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 **March 24,** **2026** until **March 24,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338220**

ISSUING OFFICER

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

MAILING DATE: JUNE 4, 2026

[redacted]

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

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 6,2026, January 7, 2026, and March 24, 2026, 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 4, 2026

[redacted]
914 W MARKET STREET OPERATING COMPANY LLC
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/06/2026, 01/07/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #**: *33822* **License Expiration**: *03/24/2026*

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

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

Administrator

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

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *01/07/2026*

Inspection Dates and Department Representative

01/06/2026 - On-Site: [redacted]

01/07/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *20* **Residents Served**: *13*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *72*

Diagnosed with Mental Illness: *10*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *23*

Have Physical Disability: *2*

Inspections / Reviews

01/06/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/07/2026*

Inspections / Reviews *(continued)*

02/19/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/02/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/02/2026*

06/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/02/2026*

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

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's most current quality management review has not been completed and the home's administrator could not provide a prior quality management review.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The administrator completed the most current Quality Management Review in accordance with 55 Pa. Code § 2600.26(b) on 2/6/26. The review addressed all required components, including:
o Reportable incident and reporting procedures
o Complaint procedures
o Staff training and competency
o Licensing violations and plans of correction
o Resident and/or family council participation, as applicable
• The administrator will meet with the leadership team on 2/11/26 to discuss the findings of the Quality Management Review and provide further education related to 2600.26b.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will ensure a quarterly Quality Management Review is completed per company policy. The completed Quality Management Review will be kept by the administrator and used for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

42b - Abuse

2. 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

Staff Member A worked as a medication technician in the home from [redacted] until [redacted].
During this time, Staff Member A became familiar with Resident [redacted] and informed the resident of personal financial difficulties, including the inability to pay various bills, rent and medical costs. Resident [redacted] stated that Staff Member A was very nice and thought that they were friends. During the time-period of [redacted] until December 2025, Resident [redacted] confirmed that cash and checks were given to Staff Member A. The checks included the following amounts: $50.00, [redacted], and [redacted]

The home terminated Staff Member A in November 2024. Following this termination, former Staff Member A visited

42b - Abuse (continued)

with Resident [redacted] in December 2025 and requested a check in the amount of [redacted]. Resident [redacted] stated that a check that large could not be written, but instead wrote former Staff Member A a check for [redacted]. Following this interaction, former Staff Member A attempted to cash this check at a local bank. The bank teller immediately flagged this transaction as suspicious and refused to cash the check even after former Staff Member A claimed to be Resident [redacted]. The bank notified Resident [redacted] financial POA and confirmed that former Staff Member A was not Resident [redacted]s [redacted]. Shortly after this, former Staff Member A contacted Resident [redacted] and explained that the first check could not be cashed and requested a second check. Resident [redacted] agreed and wrote former Staff Member A a second check, this time in the amount of [redacted]. Former Staff Member A had a relationship with Staff Member B who was employed at that time as a housekeeper in the home. Former Staff Member A requested that Staff Member B collect this check from Resident [redacted] on [redacted] behalf so that [redacted] could cash it.
Following these interactions, Resident [redacted] stated that [redacted] felt that former Staff Member A was not being honest and expressed disbelief that [redacted] gave the staff person this amount of money. Over approximately a 2-year period, former Staff Member A requested a minimum of four checks from Resident [redacted] totaling approximately [redacted].
As a result of Staff Member B's involvement, [redacted] was terminated on [redacted] with the home citing "concerns related to financial misappropriation with a resident".

