Department of Human Services
Bureau of Human Service Licensing

June 30, 2021

[redacted] REGIONAL EDUCATION DEVELOPMENT
ARDEN COURTS OF MONROEVILLE PA LLC
333 NORTH SUMMIT STREET,16TH FL
ATTN LICENSURE SUPPORT
TOLEDO, OH 43604

RE: ARDEN COURTS OF MONROEVILLE
120 WYNGATE DRIVE
MONROEVILLE, PA, 15146
LICENSE/COC#: 43552

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/09/2021, 03/10/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jody Garvey

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *ARDEN COURTS OF MONROEVILLE* **License #**: *43552* **License Expiration Date**: *05/23/2021*
Address: *120 WYNGATE DRIVE, MONROEVILLE, PA 15146*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4123801300* **Email**: [redacted]

Legal Entity

Name: *ARDEN COURTS OF MONROEVILLE PA LLC*
Address: *333 NORTH SUMMIT STREET,16TH FL, ATTN LICENSURE SUPPORT, TOLEDO, OH, 43604*
Phone: *4123801300* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/22/1998* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff**: *113* **Waking Staff**: *85*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Incident* **Exit Conference Date**: *03/10/2021*

Inspection Dates and Department Representative

03/09/2021 - On-Site: [redacted]
03/10/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *56* **Residents Served**: *56*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *56* **Have Physical Disability**: *0*

Inspections / Reviews

03/09/2021 - Full

Lead In pector: ████ **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/27/2021*

3/31/2021 POC Submi ion

Lead Reviewer: ████ **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/04/2021*

4/6/2021 - POC Submission

Lead Reviewer: ████ **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/10/2021*

6/30/2021 - Document Submission

Lead Reviewer: ████ **Follow-Up Type:** *Not Required*

15a - Resident Abuse Report

1. **Requirements**

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 2/20/21 between 5:00 p.m. and 5:30 p.m., resident #1 slowly walked into ██ bedroom with staff person A following behind. Staff person A pushed resident #1 in the back causing the resident to lose ██ balance and fall onto ██ bed and bedside table. Staff person A then assisted resident #1 into ██ bathroom, forcefully removed ██ shirt while ██ resisted and screamed, and pulled ██ pants and brief down below ██ knees for incontinence care. Resident #1 repeatedly tried to pull ██ pants back up and each time staff person A pushed ██ pants back down while grabbing and forcefully pushing on ██ hands and lower arms. Staff person A yelled at the resident, "Stop it! Do you see the poop? Look down!" Staff person A continued to yell at resident #1, "Look at the poop! Look! You comprehending that?" As the resident stood backed into the corner of the bathroom, staff person A yelled directly in resident #1's ear, "You shit yourself!"

Staff person B and staff person C heard the yelling and screaming from resident #1's bedroom. Staff person B entered the room to assist and both staff person A and staff person B entered the bathroom with resident #1. Staff person A said to staff person B in front of resident #1, "I cannot make ██ understand that ██ totally shit ██"

The event was not reported to the local Area Agency on Aging until 3/1/21 at 1:00 p.m.

Plan of Correction **Accept**

The incident was not reported until 3/1/2021 to DHS and Adult Protective Services since family only told supervisor of the incident that day and provided ██ video documentation of the event. Once supervisor was made aware all agencies were notified immediately (see attachment A). Monroeville Police were notified (██
Resident immediately had a full body assessment completed and subsequent full body assessment completed for the following 2 days (see addendum B). The resident physician was immediately notified, and the resident was seen the next morning. ██ was assessed immediately for any mental distress due to the incident by the ██, no deficit was noted (addendum C).
Staff was re-educated on being front line reporters, and the need to report any suspected abuse (physical as well as erbal) immediately.
On 3/11/2021,3/12/2021 and 3/13/21 staff, including agency, had a mandatory in-service on Act 13/14 Reporting, How to complete Act 13/14 reporting form, Resident Rights, Mandatory Abuse Reporting, Front Line Reporting (how as the witness to the abuse they need to be the reporter as opposed to the supervisor), Designated Person Notification, and Safe Management Techniques highlighting "Pushing, Hitting, Striking, Yelling or Threatening with Words" (Addendum D).
The telephone number for the Elder Abuse Hotline has been placed on the back of their ID badge for easy access.
Going forward all new hires will receive the same education as part of their initial orientation (Addendum E).
Beginning 4/1/2021, the Executive Director or designee shall audit all new hire records by the end of day 2 of work to ensure orientation training in Elder Abuse and Safe Management Techniques has been completed (Addendum F).

