellness (DOW) held an education regarding regulation 185a and the correlation to the violation and controlled substance procedures.
A "change of shift narcotic count" document was created on 3/7/2024. This document ensures the incoming Med-Tech must sign onto the medication cart and ensure all narcotic counts are accurate prior to accepting the medication cart from the previous Med-Tech on duty.
The Director of Wellness will audit the sign on sheets on a weekly basis to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented (██ - 05/17/2024)

28. Requirements

185a - Implement Storage Procedures *(continued)*

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

Description of Violation

Resident 3 is prescribed FIASP FLEX INJ Touch 4 times a day according to a sliding scale. The blood sugar readings stored on the resident's Free Style Libre meter on 2/26/24 at 8:00 AM is 332, however, the MAR states it was 337. On 2/25/24 at 5:09 PM, the meter has a reading of 86 stored, however, the MAR states 156. On 2/27/24 at 4:00 PM, the MAR has a reading of 216, however, this reading is not stored in the meter.

Resident 5 receives blood sugar checks 3 times daily at 0700, 1200, and 1900. On 2/22/24 at 7:27 AM, the resident's meter has 226 stored in the memory, however, the medication administration record (MAR) states 296. On 2/25/24 at 12:20 PM, the meter has a reading of 324 stored, however, the MAR states 392. On 2/25/24 at 6:15 PM, the meter has a reading of 275 stored and the MAR states 294. On 2/26/24 at 11:49 AM, the meter has a reading of 235 stored and the MAR states 253.

The home has an extra, unlabeled glucometer stored in the med cart with blood sugar averages stored in the memory. Staff stated that this meter belonged to a former resident who left the home on 2/9/24.

Plan of Correction ***Accept ██ - 03/25/2024)***

The extra unlabeled glucometer was disposed of by Med-Tech on 2/29/2024.
Staff education was held on 3/6/2024 by Director of Nursing regarding regulation 185a and the correlation to the violation.
A Med-Tech audit document was developed to track all blood glucose readings including documenting the correct reading into the MAR. This auditing will commence on 3/21/2024.
The Director of Nursing will audit the Med-Tech sheets on a weekly basis to ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented ██ - 05/17/2024)

190a - Completion Medication Course

29. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff B, who has not successfully completed the Department-approved medication administration course, administered medications to Resident 3 on 2/18/24 at 8:00 AM.

Plan of Correction ***Accept ██ - 03/25/2024)***

On 2/28/2024 staff B was removed from passing medications due to the expired certification.
On 2/29/2024 staff B started re-certification training. Staff B will not pass medications until staff B has successfully completed recertification for medication administration.
On 2/29/2024 Resident Care Coordinator (RCC) conducted a Med-Tech audit to ensure all Med-Techs have been up-to-date with medication administration course.

190a - Completion Medication Course (continued)

RCC will conduct monthly audits of all Med-Techs ensuring all certifications are within compliance.
RCC will be responsible for ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/13/2024*

Implemented [redacted] - 05/17/2024)

190b - Insulin Injections

30. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff B's diabetic certification expired 2/2/22.
On 2/19/23 at 7:00 AM, Staff B checked Resident 5's blood sugar.
On 2/18/24 at 8:00 AM and 11:00 AM, Staff B checked Resident 3's blood sugar and administered insulin.

Plan of Correction ***Accept [redacted] - 04/02/2024)***

On 2/28/2024 Staff B was removed from passing medications due to certifications not being up-to-date.
Resident Care Coordinator (RCC) conducted an audit on 3/6/2024 of all Med-Techs to ensure all diabetic trainings are up-to-date.
Staff B took the diabetic training course on 3/12/2024 given by [redacted] via zoom. [redacted] is a certified instructor.
RCC will audit all Med-Techs every month to ensure all recertification's are compliant with applicable regulations.
RCC will be responsible for ongoing compliance on 3/8/2024.

Licensee's Proposed Overall Completion Date: *03/26/2024*

Implemented [redacted] - 05/17/2024)

224a - Preadmission Screen Form

31. Requirements

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.

Description of Violation

Resident 6's preadmission screening form, dated [redacted]/23, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 04/02/2024)***

On 2/28/2024 resident #6 pre-admission screen was updated by Director of Wellness to yes Autumn House West are able to meet the needs of this resident.
On 3/4/2024 an audit was performed on all resident charts to ensure the pre-admission screen were completed accurately.
An education was held on 3/8/2024 by Administrator to the sales team regarding regulations 224a and the

224a - Preadmission Screen Form (continued)

correlations with the violation.
Administrator or designee will be auditing all new admissions and initialing the pre-admissions screen to ensure it is completed accurately.
A "move in" checklist will be started to ensure all documents are completed accurately.
Sales Managers will be responsible for ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/26/2024*

Implemented - 05/17/2024)

225c - Additional Assessment

32. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident 1's most recent assessment was completed on 23 and indicates that the resident has no problems with irritability, judgement, agitation, or aggression, however, has been involved in altercations with other residents and a staff person including on 1/23/24 when the resident struck a resident in the face; on 1/29/24, when the resident was fighting with another resident and grabbed a staff person's wrist and wouldn't release it; on 2/14/24, when the resident pushed another resident, causing to fall; and on 2/19/24 when the resident was shoving another resident in that resident's bedroom.