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• Upon receiving the allegation of financial abuse the resident was interviewed and their responsible party was notified. A reportable incident was submitted to DHS and AAA was notified by the administrator.
• Employee A had been previously terminated from the facility in November of 2024, Employee B was terminated from the facility on 12/11/25 ensuring no further contact would be made to the resident.
• Re-education was provided by the administrator to staff at the 1/21/26 staff meeting regarding Abuse & Abuse Reporting/Mandated Reporters as well as staffs inability to accept gifts at any time from residents. The administrator discussed the company's policy of no gifting to residents at their January 14, 26 Resident Council meeting. No further concerns were raised from residents at that time.
• The administrator or designee will complete 5 resident interviews weekly for four weeks beginning 2/9/26 then monthly for two months to ensure there are no concerns related to 2600.42b. These audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/02/2026)

82c - Locking Poisonous Materials

3. 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

On [redacted] at 9:46pm, the laundry room door in the Laurel Court Secured Dementia Care Unit (SDCU) was observed unlocked, unattended, and accessible. This laundry room contained poisonous materials such as liquid odor control, Provon foam hand cleanser, and Crest Mouth Wash. The manufacture's labels indicate "Keep out the reach of children. If swallowed get medical help or contact a poison control center immediately."

On [redacted] at approximately 1:00pm, a bottle of hand sanitizer, both with manufacture's label indicating "Keep out the reach of children. If swallowed get medical help or contact a poison control center immediately" was unlocked,

82c Locking Poisonous Materials (continued)

unattended, and accessible in rooms [redacted] occupied by Resident [redacted] and room [redacted] occupied by Resident [redacted] respectively.

Not all the residents of the home, including residents [redacted] and [redacted], have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The battery to the keypad lock on the secured memory care unit laundry room door was replaced at time of finding by maintenance director on 1/6/26. The items found in [redacted] and [redacted] were removed by the Memory Care Coordinator on 1/6/26 and placed in the locked memory care laundry room for safekeeping.
• No other keypad locks to rooms are present on the secured dementia unit. All rooms and common areas on the secured dementia unit were audited on 1/8/26 by the administrator to ensure all poisonous materials are kept locked and inaccessible to residents who are not able to safely use and avoid them.
• Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• An audit of the secured dementia unit will be conducted by the Memory Care Coordinator or designee five times weekly for one month and then once weekly for two months beginning on 2/9/26 to ensure all poisonous materials are kept properly locked and inaccessible to residents. The keypad lock to the memory care laundry room door will be audited once weekly for four weeks beginning 2/9/26 and then monthly for two months to ensure it is functioning properly by the administrator or designee. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/02/2026)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] staff discovered that 3 glucometers belonging to resident [redacted], resident [redacted], and resident [redacted] were in the wrong resident's diabetic boxes resulting in the following:

- *On [redacted] at 8:00pm Resident [redacted] blood sugar was measured with Resident [redacted] glucometer, the blood sugar reading on Resident #[redacted]s glucometer of [redacted] matched the reading entered on Resident [redacted] MAR for this date and time.*
- *On [redacted] at 8:00pm, Resident [redacted]s glucometer read [redacted] and the MAR read [redacted]. There was no other glucometer or MAR matching the [redacted] reading.*
- *On [redacted] 7:00am Resident [redacted] blood sugar was measured with Resident [redacted] glucometer; the blood sugar reading on Resident [redacted] glucometer o[redacted] matched the reading entered on Resident [redacted]'s MAR for this date and time.*
- *On [redacted] at 7:00am resident [redacted]'s blood sugar was measured with resident [redacted] glucometer; blood sugar reading on resident [redacted]'s glucometer of [redacted] matched the reading on resident [redacted]s MAR for this date and time.*

85a Sanitary Conditions (continued)

- *On [redacted] at 11:00am resident [redacted] blood sugar was taken with Resident [redacted]s glucometer, the blood sugar reading on Resident [redacted]s glucometer of [redacted] matched the reading on resident #[redacted]s MAR for this date and time.*

