



**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE**

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Room 230  
Pittsburgh, Pennsylvania 15222

**ADULT RESIDENTIAL LICENSING**

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Mailing Date: JUN 15 2012

Mr. Barry A. Lazarus, Vice President  
Arden Courts of Jefferson Hills, PA, LLC  
333 North Summit Street  
Toledo, Ohio 43604

RE: Arden Courts of Jefferson Hills  
380 Wray Large Road  
Jefferson Hills, Pennsylvania 15025

Dear Mr. Lazarus:

As a result of the Department of Public Welfare's licensing inspection on May 22, 2012, of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.

All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.

Sincerely,

A handwritten signature in cursive script that reads "Maria Stepanovich".

Maria Stepanovich  
Regional Licensing Administrator

Enclosure(s)



Violation Report: 43551 - 05/22/2012 - Garrigan, Laurie

1. REGULATION 55 Pa.Code §2600.

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2. DESCRIPTION OF VIOLATION

At approximately 6:30 PM on 5/17/12, resident #2's [redacted] was in resident #1's mouth, and resident #1 was crying and saying, "No". This took place in the dining room. Residents #1 and #2 were alone at the time. Staff person A immediately separated the two residents and assisted resident #1 with a shower. Within approximately 30 minutes of the event, resident #1 returned to the living room, where residents #2 and #3 were seated. Resident #1 sat on the opposite side of the living room from residents #2 and #3. These three residents were left unsupervised for approximately 10 minutes, while staff person A left the room. When staff person A returned to the living room, resident #1 was saying, "No, stop. Don't do this". Resident #2 had his/her hand placed up resident #1's nightgown. Resident #2 had moved from where he/she was sitting to the location of resident #1.

Both residents #1 and #2 have a diagnosis of dementia and reside in a secured dementia care unit. Resident #2 is at a higher functioning level than resident #1.

Direct care staff person A and staff person B, administrator, indicated resident #2 was placed on 15 minute checks earlier in the day, due to resident #2 telling staff person C, "I sure wish someone would take advantage of me, but you are too young to understand". However, there was no documentation of the 15 minute checks and they were not being done. Staff person D was not aware of the 15 minute checks that were to be implemented.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident #1 was sent to the emergency room for evaluation on 5/17/2012 following the incident. [redacted] returned to the facility that same night and was placed on 15 minute checks until 5/22/2012 (Attachment 1). The support plan for Resident #1 has been updated to include monitoring for signs and symptoms of anxiety related to this incident (Attachment 2). Resident #1 was seen by [redacted] physician on 6/11/2012 as a post-incident evaluation (Attachment 3). No signs or symptoms of anxiety related to this incident have been observed as of this time (Attachment 4).

Area Agency on Aging and Jefferson Hills Police Department were called to the facility on 5/17/2012 following the incident to investigate the situation. Upon completion of their investigation, Resident #2 was admitted to the hospital that same night for further evaluation. Resident #2 has been permanently discharged from the facility (Attachment 5).

Resident #3 did not appear to have any anxiety related to this incident at time of occurrence. Resident #3 will be seen by [redacted] physician on 6/11/2012 to evaluate for any signs or symptoms of anxiety related to this incident (Attachment 6). The support plan for Resident #3 has been updated to include ongoing monitoring for signs and symptoms of anxiety related to this incident (Attachment 7). No signs or symptoms of anxiety related to this incident have been observed as of this time (Attachment 8).

RECEIVED

JUN 12 2012

Western Field Office Adult Residential Licensing

See Attachment A

Repeat Violation: NO (ms) Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) Kristin Kahler

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristin Kahler, Executive Director Date 6-11-12

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

The above plan of correction is approved as of 6/13/12 (Date) Verification of Legal Entity Representative Signature 6/13/12 (Date)

The above plan of correction was approved by ms (Initials) Fully Implemented Partially Implemented - Adequate Progress Partially Implemented - Inadequate Progress ms Not Implemented

## Arden Courts of Jefferson Hills

At staff meetings to be held on 6/14 and 6/15/2012, all staff will be inserviced on the policy and procedures for Fifteen and Thirty Minute Resident Monitoring (Attachment 9). In addition, the staff meeting will also review abuse reporting (Attachment 10) and managing sexual behaviors with dementia residents (Attachment 11).

On 5/30/2012 Staff member A was inserviced on Resident Abuse and Abuse Reporting (See Attachment 10).

██████████ from Area Agency on Aging Protective Services will be conducting an inservice on resident abuse and the Older Adult Protective Services Act on 7/13/2012.

The list of residents on fifteen or thirty minute checks will be reviewed and documented at the daily morning meeting to ensure that the list is complete for all residents that require the need for more frequent checks (Attachment 12).

By 7/13/12 - The administrator or designated staff person will review supervision needs of all residents and ensure the home is providing each resident the supervision needed.  
ms 6/13/12

Maia Stepanovich  
MARIA STEPANOVICH, Regional Licensing Administrator

Kristin M. Kahler  
Kristin Kahler, Executive Director 6-11-12