Plan of Correction ***Accept - 04/02/2024)***

On 2/29/2024 Resident 1's RASP was updated by to reflect the most recent behaviors.
On 3/10/2024 an education was held by Director of Wellness (DOW) for all Resident Care Coordinators regarding regulations 225c and the correlation to the violation.
Nursing meetings are held monthly where Incident Reports and changes in resident condition will be discussed. If a residents condition has changed an assessment will be conducted and be reflected accurately on the corresponding RASP.
DOW chairs these meetings and will ensure ongoing compliance.
This will be discussed at our next quality meeting on 5/8/2024.

Licensee's Proposed Overall Completion Date: *03/26/2024*

Implemented - 05/17/2024)

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

June 12, 2024

914 W MARKET STREET OPERATING COMPANY LLC

RE: AUTUMN HOUSE OF YORK
914 WEST MARKET STREET
YORK, PA, 17401
LICENSE/COC#: 33822

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/07/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #**: *33822* **License Expiration**: *05/21/2024*

Address: *914 WEST MARKET STREET, YORK, PA 17401*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: **Issued By**:

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *139* **Waking Staff**: *104*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *05/07/2024*

Inspection Dates and Department Representative

05/07/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *98*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *97*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *41* **Have Physical Disability**: *1*

Inspections / Reviews

05/07/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/27/2024*

05/28/2024 - POC Submission

Submitted By: **Date Submitted**: *06/03/2024*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/04/2024*

Inspections / Reviews *(continued)*

06/03/2024 - Document Submission

Submitted By: [redacted] [redacted]: *06/03/2024*

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

144c1 - Smoking Area Guidelines

1. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home has two designated smoking areas: one on the bench next to the ramp into the building and another in the corner of the main parking lot. On 5/7/24, there were 10 cigarette butts observed in the mulch bed outside the entrance of the home. At 1:00 PM, a staff person was standing on the sidewalk around the rear corner of the home smoking.

Plan of Correction ***Accept [redacted] - 05/28/2024)***

On May 8, 2024, no smoking signs were placed on the patio adjacent to the main entrance, on the side of the main entrance and on the side of the building adjacent to the driveway. All cigarette butts were collected and appropriately discarded by the Maintenance Manager on May 8, 2024.
An education will be held by the Administrator on June 19, 2024 (staff meeting) regarding regulation 144c and the correlation to the citation.
AHW staff smoking policy will be reviewed and distributed to all staff during this meeting.
A letter and resident smoking policy will be distributed to all current residents at Autumn House West detailing the smoking policy and resident expectations.

Beginning 5/28/24, the Maintenance Manager will conduct checks five times a week of the smoking area and the area adjacent to the main entrance for evidence of smoking. If there are cigarette butts on the ground they will be immediately collected and appropriately be discarded. Administrator will immediately be informed if evidence is found to address asap. This area is a staff entrance, most staff will be vigilant to inspect these areas as they pass through. These checks will be recorded on an audit document and turned into the Administrator on a weekly basis to review and sign for ongoing compliance.
Staff will also monitor residents smoking habits and re-direct residents to smoke and discard their butts in the designated smoking area only.
In the near future, AHW will be obtaining another smoking tower to place in the designated smoking area.

This will be discussed at the next QA meeting on June 12, 2024.

Proposed Overall Completion Date: 05/30/2024

Licensee's Proposed Overall Completion Date: *05/30/2024*

Implemented [redacted] - 06/03/2024)

183b - Meds and Syringes Locked

2. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/7/24 at 9:55 AM, there was a small yellow tablet unlocked, unattended, and accessible on the floor outside of the 1000 hallway medication area.

Plan of Correction ***Accept (- 05/28/2024)***

On May 7, 2024 the pill in question was given to the Director of Wellness by state inspector at approximately 1:30 in the afternoon where the DOW and the RCC disposed of the pill in question.
An education was held on May 22, 2024 by DOW for all Med-Techs regarding regulation 183b explaining the correlation to the violation.
Staff will be vigilant when walking through the building to constantly survey the halls for medications or other potential harmful items.
A new audit sheet was created on May 22, 2024 to include daily area checks in and around the medication cart as well as an audit to check for loose medication after every medication pass. The med-techs will ensure all medication is locked in the med carts at all times.
This new procedure will be ongoing indefinitely.
Beginning 5/31/24, the DOW will audit the new documents as they are completed and the Administrator will also audit and sign the document to ensure ongoing compliance.

This will be discussed at the next QA meeting on June 12, 2024

Proposed Overall Completion Date: 05/22/2024

Licensee's Proposed Overall Completion Date: *05/22/2024*

Implemented (- 06/03/2024)