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• Upon report of the glucometer error, all glucometers affected were immediately removed from use. New glucometers were bought by the facility and labeled properly and returned to the appropriate resident's diabetic supply box by the Director of Wellness on 11/17/25.
• An audit of all resident glucometers was completed by the Resident Care Coordinator on 11/17/2025 to ensure no other resident's glucometers were affected.
• Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26. The staff person responsible for the glucometer error was terminated from the facility on 11/17/25.
• A glucometer audit is completed monthly by nursing staff routinely, a weekly glucometer audit will be completed by the Resident Care Coordinator or designee for four weeks beginning 2/9/2026 then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

88a - Surfaces

5. 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

On [redacted] at approximately 1:30pm the following areas were observed:

- *A hole measuring approximately 3ft by 3ft was observed in the ceiling above the sinks in the main kitchen area.*
- *Cracking dry wall and chipping paint was observed in the kitchenette area beside the washer and dryer in the B-hall on the first floor.*
- *Bubbling paint protruding from the ceiling in the 2nd floor kitchenette area*

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The 3X3 hole in the ceiling of the kitchen was repaired by maintenance on 1/29/26. The peeling paint on the 100 and 200 kitchenette areas is scheduled to be sanded and repainted before 2/28/2026 by maintenance.
• A walkthrough audit of the building was completed by the administrator looking for issues related to 2600.88a on 1/20/2026.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• A weekly walkthrough audit of the building regarding 2600.88a will be completed by the administrator or designee beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the

88a - Surfaces (continued)

administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

92 - Windows

6. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On [redacted], the window located in the stairwell of the A-Hall 3rd floor was observed to have a broken window frame mechanism and handle. The window was unable to be closed.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The window on the 3000 hall stairwell was closed by the maintenance director after the deficiency was found at time of survey on 1/6/2026. The maintenance director has contacted Susquehanna Door and Window to fix the broken window crank which is estimated to be completed by 2/28/2026.
• A walkthrough audit of the building was completed by the administrator looking for issues related to 2600.92 on 1/20/2026.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• A weekly walkthrough audit of the building regarding 2600.92 will be completed by the administrator or designee beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

95 - Furniture and Equipment

7. Requirements

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

Description of Violation

The shower door in room [redacted] occupied by Resident [redacted] was unable to be opened.

Plan of Correction ***Accept ([redacted] - 02/19/2026)***

• The maintenance director was present at the time the deficiency was found on 1/6/2026, shower door to be fixed by 2/28/2026. Staff assist resident with weekly showers in the shower room so resident does not have a need to use [redacted] in-room shower.
• A walkthrough audit of the building was completed by the administrator looking for issues related to 2600.95 on 1/20/2026.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.

95 - Furniture and Equipment (continued)

• A weekly walkthrough audit of the building regarding 2600.95 will be completed by the administrator or designee beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

103e - Left Overs

8. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated container of leftover soup and a bowl of leftover pudding in the SDCU refrigerator.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The food items found in the secured memory care unit refrigerator which were not labeled & dated were thrown away immediately at the time the deficiency was found on 1/6/2026 by nursing staff.
• No other food items were found to be unlabeled or dated at time of survey. An audit of all kitchenette refrigerators was completed by the administrator on 1/20/2026 to ensure compliance with 2600.103e.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26. Residents will be re-educated on 2/11/2026 at Resident Council by the administrator to ensure any food items they might place in kitchenette refrigerators are covered, labeled and dated per regulatory requirements or that they ask for staff assistance to do so.
• A weekly walkthrough audit of the building regarding 2600.103e will be completed by the administrator or designee beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the first floor 1000-Hall refrigerator.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• A thermometer was placed in the 1000 hall kitchenette refrigerator by the maintenance director on 1/7/2026.
• An audit was completed of all other kitchenette refrigerators by the administrator on 1/14/2026 to ensure thermometers were in place for safety purposes.

103f Refrigerator/Freezer Temps (continued)

• Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• A weekly walkthrough audit of the building regarding 2600.103f will be completed by the administrator or designee beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

105g - Lint Removal and Duct Cleaning

10. 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 [redacted] there was approximately a 3 inch accumulation of lint in the lint trap of the dryer located on the first floor, A Hall kitchenet. There were no clothes in the dryer at the time.

