pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ARDEN COURTS SUSQUEHANNA OF HARRISBURG PA LLC**
LEGAL ENTITY

To operate **ARDEN COURTS (SUSQUEHANNA)**
NAME OF FACILITY OR AGENCY

Located at **2625 AILANTHUS LANE, HARRISBURG, PA 17110**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **64**
(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 64**

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 **April 23,** **2024** until **April 23,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **324310**

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

EMAILING DATE: APRIL 23, 2024

[redacted]
Arden Courts-Susquehanna of Harrisburg PA LLC [redacted]
[redacted]

RE: Arden Courts (Susquehanna)
2625 Ailanthus Lane
Harrisburg, Pennsylvania 17110
License #: 324310

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 30, 2024, and January 31, 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

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

April 17, 2024

[redacted]
ARDEN COURTS SUSQUEHANNA OF HARRISBURG PA LLC
[redacted]

RE: ARDEN COURTS (SUSQUEHANNA)
2625 AILANTHUS LANE
HARRISBURG, PA, 17110
LICENSE/COC#: 32431

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/07/2023, 11/08/2023 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.

[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARDEN COURTS (SUSQUEHANNA)* **License #**: *32431* **License Expiration**: *03/08/2024*

Address: *2625 AILANTHUS LANE, HARRISBURG, PA 17110*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *ARDEN COURTS SUSQUEHANNA OF HARRISBURG PA LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/28/2000* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/08/2023*

Inspection Dates and Department Representative

11/07/2023 - On-Site: [redacted]

11/08/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *49*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *64* **Residents Served**: *49*

Hospice

Current Residents: *8*

Number of Residents Who:

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

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

Have Mobility Need: *49* **Have Physical Disability**: *0*

Inspections / Reviews

11/07/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/30/2023*

12/08/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2023*

Inspections / Reviews *(continued)*

01/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/15/2024*

04/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

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 11/07/2023, the home's partial inspections, dated 03/30/2023 and 07/12/2023, were not posted in a conspicuous and public place in the home.

Repeated Violation-02/07/2023, et al

Plan of Correction ***Accept (- 01/08/2024)***

Partial inspections were posted and fixed onsite on 11/7/2023 by placing them in a binder in the lobby. Executive Director was educated on time frame of these inspections needing to be posted by Licensing Representative. on 11/7/23.
Moving forward Executive Director will ensure compliance by placing new inspection summary directly into binder in the lobby. Executive Director and/or Designee will inspect binder monthly to ensure that all needed materials are in binder including current inspection summaries.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (- 04/17/2024)

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care Staff Person A, hired on /2023, is providing unsupervised ADL services. However, the staff person has no documentation that they completed and passed the Department-approved direct care training course and competency test.

Repeated Violation-02/07/2023, et al

Plan of Correction ***Directed - 01/08/2024)***

Direct Care Staff Person A was unable to access document even after reaching out help line for direct care staff training. Direct Care Staff Person A completed the new direct care staff training through Temple University on 11/8/2023. Training certificated attached.

Administrative Services Coordinator and Administrative Services Assistant were re-educated on this on 11/24/2023 by Executive Director. See attached.

Additionally, see attached documentation we send to staff prior to general orientation. The policy is that staff can no longer begin employment until they present the direct care staff certificate.

65d - Initial Direct Care Training (continued)

New Policy was started on 8/23/2023 by Executive Director and Administrative Services Coordinator.
Starting 11/10/2023 Administrative Services Coordinator and Administrative Services Assistive will audit all Direct Care Staff files to ensure that all have Department's Direct Care Certification. Audit will be complete before or by 11/13/2023. All Direct Care Staff files have been audited and all have the certification and are in compliance.

Proposed Overall Completion Date: 12/15/2023

-Directed-
If during the audit any Direct Care Staff are found to be missing their Direct Care Certification, those employees will immediately be supervised when providing care and not be allowed to provide unsupervised care until certification can be obtained.

Directed Completion Date: *01/08/2024*

Implemented [redacted] - 04/17/2024)

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 11/07/2023 at 9:58AM, 2 containers of Clorox Disinfecting Wipes with a Manufacture's label indicating "If swallowed, call a Poison Control Center or doctor immediately" and a bottle of Drug Buster Drug Disposal liquid with a Manufacture's label indicating "If shallowed, consult a physician or poison control center immediately" were unlocked, unattended, and accessible in the Health Center room. Not all the residents of the home, including Resident 1 and 5, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Health Center was recently switched from a traditional lock to a touch screen key pad. However, when the keypad was installed, the manual override mechanism was left on the back of the door. This was fixed immediately onsite on 11/7/2023 as the manual override mechanism was removed by the Building Services Coordinator. This door has no override and can only be opened via keypad lock.

