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

September 5, 2024

[redacted], EXECUTIVE VICE PRESIDENT
914 W MARKET STREET OPERATING COMPANY LLC

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/22/2024, 07/23/2024 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**: *06/26/2025*

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**: *04/27/2020* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/23/2024*

Inspection Dates and Department Representative

07/22/2024 - On-Site:
07/23/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *96*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *95*
Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *10*
Have Mobility Need: *20* **Have Physical Disability**: *1*

Inspections / Reviews

07/22/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/10/2024*

08/21/2024 - POC Submission

Submitted By: **Date Submitted**: *08/30/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/28/2024*

Inspections / Reviews *(continued)*

08/28/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *08/30/2024*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *09/06/2024*

09/05/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *08/30/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

16b - Incident Policies

1. Requirements

2600.
16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home's written policy on reportable incidents and conditions addresses investigating reportable incidents and conditions to determine factors contributing to the situation, however, according to Staff A, the home does not conduct investigations, to include gathering and maintaining witness statements. Staff A states that staff report incidents directly to medication technicians or a supervisor who in turn reports the incidents to the Department and to other required parties, such as the local area agency on aging, when required. Documentation of the incident is only what is recorded on the reportable incident forms and may not be from first-hand sources with direct knowledge of the incidents.

Plan of Correction ***Accept (- 08/28/2024)***

On 7/24/2024, Autumn House West adopted a new policy and procedure regarding the prevention, reporting, investigation and management of reportable incidences.
A staff training was held by the DOW on 7/24/2024 regarding regulation 2600.16.b and the correlation to the specific violation. Also, staff were trained on the new policy and procedure regarding all reportable incidents.
The new policy and procedure addresses the reporting, witness statements, description of any injuries sustained, investigation, and a final determination will be included and commenced on 7/25/2024.
Staff will forward initial report to DHS, however, statements, investigation and determination will be sent at a later date. Administrator will be responsible for collecting all final documents and sending to DHS. Commenced on 7/25/2024.
Administrator and DOW will oversee reporting of all incidents ensuring all elements of the new procedure are implemented prior to sending reports to the Department of Human Services and Area Agency on Aging. Commenced on 7/25/2024.
Administrator and DOW will be responsible for ongoing compliance.
This plan of correction will be discussed at our next quality meeting in September 2024.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented (- 09/05/2024)

23a - Activities of Daily Living Assistance

2. Requirements

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

Description of Violation

Resident 1's RASP, completed , indicates the resident is required to have 15-minute checks from staff for irritability and aggression. On 3 of 10 randomly selected shifts checked by licensing representatives, there was no documentation that these checks occurred on the following dates/times:
- an undated PCA (personal care aide) assignment sheet from Staff B's 3:00 PM – 11:00 PM shift

23a Activities of Daily Living Assistance (continued)

A PCA assignment sheet from Staff C's 7/20/24 7:00 AM 3:00 PM shift
an undated PCA assignment sheet from Staff D's 11:00 PM 7:00 AM shift

On 7/23/24, staff were unable to locate Resident 1 for several minutes. The resident was eventually found in another resident's bedroom and, according to Staff C, was attempting to flush clothing or other articles belonging to Resident 2 down the toilet. When asked about conducting and documenting the 15 minute checks, Staff C stated he/she was bathing another resident and was unable to monitor Resident 1. At 2:30 PM, Staff C's PCA assignment sheet was blank although she indicated that she began work at 12:00 PM.

Plan of Correction ***Accept (- 08/28/2024)***

On7/30/2024, a training was held by Administrator regarding regulation 2600.23.a and the correlation to the specific violation. PCA's have been trained on the documentation procedure regarding resident checks in the SDCU.
MCC, RCC, and Medication Technicians will ensure PCA staff are following each resident's RASP's and documenting all resident checks at the appropriate times throughout the shift. Commenced 8/1/2024.
MCC or RCC will audit PCA check sheets on a daily basis for four weeks, then weekly for eight weeks to ensure all resident checks are complete. Commenced 8/1/2024.
Administrator will audit PCA documents on a weekly basis. Commenced on 8/2/2024.
MCC and RCC will be responsible for ongoing compliance.
This plan of correction will be discussed at our next quality meeting in September 2024.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented - 09/05/2024)

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 , Resident 1 entered Resident 3's room. Resident 3 grabbed Resident 1, bent over a cart and punched repeatedly. Resident 1 was observed to have marks on chest and back from the incident.

On at Resident 4 pinned Resident 1 to the dining room wall and punched in the head and torso. Afterward, Resident 1 was observed to have a red mark on stomach.

On at Resident 5 was choking Resident 1 causing to fall to the floor. Resident 1 was observed to be short of breath and had a mark on neck.

On at , Resident 4 was in Resident 6's room. When Resident 4 was asked to leave, pushed Resident 6 to the floor.

On at , Resident 7 was yelling at Resident 8 to get up. After staff responded, Resident 8 left the room and Resident 7 followed, yelling, and pinched and twisted Resident 8's right arm, leaving a mark.

42b Abuse (continued)

On [redacted], Resident 4 punched Resident 9 in the face and stomach, knocking [redacted] to the floor.

On [redacted], Resident 4 and Resident 5 were fighting. Resident 6 intervened and Resident 5 struck [redacted] in the head leaving a red mark on [redacted] cheek.