On [redacted] there was a approximately a 3 inch accumulation of lint in the lint trap of the dryer located on the 1st floor, B Hall kitchenet. There were no clothes in the dryer at the time.

There is a total of 9 dryers, however the home's documentation shows only 3 vent ducts were serviced.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• Lint was removed from the two dryers in common area kitchenettes by the surveyor when the deficiency was found on 1/6/2026. No lint accumulation was found in other dryers during time of inspection.
• Kensol Airways was out to provide duct cleaning, however it was not clear that all dryers vents were cleaned. A new maintenance director started employment on 12/15/2025 and has reached out to Kensol Airways to ensure all dryer vents will be properly cleaned on schedule as part of the facilities' preventative maintenance plan. A scheduled date of completion will be determined by 2/28/2026 for all dryer ducts not completed at last visit.
• Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will check all common area dryers for lint five times weekly beginning 2/9/2026 for four weeks and then monthly for two months. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

107c - Food/Water 3 Day Supply

11. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

107c Food/Water 3 Day Supply *(continued)*

Description of Violation

On [redacted], the home served 73 residents, requiring 219 gallons of emergency drinking water. However, the home had only 151 gallons on site. The home does not have a contract with a local bottled water supplier that includes emergency water detailing the equivalent amount of water required.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The dietary director had a new supply of emergency water delivered on 1/8/2026 to ensure an adequate supply per 2600.107c and related to the facility's census was on site.
• The supply is kept in the loading dock area and is kept for emergency purposes only.
• Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will check the emergency water supply weekly beginning 2/9/2026 for four weeks and then monthly for two months to ensure an adequate supply per 2600.107c is available on site. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/02/2026)

132a - Monthly Fire Drill

12. Requirements

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

Description of Violation

An unannounced fire drill was not held during the month of November 2025.

An unannounced fire drill was not held during the month of December 2025. The home documented a fire drill on 12/30/25 at 10:00pm, however, residents did not evacuate to a designated meeting place away from the building or within the fire safe area. During this drill, 75 residents were in the home; the fire drill record indicates "no" to the question of residents being evacuated. The fire drill record also documents "No announcements on the radio were made. Additionally, no staff responded to area of the fire."

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• An unannounced fire drill was held by the maintenance director on 1/23/2026 with no issues noted.
• The administrator educated the new maintenance director, hired 12/15/2025 to personal care home fire drill regulatory requirements and proper documentation on 1/20/2026. A fire drill schedule was created by the administrator on 1/20/2026 which only the maintenance director and administrator will have knowledge of.
• Staff received re education in fire safety by the administrator on 1/21/2026 at the monthly staff meeting. Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26. The maintenance director is scheduled for Train the Trainer Fire Safety Training on 3/25/2026.
• The administrator or designee will review each fire drill monthly times three months to ensure compliance with 2600.132a beginning 1/26/2026. The results of these audits will be kept by the administrator for quality assurance purposes.

132a - Monthly Fire Drill *(continued)*

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

141b1 - Annual Medical Evaluation

13. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 02/19/2026)***

• Resident[redacted] schedules their own appointments and prefers to use their physician only. Their physician was unavailable in November 2025 when medical evaluation was due and resident preferred to wait for their physician to be available which is scheduled for 2/23/2026. The director of wellness noted in the resident's chart attempts made to schedule a medical evaluation by the due date. Resident has had no health concerns during this time but could have seen another physician in their PCP's practice if the need arose.
• An audit of all resident DME's was completed by the Director of Wellness on 1/26/2026 to ensure all other DME's are up to date.
• Staff were educated to DME & RASP requirements during the annual employee education review by the administrator at the 1/21/2026 staff meeting. Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will audit five resident's DME's monthly times three months beginning 2/12/2026 to ensure compliance with 2600.141.b1. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] 04/02/2026)

144c1 - Smoking Area Guidelines

14. 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

On [redacted] at approximately 11:00am, a person believed to be a resident was observed smoking a cigarette on the front porch at the main entrance of the home; however, the front porch is not the designated smoking area.