All nurses that have access to the health center were educated on regulation 82c by Executive Director and the importance of making sure the Health Center door is locked at all times. In-service attached.

12/15/2023 Resident Services Coordinator will conduct random audits of the Health Center door 3 times a week for 6 weeks, during varies shifts to ensure it is secured and no unauthorized personnel have access to Health Center. If at anytime it is found during the audits there is noncompliance there will be reeducation and disciplinary action. Audits will then continue for a additional 3 weeks until compliance is maintained.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 04/17/2024)

84 - Heat Sources

4. Requirements

2600.
84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source.

Description of Violation

On 11/07/2023, there were no protective guards in place to prevent residents from coming in contact with the electric fireplace. It was observed the electric fireplace becomes very hot to the touch within 30 seconds of being turned on.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Electric fireplace had been installed by a contractor prior to inspection. Building Services Coordinator (Maintenance Director) immediately removed heating element on 11/7/23 when licensing representative brought this to [redacted] attention during initial walk through. BSC then ensured all decorative fireplaces throughout the building (total of 4) had no capability of heating. Moving forward upon any renovation to the building, BSC will inspect all upgraded pieces of furniture to ensure this will not happen again. [redacted] will sign off on inspection and keep in the life safety manual. See attached document.

BSC was also educated Executive Director on regulation on 11/27/23. See attached training log.

Proposed Overall Completion Date: 11/30/2023

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 04/17/2024)

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 11/07/2023, outside the door to the cottage in the courtyard, there is a piece of siding missing from the exterior wall, measuring approximately 6x24 inches.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Closest available color match siding ordered and was installed by BSC on 11/28/23. Exact color match siding backordered until January. Will replace to exact color upon delivery. Building Services Coordinator educated by Executive Director on regulation 88a. See attached.
Starting 12/18/2023 will conduct weekly inspections of the exterior building for any concerns by the Building Services Coordinator.
The weekly Checklist will be used that is already in place and exterior building will be added to it. If at anytime there is a concern during a weekly inspection the Building Services Coordinator will remedy the concern with in 72 hours or make contact with and set up a appointment with a contractor as soon as possible to fix the concern.
All staff will be educated by 12/31/2023 on submitting a work request/or inform Building Services Coordinator or any building issue concerns immediately.

88a - Surfaces (continued)

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] 04/17/2024)

103f - Refrigerator/Freezer Temps

6. 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

On 11/07/2023 at 10:20AM, the temperature in the refrigerator section of the Silver and Black GE refrigerator was 50 degrees Fahrenheit and the freezer section temperature was 10 degrees Fahrenheit.

On 11/08/2023 at 9:50AM, the same unit had a refrigerator section temperature of 50 degrees Fahrenheit and the freezer section temperature was 15 degrees Fahrenheit.

On 11/08/2023 at 1:21PM, the same unit had a freezer section temperature of 15 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

New refrigerator was immediately purchased on 11/7/2023 by the Building Services Coordinator and delivered on 11/10/23 from Home Depot. New refrigerator is in good working order as evidence by the temperature logs attached.

ED educated BSC and Dietary Department on regulation and moving forward, BSC will keep evidence of temperature logs in the life safety book.

12/15/2023 Regulation 103f on appropriate temperatures for all frozen foods was rereviewed with Food Service Coordinator and Building Services Coordinator by Executive Director. During this re-review the dietary staff was also educated by Executive Director on notifying the Building Services Coordinator to any temperature readings that exceed 40 degrees in the refrigerator and temperature readings over 0 degrees in the freezer section so that the Building Services Coordinator can adjust or repair the units accordingly. They must inform Building Services Coordinator within 24 hours of any high readings.
Temperature logs were correct on 12/12/2023 by Building Services Coordinator to reflect correct temp for the freezer temp of 0 degrees

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 04/17/2024)

132g - Fire Drills Days/Times

7. Requirements

2600.