Completion Date: *03/18/2021*

Document Submission **Implemented**

see attached

15b - Supervisor Plan

1. **Requirements**

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 2/20/21 between 5:00 p.m. and 5:30 p.m., resident #1 slowly walked into [redacted] bedroom with staff person A following behind. Staff person A pushed resident #1 in the back causing the resident to lose [redacted] balance and fall onto [redacted] bed and bedside table. Staff person A then assisted resident #1 into [redacted] bathroom, forcefully removed [redacted] shirt while [redacted] resisted and screamed, and pulled [redacted] pants and brief down below [redacted] knees for incontinence care. Resident #1 repeatedly tried to pull [redacted] pants back up and each time staff person A pushed [redacted] pants back down while grabbing and forcefully pushing on [redacted] hands and lower arms. Staff person A yelled at the resident, "Stop it! Do you see the poop? Look down!" Staff person A continued to yell at resident #1, "Look at the poop! Look! You comprehending that?" As the resident stood backed into the corner of the bathroom, staff person A yelled directly in resident #1's ear, "You shit yourself!"

Staff person B and staff person C heard the yelling and screaming from resident #1's bedroom. Staff person B entered the room to assist and both staff person A and staff person B entered the bathroom with resident #1. Staff person A said to staff person B in front of resident #1, "I cannot make [redacted] understand that [redacted] totally shit [redacted]."

The home did not immediately develop and implement a plan of supervision or suspend staff person A.

15b - Supervisor Plan *(continued)*

Plan of Correction **Accept**

The incident was not reported until 3/1/2021 to DHS and Adult Protective Services since family only told supervisor of the incident that day and provided [redacted] video documentation of the event. Once supervisor was made aware all agencies were notified immediately (see attachment A). Monroeville Police were notified ([redacted]
Resident immediately had a full body assessment completed and subsequent full body assessment completed for the following 2 days (Addendum B). The resident physician was immediately notified, and the resident was seen the next morning. [redacted] was assessed immediately for any mental distress due to the incident by the [redacted]. No deficit was noted addendum C).
The staffing agency was notified of the allegation. Staff person 1's last shift was [redacted]. The agency at that time was notified not to send [redacted] back. [redacted] contract employment with the facility has been terminated.
Staff was re-educated on being front line reporters, and the need to report any suspected abuse (physical as well as erbal) immediately.
On 3/11/2021, 3/12/2021 and 3/13/2021 staff, including agency, had a mandatory in-service on Act 13/14 Reporting, how to complete Act 13/14 reporting form, Resident Rights, Mandatory Abuse Reporting, Front Line Reporting (how as the witness to the abuse they need to be the reporter as opposed to the supervisor), Designated Person Notification, and Safe Management Techniques highlighting "Pushing, Hitting, Striking, Yelling or Threatening with Words" (Addendum D). Supervisor education included re-education that anytime there is a suspected abuse allegation the staff member must immediately be suspended until investigation completed. Executive Director and RSC will be immediately notified involving the suspension. There will be additional education on this at the mandatory supervisor meeting on April 19,2021
The telephone number for the Elder Abuse Hotline has been placed on the back of their ID badge for easy access.
Going forward all new hires will receive the same education as part of their initial orientation (Addendum E).
Staff has been oriented on the policy of immediate reporting to Area Agency on Aging and the reporting of incidents to the Personal Care Home Regional office.
A copy of the policy has been posted in the Health Center for access to all nursing staff 24/7.
Executive Director or designee will review all incident reports for timely reporting. bi-weekly, and documentation will kept.
Beginning 4/1/2021, the Executive Director or designee shall audit all new hire records by the end of day 2 of work to ensure orientation training in Elder Abuse and Safe Management Techniques has been completed (Addendum F).