Plan of Correction ***Accept [redacted] 02/19/2026)***

• The person observed to be smoking in a non-smoking area by surveyors on 1/6/2026 was not identified. No Smoking Postings are present in this area.

144c1 - Smoking Area Guidelines (continued)

• The administrator re-educated residents at Resident Council to the appropriate smoking areas on the property and why smoking is prohibited in other areas on 1/14/2026. All residents receive copies of Resident Council Minutes in case they are not able to attend.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will walk the property five times weekly for four weeks and then five times monthly for two months to ensure no person(s) are smoking in non-smoking areas and will provide re-education as needed. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/02/2026)

183b - Meds and Syringes Locked

15. 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 [redacted] at approximately 1:30pm, Gas Relief pills, Benadryl, Mucus Relief Guaifenesin, Amazon Nighttime Cold & Flu Multi-Symptom Relief medications were observed unlocked and accessible in room [redacted] occupied by Resident [redacted] However, the resident has not been assessed to self-administer these medications.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The following medications were removed from Resident [redacted]s room immediately after the deficiency was found on 1/6/2026 by nursing staff. The resident's wife was notified by the Director of Wellness and came and picked the medications up. This resident often orders medications online and has been re-educated several times by nursing to alert staff so that the resident's PCP can be notified and an order for self-store/self-administer can be obtained if deemed appropriate.
o Gas Relief pills, Benadryl, Mucus Relief Guaifenesin, Amazon Nighttime Cold & Flu Multi-Symptom Relief
• No other medications were noted to be in resident's rooms without a self-store/self-administer order at time of survey.
• Residents have been re-educated at Resident Council previously and will be re-educated again as to the regulatory requirements that all medications in the home must have orders, specifically self-store/self-administer orders if they are to be kept in resident rooms by the administrator during the Resident Council meeting on 2/11/2026. Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• A walk through audit will be completed by the administrator or designee of 5 resident rooms to ensure compliance with 2600.183b weekly times four weeks beginning 2/9/2026 and then monthly times two months. Medication Cart Audits will continue monthly as scheduled by the Director of Wellness or designee. The results of these audits will be kept by the administrator for quality assurance purposes.

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

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], at approximately 2:30pm a bottle of [redacted] Probiotics) was observed in a lockbox in the refrigerator in the first floor A-Hall Kitchenette. The medication is prescribed to Resident [redacted]; however, the resident was discharged on [redacted]

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• The medication found in a locked box in the refrigerator of the 1000 hall was immediately removed by the administrator at the time the deficiency was found on 1/6/2026. The medication was discarded per policy by nurse management.
• Routine medication cart audits have been completed as schedule by the Director of Wellness and any medications needing removed due to being discontinued or a resident's discharge have been destroyed per policy. An audit of all overflow medication closets will be completed by the administrator or designee by 2/13/2026 to ensure no other discontinued medications are on site.
• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• A walk through audit will be completed by the administrator or designee of all locked medication boxes present in the home and overflow medication closets to ensure compliance with 2600.183d weekly times four weeks beginning 2/9/2026 and then monthly times two months. Medication Cart Audits will continue monthly as scheduled by the Director of Wellness or designee. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

185a - Implement Storage Procedures

17. 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 [redacted] is prescribed [redacted] take 1 tablet by mouth daily as needed for nausea or vomiting. [redacted] was not found in the medication cart or otherwise in the home.