132g - Fire Drills Days/Times *(continued)*

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the drills held on the following dates:
06/30/2023
07/31/2023
08/31/2023
09/30/2023
10/30/2023

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Discussion with Building Services Coordinator (Maintenance Director) to pre-schedule and begin varying the times the fire drills are conducted through the month. Educated by Executive Director 11/27/2023 on Regulation future compliance Building Services Coordinator will generate a pre-populated fire drill for the following year each December which will vary the times that fire drills are conducted through the month. The document will be kept secure by either the Executive or Building Service Coordinator to ensure no other staff become aware of the drill schedule for the year.
The pre-schedule was created on 11/22/2023 See attached in-service and see attached pre-planned schedule.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented ([redacted] - 04/17/2024)

132h - Designated Meeting Place

8. 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 03/30/2023 at 3:56PM, there were 46 residents in the home. However, only 14 residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 04/29/2023 at 3:37AM, there were 44 residents in the home. However, no residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 05/16/2023 at 1:05PM, there were 46 residents in the home. However, only 22 residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 06/30/2023 at 2:34PM, there were 48 residents in the home. However, no residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 07/31/2023 at 4:33PM, there were 54 residents in the home. However, only 10 residents evacuated to a designated meeting place or within the fire-safe area.

132h - Designated Meeting Place (continued)

During the fire drill on 08/31/2023 at 05:45AM, there were 54 residents in the home. However, no residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 09/30/2023 at 4:01PM, there were 52 residents in the home. However, only 10 residents evacuated to a designated meeting place or within the fire-safe area.

During the fire drill on 10/30/2023 at 7:55AM, there were 51 residents in the home. However, only 12 residents evacuated to a designated meeting place or within the fire-safe area.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Building Services Coordinator and Executive Director were educated on all drills needing to be full evacuation drills by licensing representative during LIS on 11.7.2023. Effective immediately, Building Services Coordinator has begun to run drills with full evacuation. See attached November 2023 Drill log. This will continue ongoing.
All staff will be educated by December 31, 2023 on the procedure to ensure that all residents participate with fire drills so that Residents are fully evacuated in the simulated affected area and also that Residents need to be ready to evacuate if they are not in an affected area aka fire safe area.

Building Services Coordinator was educated on regulation 132h by Executive Director on 11/27/23. See attached training log.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

132i - Testing Fire Alarm

9. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drill on 10/30/2023, the fire alarm was not sounded. In its place, staff indicated on the fire drill documentation a "Silent Drill" was used.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Building Services Coordinator and Executive Director were educated on all drills needing to have an active alarm by licensing representative during LIS. Effective immediately, Building Services Coordinator has begun to run drills with full alarm being set off. See attached November 2023 Drill log. This will continue ongoing.

Building Services Coordinator was educated on regulation 132i by Executive Director on 11/27/23. See attached training log.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

141b1 - Annual Medical Evaluation

10. Requirements

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

Description of Violation

Resident 5's most recent medical evaluation was completed on [redacted]08/2023. The resident's previous medical evaluation was completed on 01/18/2022.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

All medical evaluations were audited on 11/8/2023 by Resident Services Coordinator and are in compliance with proper dates . Nursing now has a tracking system which was put into place 11/8/2023 to ensure medical evaluations are done annually and accompanied by a signature from the medical director and POA.

All nursing staff were education and in-serviced on regulation 141b1 by Executive Director on 11/27/2023 and in-service is attached.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

183a - Original Containers and Injections

11. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 11/08/2023 at 11:41AM, there was half of a reddish/pink tab of medication discovered in a drawer of the Garden Hall med cart which was not in its original packaging and not being dispensed for administration.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Med Cart Audits are implemented in addition to completing sweep of each cart for loose medication. No additional medications were found. See attached Med Cart Audit Sample that will be implemented for each cart monthly. Medication Carts were audited by Resident Services Coordinator on 11/8/2023 to ensure there were no other loose medications in carts. Resident Services Supervisors will conduct monthly audits on carts and report any findings to Resident Services Coordinator. They will give Audit Tool to Resident Services Coordinator at completion of Audit monthly.

All nurses were educated on regulation 183a by Executive Director on 11/27/2023. See training attached.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

183b - Meds and Syringes Locked

12. Requirements

2600.

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

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 11/07/2023 at 9:58AM, resident routine medication baskets, PRN medications and OTC medications were unlocked, unattended, and accessible in the Health Care Center.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Health Center was recently switched from a traditional lock to a touch screen key pad. However, when the keypad was installed, the manual override mechanism was left on the back of the door. This was fixed immediately onsite on 11/7/2023 as the manual override mechanism was removed by the Building Services Coordinator. This door has no override and can only be opened via keypad lock.