Completion Date: *04/04/2021*

Document Submission **Implemented**

see attached

16c - Written Incident Report

1. **Requirements**
   2600.

16c - Written Incident Report *(continued)*

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Repeat Violation

On 2/20/21 between 5:00 p.m. and 5:30 p.m., resident #1 slowly walked into ██ bedroom with staff person A following behind. Staff person A pushed resident #1 in the back causing the resident to lose ██ balance and fall onto ██ bed and bedside table. Staff person A then assisted resident #1 into ██ bathroom, forcefully removed ██ shirt while ██ resisted and screamed, and pulled ██ pants and brief down below ██ knees for incontinence care. Resident #1 repeatedly tried to pull ██ pants back up and each time staff person A pushed ██ pants back down while grabbing and forcefully pushing on ██ hands and lower arms. Staff person A yelled at the resident, "Stop it! Do you see the poop? Look down!" Staff person A continued to yell at resident #1, "Look at the poop! Look! You comprehending that?" As the resident stood backed into the corner of the bathroom, staff person A yelled directly in resident #1's ear, "You shit yourself!"

Staff person B and staff person C heard the yelling and screaming from resident #1's bedroom. Staff person B entered the room to assist and both staff person A and staff person B entered the bathroom with resident #1. Staff person A said to staff person B in front of resident #1, "I cannot make ██ understand that ██ totally shit ██"

The event was not reported to the Department until 3/1/21 at 1:30 p.m.

Repeat Violation: 7/7/20

Plan of Correction **Accept**

Staff Person A was an agency employee. Immediately the agency was notified of the suspected abuse and was nstructed not to send back the agency employee. Staff person A employment was terminated on ██ after ██ ast shift from ██
Staff from Arden Courts and agency staff have been re-educated on being front line reporters, and the need to report any suspected abuse (physical as well as verbal) immediately. Agency orientation packet contains "Safe Management Techniques" for review prior to start of first shift.
On 3/11/2021,3/12/2021 and 3/13/2012 staff (Arden Courts and Agency) had a mandatory in-service on Act 13/14 Reporting, how to completed Act 13/14 reporting form, Resident Rights, Mandatory Abuse Reporting, Front Line Reporting (how as the witness to the abuse they need to be the reporter as opposed to the supervisor), Designated Person Notification, and Safe Management Techniques highlighting "Pushing, Hitting, Striking, Yelling, or Threatening with Words" (Addendum D).
The telephone number for the Elder Abuse Hotline has been placed on the back of their ID badge for easy access. Going forward all new hires will receive the same education as part of their initial orientation (Addendum E).
On 3/24/21 all management staff /nursing supervisors were educated on procedure on reporting in a timely manner to Agency on Aging and the Personal Care Home Regional Office as part of the 1st quarter quality assurance meeting.
Beginning 4/1/2021, the Executive Director or designee shall audit all new hire records and agency orientation checklist by the end of day 2 of work to ensure orientation training in Elder Abuse, Safe Management Techniques has been completed (Addendum F). Reporting incident reports to DHS will be In- serviced for a second time on 4/19/2021 mandatory meeting. Documentation will be kept.

Completion Date: *04/04/2021*

16c - Written Incident Report *(continued)*

Document Submission **Implemented**

see attached

42b - Abuse

1. **Requirements**

2600.

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

Description of Violation

On 2/20/21 between 5:00 p.m. and 5:30 p.m., resident #1 slowly walked into ██ bedroom with staff person A following behind. Staff person A pushed resident #1 in the back causing the resident to lose ██ balance and fall onto ██ bed and bedside table. Staff person A then assisted resident #1 into ██ bathroom, forcefully removed ██ shirt while ██ resisted and screamed, and pulled ██ pants and brief down below ██ knees for incontinence care. Resident #1 repeatedly tried to pull ██ pants back up and each time staff person A pushed ██ pants back down while grabbing and forcefully pushing on ██ hands and lower arms. Staff person A yelled at the resident, "Stop it! Do you see the poop? Look down!" Staff person A continued to yell at resident #1, "Look at the poop! Look! You comprehending that?" As the resident stood backed into the corner of the bathroom, staff person A yelled directly in resident #1's ear, "You shit yourself!"