185a - Implement Storage Procedures (continued)

Resident [redacted] is prescribed [redacted], give 0.25ml by mouth every 3 hours as needed for pain or shortness. The Controlled Drug receipt/record/disposition form shows that on [redacted] at 5:52 the resident was given 0.25ml of the medication and documents 12.50ml left. However, the medication bottle shows there is approximately 8ml remaining.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• Resident [redacted]s [redacted] was reordered by nursing staff on 1/6/2026 after deficiency was found. The facility had implemented a requirement that liquid morphine be supplied by hospice companies in prefilled syringes as it has been a common issue that more than the prescribed amount is received at time of pharmacy delivery due to the manufacturer. The Director of Wellness began holding meetings with all hospice companies in the facility weekly beginning 6/17/2025. Resident [redacted] morphine was still in a bottle and not prefilled syringes as the supply had not expired yet.

• All morphine orders and supplies will be audited by 2/12/2026 by the Director of Wellness or designee to ensure prefilled syringes are in place for narcotic count accuracy purposes. Medication cart audits continue monthly as scheduled by the Director of Wellness.

• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.

• Medication cart audits will continue monthly as scheduled by the Director of Wellness or designee. Narcotic count audits will be completed by the Director of Wellness or designee on random shifts and times three times weekly for four weeks beginning 2/9/2026 and then monthly for two months to ensure compliance with 2600.185a. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 06/04/2026)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

On [redacted] the following medications were not administered:
Resident [redacted] –

- *At 8:00pm [redacted] take capsule by mouth 3 times daily for supplement; [redacted] tab take 1 tablet by mouth 2 times daily for [redacted] take 2 tablets by mouth twice daily for DM.*
- *At 9:00pm [redacted], take 1 tablet by mouth 3 times daily for [redacted].*
- *At 10:30pm [redacted] take 2 tablets (650mg) by mouth 3 times daily for [redacted]*

Resident [redacted] -

- *At 8:00am [redacted], and [redacted]*
- *At 7:00am [redacted].*

Resident [redacted] –

187d Follow Prescriber's Orders (continued)

- At 8:00pm, [redacted] mix 1 scoop in 8 ounces of liquid take by mouth twice daily with meals for [redacted]; [redacted] take 2 tablets by mouth twice daily with meals for DM; Mucus Relieve ER 600mg, take 2 tablets by mouth twice daily for cough/congestion; [redacted] tale 1 tablet by mouth one daily at bedtime for cholesterol.

On [redacted] the residents were not administered various medications, such as the following:

Resident [redacted]

- At 6:30am and 2:00pm [redacted] take 2 tablets (650mg) by mouth 3 times daily for pain.
- At 9:00am [redacted] take 1/2 tablet daily for [redacted].
- At 12:00pm [redacted] twice a day with meals for [redacted].

Resident [redacted]

- At 9:00am [redacted] take 1 tablet by mouth once daily in the morning for [redacted], take 1 tablet by mouth once daily for supplement; [redacted], take 1 tablet by mouth once daily for allergies; [redacted], take 1 tablet by mouth once daily for [redacted]; [redacted], take 1 tablet by mouth twice daily with meals for DM; [redacted], take 1 tablet by mouth twice daily for [redacted]; [redacted], take 3 tablets by mouth once daily for [redacted]; [redacted], take 1 capsule by mouth once daily for urinary retention.

Resident [redacted]

- At 8:00am [redacted], take 2 tabs by mouth twice daily for pain; [redacted], take 1 tablet by mouth one daily for [redacted]; [redacted], take 1 tablet by mouth one daily for supplement.

Resident [redacted] –

- At 7:30am [redacted], 1 tablet by mouth once daily for [redacted]n; [redacted], take 1 tablet by mouth one daily for supplement.
- At 8:00am [redacted] take 1 tablet by mouth once daily for supplement; [redacted], take 1 capsule by mouth twice daily for neurological pain; [redacted], take 1 tablet by mouth once daily for [redacted].

Plan of Correction ***Accept[redacted] - 02/19/2026)***

• On 12/2/2025 the facility's internet was inoperable. Upon notification from staff, the administrator got the IT department working on the issue and it appeared to be operational. During the early morning hours of 12/3/2025 the internet went out again due to piece being broken off of the Verizon Wireless equipment unknown to staff. Upon the administrator being notified, Medication Administration Records for all residents were printed and provided to med techs for proper medication administration to all residents.