All nurses that have access to the health center were educated on regulation 183b on 11/27/2023 by Executive Director and the importance of making sure the Health Center door is locked at all times. In-service attached.

12/15/2023 Resident Services Coordinator will conduct random audits of the Health Center door 3 times a week for 6 weeks, during varies shifts to ensure it is secured and no unauthorized personnel have access to Health Center. If at anytime it is found during the audits there is noncompliance there will be reeducation and disciplinary action. Audits will then continue for a additional 3 weeks until compliance is maintained.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

185a - Implement Storage Procedures

13. 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 1 is prescribed a PRN Dulcolax Suppository 10mg. On 11/08/2023, this medication was unavailable in the home.

Resident 3 is prescribed PRN Naloxone HCL 4mg Spray and PRN Ondansetron ODT 4mg tablet. On 11/08/2023, these medications were not available in the home.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Both medications were not used in the past 30-days and unnecessary per DON and Medical Director. These medications were discontinued by the medical director and no long reflected on the MAR.

185a - Implement Storage Procedures (continued)

All nursing staff educated on regulation 185a on 11/27/2023 on the necessity of discontinuing PRN medications that are not actively in use by ED and RSC. In-service attached.

On 11/13/2023 Resident Services Coordinator began conducting an audit of all Residents Medication Administration Records to ensure all needed medicines, as needed medicines and Over the counter medicines are present in the home. Resident Services Coordinator also did a audit for any medication orders that are no longer current or that are unnecessary. Orders will be obtained to have these medications discontinued. Audit was completed on 11/15/2023. Resident Services Coordinator will conduct monthly Resident Medication Administration audits to ensure that all medications are present in the home and that orders are correct

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident 3 is prescribed Novolog Flexpen 100 units/ML, inject 3 units subcutaneously if blood sugar is greater than 300. On the following dates, the resident's blood sugar levels were greater than 300. However, the resident did not receive the additional 3 units of Novolog:
On 11/03/2023 at 11:30AM, the resident's blood sugar was 314.
On 11/03/2023 at 4:30PM, the resident's blood sugar was 331.
On 11/04/2023 at 8:30PM, the resident's blood sugar was 338.
On 11/05/2023 at 4:30PM, the resident's blood sugar was 388.
On 11/06/2023 at 11:30AM, the resident's blood sugar was 336.
On 11/07/2023 at 11:30AM, the resident's blood sugar was 485.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Resident Services Coordinator confirmed the medication was given but was not recorded on MAR during those days. 11/8/2023 Resident Services Coordinator did a audit of the Medication Administration Records and will continue auditing daily for the next 2 weeks ending date 11/22/2023. If the audit finds an issue the Resident Services Coordinator will continue with 2 more weeks of audits until clear.
Resident Services Coordinator is now auditing the blood sugar MAR and binder daily to ensure completion of transcription.

All nurses were educated on regulation 187d on 11/27/2023 by Executive Director. See attached in-service attached.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 04/17/2024)

225c - Additional Assessment

15. Requirements

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

Description of Violation

Resident 4's current assessment was completed on [redacted]/2023. However, the resident's previous assessment was completed on 10/07/2021.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

All resident charts were audited on 11/9/2023 and completed by 11/15/2023 by Resident Services Coordinator and no other outstanding missing assessments were found. Resident Services Coordinator has a tickler system (note card for all residents with there info and dates that RASP and DME's are due organized by month) in place which has been audited as well. Monthly audits will be completed by Resident Services Coordinators to ensure compliance with state regulations this began on December 8 2023 going forward monthly.

All nursing staff were educated by Executive Director on 11/27/2023 on regulation 225c as evidence by in-service attached.

Proposed Overall Completion Date: 11/29/2023

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 04/17/2024)

16. 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 current assessment, dated 0[redacted]/2023, does not include resident started hospice services on 09/23/2023.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

All nursing staff were educated by Executive Director on 11/27/2023 on regulation 225c as evidence by in-service attached.
Residents charts were audited but Resident Services Coordinator beginning on 11/ 09/23 and completed on 11/16/2023 for compliance of additional assessments.
Resident Services Coordinator will use her cardex file system and 24 hour nursing reports to identify any change in conditions.
Resident Service Coordinator will do monthly audits of residents to ensure that all significant changes are identified this began 12/9/2023

Licensee's Proposed Overall Completion Date: *12/21/2023*

Implemented ([redacted] - 04/17/2024)

227d - Support Plan Medical/Dental

17. Requirements

2600.
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

The DME for Resident 1, dated 07/14/2023, indicates the resident has a need for a special diet to include mechanical soft foods and ground meats. However, the resident's current support plan, dated 07/18/2023, does not document how this need will be met and states "No Issues or Concerns".

