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

March 15, 2023

[redacted]
ARDEN COURTS OF MONROEVILLE PA LLC
120 WYNGATE DRIVE
ATTN LICENSURE SUPPORT
MONROEVILLE, PA, 15146

RE: ARDEN COURTS (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 11/21/2022, 11/22/2022 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 (MONROEVILLE)* **Licen e #**: *43552* **Licen e Expiration**: *05/23/2023*

Address: *120 WYNGATE DRIVE, MONROEVILLE, PA 15146*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ARDEN COURTS OF MONROEVILLE PA LLC*

Address: *120 WYNGATE DRIVE, ATTN LICENSURE SUPPORT, MONROEVILLE, PA, 15146*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *09/29/1997* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *11/22/2022*

Inspection Dates and Department Representative

11/21/2022 On Site [redacted]

11/22/2022 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *56* **Residents Served**: *52*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*

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

Have Mobility Need: *52* **Have Physical Disability**: *0*

Inspections / Reviews

11/21/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2022*

12/14/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/10/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/20/2022*

Inspections / Reviews *(continued)*

12/29/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/10/2023*

03/15/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/10/2023*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 11/21/22 at 10:07am, an unlocked, unattended and accessible binder was present on the counter in the Cloverdale kitchenette, which contained numerous resident records, to include resident #1's [redacted] and shower schedule, resident #2's [redacted] and shower schedule and resident #3's [redacted] and shower schedule.

On 11/21/22 at 10:29am, an unlocked, unattended and accessible binder was present on the counter in the Dockside kitchenette, which contained numerous resident records, to include resident #4's [redacted] and shower schedule and resident #5's [redacted] and shower schedule.

Plan of Correction ***Accept ([redacted] - 12/23/2022)***

On 11/21/22, the binders were immediately locked upon finding them on the counters unattended. Executive Director provided education to direct care staff on 12/5/22, 12/7/22, 12/9/22 about the need to keep the documentation binders locked when not in use. An audit tool was developed by the Executive Director to be used by the Resident Services Coordinator and Resident Services Supervisors to monitor each shift to ensure the documentation binders are not left unattended when not in use. This audit was implemented on 12/8/22. This audit will continue each shift for four weeks. Any issues of non-compliance will be immediately addressed. If compliance is not maintained after the initial 4 weeks, the audit will continue until substantial compliance is maintained.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/15/2023)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #2's resident-home contract, dated [redacted]/22, is not signed by the resident.

Resident #6's resident-home contract, dated [redacted]/22, is not signed by the resident.

Resident #7's resident-home contract, dated [redacted]22, is not signed by the resident.

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept (LM 12/23/2022)***

Resident #2 passed away [redacted] Signature unable to be obtained. Resident #6 recently had a guardian appointed and contract was emailed the new guardian for signature [redacted] 22. #7 signature was obtained on [redacted] 22. Executive Director will conduct an audit of all current resident contracts to determine if signatures are need or have the proper documentation to indicate the resident is unable to sign by January 13, 2023. Corrective action will be taken if signature is missing. The executive director and memory care advisor reviewed regulation 2600.25(b) on 12/8/22 regarding the contract being signed by the resident.

Executive Director will conduct a monthly audit of new move-ins to determine that the resident's signature was obtained on the contract or it is documented as to why the resident is unable to sign with witness to that reason. The first monthly audit will be conducted by 2/10/23. Any issues identified will be immediately addressed.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/15/2023)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] /22 at approximately [redacted] am, staff member A hit resident #8 [redacted], leaving a large red mark on the resident's chest.

REPEAT VIOLATION: 3/9/2021, et. al.

Plan of Correction ***Directed [redacted] - 12/23/2022)***

Resident #8 did not sustain any serious injury. All staff are educated on the prevention of abuse and neglect upon hire and at least annually, including the staff person involved in this incident. The staff person cited in the incident nvolving resident #8 was immediately suspended and then terminated following the investigation of this incident. Executive Director re-educated staff on preventing abuse and neglect on 12/5, 12/7, 12/9 2022. All allegations of abuse and neglect are reported to DHS and AAA Protective Services and in estigated with the appropriate action taken to the address the incident.
The executive director or program services coordinator will interview 5 residents a month to assess if any residents are experiencing any abuse or neglect.. This will begin in January 2023. (DIRECTED: The resident interviews shall begin on 1/9/23. Documentation of the interviews shall be kept. [redacted] 12/23/22).
Executive Director will conduct a review and evaluation of the quality management plan by January 3, 2023. The Executive Director will place increased emphasis on these plans of correction and take action to improve the quality of resident rights and Older Adult Protective Services action training for all new hires within 40 scheduled working hours in accordance with 2600.64(b0(1) and 2600.65(b)(3) and annually in accordance with 2600.65(g(3) and 2600.65(g) (4) which is currently happening. Documentation of the quality management plan review will be kept.