• Verizon Wireless came on site to fix the broken equipment. The IT department has also identified the need for an upgraded server. Cloud migration has taken place at the facility over the last few weeks and it is expected that the server will be fully upgraded for more reliable internet service by 2/28/26. In the meantime staff have been re-educated to alert the on-call supervisor or administrator IMMEDIATELY if the internet goes down so that Medication Administration Records can be printed and delivered to the facility IMMEDIATELY by the pharmacy, nurse management or the administrator.

• Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.

187d Follow Prescriber's Orders (continued)

• The administrator or designee will audit PointClickCare and the resident's MARs five times weekly beginning 2/9/2026 for four weeks and then monthly for two months for any medications that are not documented as given. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented (- 04/02/2026)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident s most recent assessment was completed on

Plan of Correction ***Accept 02/19/2026)***

• Resident schedules their own appointments and prefers to use their physician only. Their physician was unavailable in November 2025 when medical evaluation was due and resident preferred to wait for their physician to be available which is scheduled for 2/23/2026. The director of wellness noted in the resident's chart attempts made to schedule a medical evaluation by the due date. Resident has had no health concerns during this time but could have seen another physician in their PCP's practice if the need arose. The Director of Wellness will complete a new Resident Assessment and Support Plan for Resident upon receiving their new DME after their appointment on 2/23/2026.
• An audit of all resident RASP's was completed by the Director of Wellness on 1/26/2026 to ensure all other RASP's are up to date.
• Staff were educated to DME & RASP requirements during the annual employee education review by the administrator at the 1/21/2026 staff meeting. Staff will be re educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6 7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.
• The administrator or designee will audit five resident's RASPs's monthly times three months beginning 2/12/2026 to ensure compliance with 2600.225c. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented - 04/02/2026)

227d - Support Plan Medical/Dental

20. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident [redacted] does not have a bed in [redacted] room. The resident states [redacted] prefers to sleep in [redacted] recliner. The resident's assessment dated [redacted] does not document the use and need for the recliner.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

• Resident [redacted] prefers to sleep in a recliner and requested their bed be removed from the resident's room for mobility purposes. Nursing staff received a [redacted] order for this resident's preference and need to sleep in their recliner. On 2/6/2026 the Director of Wellness reviewed the resident's RASP and included this information to ensure it was up to date.

• An audit was completed of any resident's with similar orders to ensure all resident's RASPs included up to date information by the Director of Wellness on 1/26/2026.

• Staff were educated to DME & RASP requirements during the annual employee education review by the administrator at the 1/21/2026 staff meeting. Staff will be re-educated by the administrator to all violations found and plans to ensure regulatory compliance during the current 1/6-7/2026 survey during the staff meetings scheduled for 2/16/26 and 2/18/26.

• The administrator or designee will audit five resident's RASPs's monthly times three months beginning 2/12/2026 to ensure compliance with 2600.227d. The results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 04/02/2026)

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

June 4, 2026

[redacted]
914 W MARKET STREET OPERATING COMPANY LLC
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #**: *33822* **License Expiration**: *03/24/2026*

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

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

Administrator

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

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/07/2000* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *97* **Waking Staff**: *73*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *03/24/2026*

Inspection Dates and Department Representative

03/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *76*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *74*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *21* **Have Physical Disability**: *2*

Inspections / Reviews

03/24/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2026*

05/05/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/12/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/12/2026*

Inspections / Reviews *(continued)*

06/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/12/2026*

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

182c - Medication Administration

4. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

Resident [redacted]s blood sugar is required to be checked 4 times daily at meals and bedtime. On [redacted], the glucometer shows a reading of [redacted] at 6:33am. This reading was documented on the Blood Sugar Documentation Sheet but was not documented on the resident's Medication Administration Record (MAR).