The DME for Resident 2, dated 08/11/2023, indicates the resident has a need for a Special Diet to include "Pureed Texture.". However, the resident's current support plan, dated 08/15/2023, does not document how this need will be met and states "Resident cannot cut their own food".

On 11/08/2023, Resident 5 has an order in the kitchen for a mechanical soft diet. However, the resident's current support plan, dated 02/14/2023, does not document how this need will be met and states "No Issues or Concerns."

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

An audit was completed and all diet orders now match the Support Plans by Resident Services Coordinator starting on 11-8-2023 and ending on 11-22-2023
Starting on 12-26-2023 Resident Services Coordinator will a monthly audit of all residents with special diets to ensure diets reflect correctly on the Support Plan and with dietary.
If any diet changes Resident Services Coordinator will immediately add the special diet to the resident Care Plan and also notify the Dietary department.

All clinical staff were educated on 11/27/2023 by Executive Director regulated 227d. In-service attached.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 04/17/2024)

231c - Preadmission Screening

18. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/2022. However, the resident's written cognitive preadmission screening was completed on 01/18/2022.

Resident 1 was admitted to the SDCU on [redacted]2023. However, the resident's written cognitive preadmission

231c - Preadmission Screening (continued)

screening was completed on 07/14/2022.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Admissions Department and Nursing Staff educated by Executive Director on 11/27/2023 on regulation 231c. In-service attached. Moving forward, all admission paperwork will be audited by Executive Director/designee prior to a resident being admitted to ensure the timeliness of paper work.
Will utilize a check list to ensure that all documentation for admissions is within compliance. See attached sample form.

Licensee's Proposed Overall Completion Date: *12/21/2023*

Implemented ([redacted] - 04/17/2024)

236 - Staff Training

19. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care Staff Person B, who works in the Secure Dementia Care Unit (SDCU), had only 4.12 hours of training in dementia care during the 2022 training year.

Direct care Staff Person C, who works in the SDCU, had only 4.12 hours of training in dementia care during the 2022 training year.

Plan of Correction ***Accept ([redacted] 01/08/2024)***

Monitoring tools continue to be in place. This was also discussed in February 2023 in our initial annual LIS. Administrative Services Coordinator began monitoring for completion for 2023 after the February 2023 inspection and all staff are on track to be in compliance for end of calendar year 2023. 2022 trainings were looked at twice this year and we began fixing 2023 following our approved POC for 2023.
12/22/2023: Monitoring tool is online program with our company that can be checked daily/weekly/monthly to see who is current in their training.
Executive Director In-serviced Administrative Services Coordinator on 11/27/2023 again on regulation 236, and

236 - Staff Training (continued)

[redacted] *demonstrated understanding of completion and reiterated all staff will have required hours for EOY 2023.*

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 04/17/2024)

254c - Records Storing

20. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On 11/07/2023 at 9:58AM, all resident records were unlocked, unattended and accessible in the Health Center Room

Plan of Correction ***Accept ([redacted] 01/08/2024)***

Health Center was recently switched from a traditional lock to a touch screen key pad. However, when the keypad was installed, the manual override mechanism was left on the back of the door. This was fixed immediately onsite on 11/7/2023 as the manual override mechanism was removed by the Building Services Coordinator. This door has no override and can only be opened via keypad lock.

ll nurses that have access to the health center were educated on regulation 254c on 11/27/2023 by Executive Director and the importance of making sure the Health Center door is locked at all times. In-service attached.