Staff person B and staff person C heard the yelling and screaming from resident #1's bedroom. Staff person B entered the room to assist and both staff person A and staff person B entered the bathroom with resident #1. Staff person A said to staff person B in front of resident #1, "I cannot make ██ understand that ██ totally shit ██████"

42b - Abuse *(continued)*

Plan of Correction **Accept**

On 2/20/2021 at about 5:30 pm Resident 1 was observed with a dirty brief. ██ was taken to ██ room by Staff Person A, an Agency staff person. The resident has a diagnosis of Dementia/Alzheimer's and Anxiety. Staff Person A was observed pushing, pulling, cursing, and being overly aggressive with Resident 1.
The incident was not reported until 3/1/2021 to DHS and Adult Protective Services since family only told supervisor the incident that day and provided ██ video documentation of the event. Once Supervisor was made all agencies were notified immediately (see attachment A). Monroeville Police were notified (██████ Resident mmediately had a full body assessment completed and subsequent full body assessment completed for the following 2 days (Addendum B). The resident physician was immediately notified, and the resident was seen the next morning. He was assessed immediately for any mental distress due to the incident by the RSS No deficit was noted (Addendum C).
Staff was re-educated on being front line reporters, and the need to report any suspected abuse (physical as well as erbal) immediately.
On 3/11/2021, 3/12/2021 and 3/13/2021 staff had a mandatory in-service on Act 13/14 Reporting, How to complete Act 13/14 reporting form, Resident Rights, Mandatory Abuse Reporting, Front Line Reporting (how was a witness to the abuse they need to be the reporter as opposed to the supervisor), Designated Person Notification, and Safe Management Techniques highlighting "Pushing, Hitting, Striking, Yelling, or Threatening with Words". The telephone number for the Elder Abuse Hotline has been placed on the back of their ID badge for easy access. Going forward all new hires will receive the same education as part of their initial orientation (Addendum D).
Beginning 4/1/2021, Executing Director or designee shall audit all new hire records by the end of day 2 of work to ensure orientation training in Elder Abuse, Safe Management Techniques has been completed (Addendum E). These files will be reviewed again at the QA meeting by the QA team, incident reports will also be reviewed at the time. A record of the QA meeting will be kept on file.
There will be 4 residents interviewed monthly (one from each house) and asked how they are being treated, is care being provided, and if they are feeling threatened in any way. Documentation will be kept of the interviews.

Completion Date: *03/30/2021*

Document Submission **Implemented**

see attached

85a - Sanitary Conditions

1. **Requirements**

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

Description of Violation

On 3/9/21 at 10:20 a.m., there were no paper towels, mechanical air dryer, individual cloth towels or other sanitary means of drying hands in the bathroom of bedroom ██

85a - Sanitary Conditions *(continued)*

Plan of Correction **Accept**

No paper towels, mechanical air dryer, individual cloth towels or other sanitary means of drying hands was available n bedroom ■
When housekeeping deep cleans a room they remove all sheets and towels from the room and immediately place in aundry for cleaning. Housekeeping would replace these supplies when they were done cleaning the room. On this occasion they were in the laundry room and had not replaced the towels immediately.
The housekeeper was asked immediately to replace the towels in each bathroom. They have been instructed to carry a clean set of towels when cleaning a room and immediately upon removal of the dirty one they are to replace with a clean one.
All staff has been educated on checking each time they go in to a room to check for towels and replace if missing.
Housekeeping will always keep a set of clean towels to place immediately in rooms if they clean a room and towels are missing (Addendum G).
A daily check will be done on each shift by the supervisor that towels are present in each bathroom. Documentation will be kept on the daily check list (Addendum G).
The Executive Director or designee will review checklist for documentation of checks. The daily check lists will be reviewed at the quarterly quality assurance meeting by the QA team.

Completion Date: *03/30/2021*

Document Submission **Implemented**

see attached

91 - Telephone Numbers

1. **Requirements**

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 3/9/21 at 10:05 a.m., there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the Berry Ridge kitchen.