Plan of Correction ***Accept ([redacted] - 05/05/2026)***

• The blood glucose reading for Resident [redacted]on 3/19/26 of 96 at 6:33am was added to the resident's electronic record by the administrator on 4/16/2026 as a late entry.
• An audit of all resident MARs for the month of March 2026 was completed by the administrator on 4/6/2026 for any documentation errors.
• Any med techs indicated in missing or incorrect documentation from 4/6/2026 MAR audit are scheduled for re-education and disciplinary action as appropriate. Re-education was provided to all staff at the monthly staff meeting on 4/15/2026 by administrator to ensure concerns regarding 2600.182c are reported in a timely manner.
• The administrator will do a weekly audit of all MARs for four weeks and then monthly for two months beginning 4/20/2026 to ensure direct MAR documentation. Results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented [redacted] - 06/04/2026)

183b - Meds and Syringes Locked

5. 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 [redacted] at approximately 9:20am, a bottle of acetaminophen along with other over the counter medications were observed sitting on a cart unlocked and accessible in resident [redacted]s room. The resident is not assessed to self-administer medications.

Plan of Correction ***Accept ([redacted] 05/05/2026)***

• On 3/25/2026 resident's POA was notified by Resident Care Coordinator and came to collect any medications in the resident's room where an order could not be obtained for the resident to self-store/self-administer. Resident has been re-educated on multiple occasions and continues to order medications online.
• No other medications were observed in other resident rooms or in other areas where they would accessible to anyone who is unable to self-store/self-administer.
• Re-education was provided to all staff at the monthly staff meeting on 4/15/2026 by administrator to ensure

183b Meds and Syringes Locked (continued)

concerns regarding 2600.183b are reported in a timely manner. Re education was provided to all residents present at the monthly resident council meeting on 4/8/2026 by administrator and minutes were delivered to every resident on 4/15/2026 by the activities director.

• The administrator will do a weekly check of resident #1's room for four weeks and then monthly for two months beginning 4/20/2026 to ensure there are no medications present without self store/self administer orders present. Results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented (06/04/2026)

183e - Storing Medications

6. 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

Resident is prescribed . On the insulin pen was observed in the medication cart; however, the date the medication was opened, and the name of the resident was not documented on the

Plan of Correction ***Accept (- 05/05/2026)***

• At the time of survey on 3/24/26 the Administrator advised the med tech on duty to take a new pen out of the supply closet and to document the resident's name on it as well as the open date of 3/24/26.

• An audit of all insulin pens was conducted by the Administrator on 4/6/2026.

• Re education was provided to all staff at the monthly staff meeting on 4/15/2026 by administrator to ensure concerns regarding 2600.183e are reported in a timely manner.

• The administrator will do a weekly audit of all insulin pens to ensure they are labeled properly with resident name and open date for four weeks and then monthly for two months beginning 4/20/2026. Results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented - 06/04/2026)

184a - Resident's Meds Labeled

7. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.

Description of Violation

Resident is prescribed . On , the insulin pen was observed in the medication cart; however, the resident's name was not documented on the insulin pen.

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

Plan of Correction ***Accept [redacted] - 05/05/2026)***

• At the time of survey on 3/24/26 the Administrator advised the med tech on duty to take a new Glargine Insulin pen out of the supply closet and to document the resident's name on it as well as the open date of 3/24/26.
• An audit of all insulin pens was conducted by the Administrator on 4/6/2026.
• Re-education was provided to all staff at the monthly staff meeting on 4/15/2026 by administrator to ensure concerns regarding 2600.184a are reported in a timely manner.
• The administrator will do a weekly audit of all insulin pens to ensure they are labeled properly with resident name and open date for four weeks and then monthly for two months beginning 4/20/2026. Results of these audits will be kept by the administrator for quality assurance purposes.

Licensee's Proposed Overall Completion Date: *05/04/2026*

Implemented [redacted] - 06/04/2026)