12/15/2023 Resident Services Coordinator will conduct random audits of the Health Center door 3 times a week for 6 weeks, during varies shifts to ensure it is secured and no unauthorized personnel have access to Health Center. If at anytime it is found during the audits there is noncompliance there will be reeducation and disciplinary action. Audits will then continue for a additional 3 weeks until compliance is maintained.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 04/17/2024)

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

April 17, 2024

[redacted]
ARDEN COURTS SUSQUEHANNA OF HARRISBURG PA LLC
[redacted]

RE: ARDEN COURTS (SUSQUEHANNA)
2625 AILANTHUS LANE
HARRISBURG, PA, 17110
LICENSE/COC#: 32431

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/30/2024, 01/31/2024 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARDEN COURTS (SUSQUEHANNA)* **License #**: *32431* **License Expiration**: *03/08/2024*

Address: *2625 AILANTHUS LANE, HARRISBURG, PA 17110*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *ARDEN COURTS SUSQUEHANNA OF HARRISBURG PA LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/28/2000* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal, Provisional, Interim* **Exit Conference Date**: *01/31/2024*

Inspection Dates and Department Representative

01/30/2024 - On-Site: [redacted]

01/31/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *49*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *64* **Residents Served**: *49*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *49* **Have Physical Disability**: *0*

Inspections / Reviews

01/30/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/15/2024*

03/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/29/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/11/2024*

Inspections / Reviews *(continued)*

03/22/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/29/2024*

04/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2024*

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

85e - Trash Outside Home

1. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 01/30/23 at approximately 8:55 AM, the trash dumpsters were observed overflowing with trash. On 01/30/23 at approximately 2:00pm both dumpsters were observed cleared of trash but remained opened.

Plan of Correction ***Accept [redacted] - 03/22/2024)***

In response to the violation on 01/30/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 01/30/2024 by the Building Services Coordinator to Both dumpsters lids were closed after the 2pm time by the Building Services Coordinator.

To enhance the currently compliant operations:
1. Staff was in-serviced on 2/5 and 2/6/2024 by Resident Services Coordinator on Regulation 85e. See Attached Staff Development Records
2. Signs were posted on Dumpsters as reminders to close doors at all times on 2/5/24. See attached documents.
3. Immediately on 2/1/24, a daily tracking document (daily rounds) was implemented into the BSC's daily rounds checklist. See attached document.
4. Upon executive director's return from maternity leave on [redacted]/24, the plan of correction was implemented.

Effective 01/31/2024 the Building Services Coordinator/designee will perform daily checks through 02/29/2024 to maintain ongoing compliance with keeping trash outside the home in covered receptacles that prevent the penetration of insects and rodents these receptacles will be monitored daily to ensure that lids are down and sliding door is closed.
Executive Director will over see ongoing Plan of Correction to ensure compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Implemented ([redacted] 04/08/2024)

103i - Outdated Food

2. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 01/30/24 the kitchen refrigerator in the Boathouse Cove household was observed containing wrapped, unlabeled, and undated lunch meat.

Plan of Correction ***Accept[redacted] - 03/01/2024)***

In response to the violation on 01/30/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

103i - Outdated Food (continued)

1. *On 01/30/2024 by the Resident Services Coordinator to remove out dated food from Refrigerator.*
2. *On 1/30/2024 Resident Services Coordinator checked all other refrigerators on the other house to ensure that there was no other wrapped ,unlabeled and undated food.*

To enhance the currently compliant operations, on 2/5-2/6/2024 staff were in-serviced on Regulation 103i by Resident Services Coordinator. See attached Staff Development Record.

To maintain ongoing compliance with regulation 103i effective 2/2/2024 the Food Services Coordinator/designee will perform weekly checks through 3/2/2024 to maintain ongoing compliance with labeling and dating of all food items that require to be labeled and dated in the each House Kitchen. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Executive Director will oversee Plan Of Correction to ensure ongoing compliance

Licensee's Proposed Overall Completion Date: *03/02/2024*

Implemented [redacted] - 04/08/2024)

185a - Implement Storage Procedures

3. 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 #2 is prescribed Diphenhydramine (Benadryl) 50 MG give 1 tab by mouth every 6 hours as needed. DX. Insomnia/EPS. On 01/31/24 at approximately 11:00 AM, the medication was not found in the home.

Plan of Correction ***Accept [redacted] - 03/01/2024)***

In response to the violation on 01/30/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken 1/31/2024 by the Resident Services Supervisor to contact the Physician and have the medication Discontinued.

To enhance the currently compliant operations, on 2/5-2/6/2024 the Resident Services Coordinator in-serviced the Resident Services Supervisors on Regulation 185a. See attached Staff Development Sheets.