On [redacted] at [redacted] Resident 4 grabbed Resident 9's right arm and caused a skin tear.

On [redacted], Resident 5 was sitting on the floor and Resident 1 approached and told [redacted] to get up. When Resident 5 got up, [redacted] pushed Resident 1 to the floor and kicked [redacted]

On [redacted], Resident 5 was trying to force Resident 10 out of a chair. Resident 6 told Resident 5 to stop. Resident 5 tackled [redacted] to the floor and Resident 6 put Resident 5 into a headlock and hit [redacted] multiple times.

On [redacted], Resident 11 was receiving care from Staff E and a contracted agency caregiver. During care, the Resident attempted to hit Staff E and called [redacted] a "bitch." The agency caregiver grabbed the resident's chin aggressively and said, "watch your mouth," then balled up [redacted] fist and asked the resident, "Do you want to box?"

On [redacted], Resident 7 and Resident 1 got into a physical altercation. In a notification from the facility to the primary care physician dated [redacted], it is documented that Resident 7 was pushed to the floor resulting in an abrasion noted as a "brush burn" on an unspecified elbow. Furthermore, while staff was assisting Resident 7 off the floor, an unknown staff member's "walkie" fell off the staff person and hit Resident 7 on the head causing a "dime sized knot."

On [redacted], Resident 12 knocked over his glass of water spilling onto Resident 13. Resident 13 became upset and hit Resident 12 on [redacted] right arm.

On [redacted] at approximately [redacted] Resident 10 pushed Resident 14 to the floor causing [redacted] to strike [redacted] head. Resident 14 was sent to the hospital and diagnosed with a closed head injury.

Repeated Violation 2/27/24

Plan of Correction ***Accept ([redacted] - 08/28/2024)***

An in service has been scheduled for 8/21/2024 with Ascend Hospice Social Worker to train staff on Abuse, Neglect and positive interventions with residents. Resident Rights will also be reviewed. We will also discuss 2600.42.b and the correlation to the violation.

Staffing in the SDCU was upgraded to include two staff and one Medication Technician during first and second shift. The Med Tech will not always be in the SDCU as they will also be passing medications on another floor, however, will be in the unit frequently. However, two staff will remain in the SDCU at all times during waking hours. If one staff is performing cares on a resident the other will supervise the unit ensuring resident oversight. Commenced on 8/1/2024.

SDCU Program Coordinator will receive assistance from a second activities staff running programs three afternoons per week to keep residents engaged on a regular basis. Commenced on 8/1/2024.

42b Abuse (continued)

Administrator and Resident Care Coordinator (RCC) will conduct periodic reassessments of the residents listed in this report to identify services of need related to wandering, behaviors, aggression and mental health concerns. Will commence 8/30/2024.
This plan of correction will be discussed at our next quality meeting in September 2024.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented (█ - 09/05/2024)

101r - Bedroom - shades/drapes/window covering

4. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The windows in bedroom LC10 do not have shades, blinds, or shutters.

Plan of Correction ***Accept █ - 08/28/2024)***

On 7/22/2024 two sets of new blinds were added to LC 10's room covering both windows by the Maintenance Manager.

On 8/5/2024, Administrator held a training for Maintenance Manager regarding regulation 2600.101.r. and the correlation to the specific violation.

As of 8/12/2024 Maintenance Director will conduct weekly room audits to ensure rooms have window coverings, bed, chair, dresser, night stand, lamp, and the room and furniture are all in good repair. Maintenance Manager will inspect five random rooms per week commencing on 8/12/2024.
These checks will be weekly for the first 30 days, bi weekly for 30 days and monthly thereafter, commencing on 8//12/2024.

Maintenance manager will complete the audit documentation and Administrator will review on a weekly bi weekly and monthly basis commenced on 8/16/2024.

Maintenance Manager will be responsible for ongoing compliance.
This plan of correction will be discussed at our next quality meeting in September 2024.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented █ - 09/05/2024)

228b - Discharge or Transfer

5. Requirements

2600.

228b - Discharge or Transfer *(continued)*

228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

Resident 4 was sent to the hospital on [redacted]. The home refused to accept the resident back because of behavioral issues, however, the home has not issued a discharge notice to the resident and has not sought certification from the Department or the resident's physician that a delay in the discharge would jeopardize the health, safety, or well-being of the resident or others in the home.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On [redacted] Administrator wrote a 30 day notice regarding resident #4. A signed copy was mailed to the resident's POA and placed in the resident file.
On 8/5/2024 Administrator familiarized [redacted] with regulation 2600.228.b. and the correlation to the specific violation.
Administrator will be responsible for writing all resident 30 day notices for discharge no matter the rationale. Each 30 day notice will be sent to the resident, POA and a copy for the resident file.
If a resident is sent to a local health care center due to behavioral concerns, Administrator will reach out to the Department of Human Services and the resident's PCP regarding the potential impact of health and wellness of other residents within the facility if said resident was to return. If a 30 day notice was not issued and the department or the residents PCP do not agree with immediate discharge of the resident, Administrator will allow resident to be discharged to Autumn House West.
This procedure will commenced on 7/24/2024.
Administrator will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/05/2024*

Implemented ([redacted] - 09/05/2024)