Plan of Correction **Accept**

On 3/9/2021 at 10:05 a.m., there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the Berry Ridge kitchen. These numbers have been taped to the counter by the phone. Residents will peel the tape up and take the numbers with
The phone numbers have been laminated and adhered to the small wall space between the kitchen counter and the shelf above the phone and attached to the telephone cord (Addendum J).
By placing on the wall/telephone cord this may deter residents from trying to pick it up and remove it. Staff will erify daily that the numbers have not been remove There is also a copy of the emergency telephone numbers being placed on the cabinet alongside the phone for immediate access.
As part of the daily checklist, it will be verified that telephone numbers are remaining in place. Documentation will be kept on file and reviewed at the quarterly QA meetings.

Completion Date: *03/30/2021*

91 - Telephone Numbers *(continued)*

Document Submission **Implemented**

se attached

102f - Towel/Washcloth/Soap

1. **Requirements**

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

On 3/9/21 at 10:20 a.m., there was no soap at the sink in the bathroom of bedroom [redacted].

Plan of Correction **Accept**

102f
No soap was available in bedroom [redacted]
mmediately pump soap was placed in resident [redacted] bedroom.
The housekeeper was immediately asked to place in the resident's room.
On 3/11/2021,3/12/2021 and 3/13/2012 staff (Arden Courts and Agency) were educated to check that soap regulation 102f) is available in resident rooms at all times. Housekeeping/caregivers will replace if/when they see it s missing out of the bathroom. The room will be checked by caregivers each time they are in the room.
From April 1 to April 30,2021 there will be a checklist placed in each resident's bathroom that will be completed daily when room checked for soap. All staff will be educated by 4/1/2021 on monitoring soap in resident's rooms. Documentation will be kept. They will have All staff will receive addition education on 102f at the mandatory staff meeting on 4/19/2021.Instructions to check on each shift at a minimum if there is soap in each bathroom. Documentation will be kept on the daily check list.
The Executive Director or designee will review the checklists at the end of 30 days.
The QA team at the quarterly meeting will review frequency of missing soap reported on the reports.

Completion Date: *04/04/2021*

Document Submission **Implemented**

see attached

102h - Toilet Paper

1. **Requirements**

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 3/9/21 at 11:00 a.m., there was no toilet paper for the toilet in the bathroom of bedroom [redacted].

102h - Toilet Paper *(continued)*

Plan of Correction **Accept**

ON 3/9/2021 at 11:00 a.m., there was no toilet paper for the toilet in the bathroom of bedroom ███. There was no spare roll under the sink in the bathroom. Upon discussion with staff, Resident █ packs ██ belonging daily to take home with ██. ██ packs the toilet paper to take home with ██ for ██ ██████
Additional toilet paper roll was placed under the bathroom sink and in the resident's closet so there is always toilet paper available in the room.
Staff will check daily to see if there is sufficient toilet paper on the roll and for a spare roll under the sink. There will be a checklist (Addendum H) placed in the bathroom so staff can initial daily when checked for the next 30 days. These checklists will be maintained and reviewed at the Quarterly QA meeting to monitor for trends of frequency of missing toilet paper.

Completion Date: *03/30/2021*

Document Submission **Implemented**

see attached

102i - Soap Dispenser

1. **Requirements**

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 3/9/21 at 11:00 a.m., there were two unlabeled used bars of soap in grey plastic dishes on the sink counter in the bathroom of bedroom ███

102i - Soap Dispenser *(continued)*

Plan of Correction **Accept**

There were two unlabeled bars of soap in grey plastic dishes on the sink counter in the bathroom of bedroom ■

The bar soap and soap and unlabeled soap dishes were immediately removed and replaced with pump bottle soap for each resident and properly labeled to identify what bottle is for each individual resident. Housekeeping/caregivers will replace if/when they see it is missing out of the bathroom. The room will be checked by caregivers each time they are in the room for soap and proper labeling for each individual resident in the semi-private. A checklist will be placed in the semi-private room on the back of the door from March 29th thru April 27th. Documentation of checks will be kept.