Effective 2/12/2024 through 3/12/2024 the LPN's (Resident Services Supervisors) will perform Medication Cart Audits and the Resident Services Coordinator will review them. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Executive Director will oversee Plan of Correction for ongoing compliance

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: *02/16/2024*

Implemented [redacted] - 04/08/2024)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

Resident #1 is prescribed Novolog Flexpen 100 Units/ML 100/ML Insulin Pen Inject 4 Units Subcutaneously before meals, hold if blood sugar is less than 200. DX: DM II.

- *On 01/19/24 at 7:30 AM Resident #1's blood glucose level measured 167, the Sliding Scale Coverage and Glucose Monitoring Flow Sheet used to document insulin administration, documents 4 Units of Novolog was administered to Resident #1.*

The Sliding Scale Coverage and Glucose Monitoring Flow Sheet does not document if the resident was administered 4 Units of Novolog on the following dates where Resident #1's blood glucose was measured at greater than 200:

- *On 01/15/24 at 11:30 AM the blood glucose level measured at 252, and 289 at 4:30 PM.*
- *On 01/24/24 at 11:30 AM the blood glucose level measured at 354, and 404 at 4:30 PM.*
- *On 01/27/24 at 07:30 AM the blood glucose level measured at 235, and 348 at 11:30 AM.*

Repeated Violation-11/7/23, et al

Plan of Correction ***Accept [redacted] - 03/01/2024)***

In response to the violation on 01/30/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken by Resident Services Coordinator to ensure that all Blood Glucose Monitoring Flow Sheets and all insulin had been documented. Resident 1 is the only one that receives Blood Glucose Monitoring and Insulin.

To enhance the currently compliant operations, on 2/5-2/6/2024 the LPN's were re-in-serviced by Resident Services Coordinator on Regulation 187d. See attached Staff Development Sheets.

Effective 2/5/2024 the Resident Services Coordinator/designee will now conduct daily Medication Review Audits to ensure that Glucose Monitoring is accurate to maintain ongoing compliance with Regulation 187d. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. See attached Audit Tool.

Executive Director will oversee Plan Of Correction for over all compliance

187d - Follow Prescriber's Orders *(continued)*

Licensee's Proposed Overall Completion Date: *02/16/2024*

Implemented [redacted] - 04/15/2024)

234a - Admission Support Plan

5. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/24. However, the resident's initial support plan was not completed until 1/14/24.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/23. However, the resident's initial support plan was not completed until 7/3/23.

Plan of Correction ***Accept [redacted]/22/2024)***

To enhance the currently compliant operations, on 2/5-2/6/2024 the Health and Wellness Specialist in-serviced the Resident Services Coordinator and Resident Services Supervisors on Regulation 234a. See attached Staff Development Record

Effective 2/12/2024 the Executive Director/Designee will audit all new admissions 72 hours after move-in to maintain ongoing compliance with 234a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. See Attached Audit Sheet.

Executive Director will oversee Plan Of Correction for ongoing compliance beginning on 3/19/24.

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

Implemented [redacted] - 04/08/2024)

254c - Records Storing

6. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On 01/30/24 at 9:55 AM, the top drawer in the Garden Path House Kitchen area was observed unattended, unlocked, and accessible containing a green binder which in turn contained resident names, hospice statuses and special diets.

On 01/30/24 at 10:00 AM, the cabinet in the Cottage Place kitchen area was observed unattended, unlocked, and accessible showing a yellow sheet of paper taped to the inside of the cabinet door which lists residents' names and

254c - Records Storing (continued)

dietary needs.

Repeated Violation-11/7/23, et al

Plan of Correction ***Accept [redacted] 03/22/2024)***

In response to the violation on 01/30/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 1/20/24 to lock all records in all houses in a secured area above the microwave which has a self locking device once the cabinet is closed. All papers taped to the inside of doors where removed and placed in binder and secured in the same area as above the microwave. On 3/19/24, executive director added additional audit measure by ensuring the cabinets are locked in each kitchen during the daily rounds as evidence by the daily rounds checklist. See attached.

To enhance the currently compliant operations, on 2/5-2/6/24 staff were in-serviced on Regulation 254c by the Resident Services Coordinator. See attached Staff Development Plan

Effective 2/12/2024 the Resident Services Coordinator/Designee will do spot checks through out the day to ensure that proper Record Storing is being maintained. This is to maintain ongoing compliance with 254c Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Executive Director to oversee Plan of Correction for overall compliance upon return from maternity leave, on [redacted]/24.

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

Implemented ([redacted] - 04/08/2024)