On 3/11/2021,3/12/2021 and 3/13/2012 staff (Arden Courts and Agency) were educated to check that soap regulation 102j) is available in resident rooms at all times.

All staff will be educated by 4/1/2021 on monitoring soap in resident's rooms. They will have instructions to check on each shift at a minimum if there is soap in each bathroom. Documentation will be kept on the daily check list.

Daily checks will be made by staff to ensure soap available and properly labeled.
The QA team at the quarterly meeting will review frequency of missing soap reported on the shift reports.

Completion Date: *04/04/2021*

Document Submission **Implemented**

see attached

103f - Refrigerator/Freezer Temps

1. **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 3/9/21 at 10:52 a.m., the temperature in the refrigerator in the Dockside kitchen was 42 degrees Fahrenheit and on 3/10/21 at 2:49 p.m., it was 44 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction **Accept**

On 3/9/2021 at 10:52 a.m., the temperature in the refrigerator in the Dockside kitchen was 42 degrees Fahrenheit and on 3/10/2021 at 2:49 p.m., it was 44 degrees Fahrenheit.

The temperature on morning rounds was documented at 39 degrees. The temperature was done while dining services was stocking and preparing for the lunch meal. The next morning when dietary did the temperature it was also at 39 degrees. Maintenance had replaced the seal on the refrigerator, and it was just completing replacement when the temperature was checked on 3/10/2021.
The temperature was checked 30 minutes after replacing the seal and was at 37 degrees Fahrenheit.

Temperatures have been monitored daily since the seal has been replaced and has been running at 39 degrees. Beginning 3/29/2021 the temperature will be recorded 2x a day for 7 days.

Documentation of 2x a day temperature will be kept in the main kitchen (Addendum L) Beginning immediately the temperature will be recorded 2x a day for 7 days. Documentation of 2x a day temperature will be kept in the main kitchen. If temperature runs high a new refrigerator will be ordered and it will be replaced.

Staff training was completed on 3/29/2021 on regulation 103f. Education was completed on 2X day temperature checks in all refrigerators from 3/29/21 thru 4/4/2021.Temperatures will be reviewed by the Executive Director or designee to ensure compliance on a daily basis from 3/29/2021 thru 4/4/2021.

The temperatures will be discussed at the quarterly quality management meetings by the Executive Director and the quality assurance team.

Staff has been educated on Policy and Procedure for food storage/ temperatures. Documentation will be kept. Policy and Procedures were reviewed on 4/1/2021 all dietary staff.

Completion Date: *04/04/2021*

Document Submission **Implemented**

see attached

231b - Medical Evaluation

1. **Requirements**

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation, signed on [redacted] does not include the need for an SDCU, the date the resident was evaluated, or the date the form was completed. These sections were blank.

Resident #3 was admitted to the SDCU on [redacted]; however, the resident's medical evaluation, dated [redacted], does not include the need for an SDCU. This section was blank.

231b - Medical Evaluation *(continued)*

Plan of Correction **Accept**

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation, signed on [redacted] does not include the need for an SDCU, the date the resident was evaluated, or the date the form was completed. These sections were bank. Resident #3 was admitted to the SDCU on [redacted]; however, the resident's medical evaluation, dated [redacted], does not include the need for an SDCU. This section was blank.
An updated medical evaluation has been completed to indicate dates of completed/evaluation/ and SCDU is indicated.
RSC or designee will complete an audit of resident DME's to ensure they are completed with all required information. Documentation of the audit will be kept (Addendum N).
RSC and shift supervisors have been educated as part of the first quarter quality assurance meeting on verifying dates and appropriateness for admission to SDCU (the box marked on the DM) . Documentation kept.
Shift supervisors were educated on checking the SDCU box is marked off on the DME. All nurses will be educated on verification of dates of physical exam, date of form completion is filled out on all pages of the DME. All nurses will be educated on regulation 231b again April 19,2021.
Executive Director or designee will review all new DME's (new admission and annual in quarterly quality assurance meeting) quarterly
Documentation will be kept.

Completion Date: *04/04/2021*

Document Submission **Implemented**

see attached