Directed Completion Date: *01/09/2023*

Implemented [redacted] 03/15/2023)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff member B, hired on [redacted]/20, does not have a high school diploma, GED diploma or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 12/23/2022)***

Direct Care staff member B was hired prior to the current Executive Director and human resources coordinator were n place. The employee was removed from the schedule until verification of high school graduation could be obtained. We obtained a high school transcript directly from the school on [redacted]/22 which indicated the employee's graduation date. Employee was then returned to work.
Our new human resources coordinator was been educated on acceptable documents to verify high school graduation or GED on 12/8/22. The human resources coordinator will ensure high school verification is obtained prior to the hire of any direct care staff effective immediately. The human resources coordinator will audit all current direct care staff employee files to determine if proper high school graduation was obtained and present in the file by January 13. 2023. Any issues of missing documentation of high school graduation or GED will be addressed. The Executive Director will conduct a monthly audit on all new hires for three months to ensure the proper verification of high school graduation is obtained for all direct care staff hired. The first monthly audit will be conducted by 2/10/23. Any ssues of non-compliance will be immediately addressed by removing the employee from working until the acceptable form of high school graduation is obtained

Licensee's Proposed Overall Completion Date: *02/10/2023*

Implemented [redacted] - 03/15/2023)

91 - Telephone Numbers

5. 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 11/21/22, none of the emergency telephone numbers specified in 2600.91 were posted on or by the telephone in the [redacted] kitchenette.

REPEAT VIOLATION: 3/9/2021, et. al.

Plan of Correction ***Accept [redacted] 12/23/2022)***

Upon identifying that the emergency phone numbers were not present by a telephone during survey, the numbers were placed by that phone that day. The building services coordinator will conduct a monthly audit to determine that emergency numbers referenced in 2600.91 are placed by all phones with outside lines. Any missing emergency numbers will be immediately replaced. The building services coordinator will conduct this monthly audit for at least 3 months or until sustained compliance is maintained. The first audit will be conducted by 12/30/2022.

Licensee's Proposed Overall Completion Date: *12/30/2022*

Implemented [redacted] - 03/15/2023)

91 - Telephone Numbers *(continued)*

141b1 - Annual Medical Evaluation

6. Requirements

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

Description of Violation

Resident #8's most recent medical evaluation was completed on [redacted]22; however, resident #8's previous medical evaluation was completed on [redacted]/20.

Resident #9's most recent medical evaluation was completed on [redacted]22; however, resident #9's previous medical evaluation was completed on [redacted]/20.

Plan of Correction ***Accept [redacted] - 12/23/2022)***

Resident #8 and #9's annual medical evaluations were not completed prior to the current Executive Director and Resident Services Coordinator being in place. Resident Services Coordinator has spent months getting all resident annual medical evaluations completed that were overdue and finished that audit in November 2022. Resident Services Coordinator has created a tracking system for when all resident annual medical evaluations are due to ensure compliance with the annual requirements. The Executive Director will conduct a monthly audit with the Resident Services Coordinator to ensure all annual medical evaluations were conducted timely. The first monthly audit will be conducted by 1/13/22. Any issues of non-compliance will be addressed. This audit will be conducted monthly for at least three months or until sustained compliance is maintained. The audits will be conducted by the end of the first week of the month for the previous month.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 03/15/2023)

185a - Implement Storage Procedures

7. 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

On 11/22/22, resident #7's glucometer was not set to the current date and time.

Plan of Correction ***Accept [redacted] 12/23/2022)***

Resident #7's glucometer was replaced the same day that it was identified as not having the current date and time. There were no other glucometers to check for accuracy of date and time.The resident services coordinator has added a checklist to the move-in process as of 11/22/22 to assess that any glucometers brought from home are accurately programmed with date and time. If the date and time cannot be corrected, a new glucometer will be obtained. The Resident Services Coordinator will conduct an audit after every new move-in to ensure that any glucometer brought from home is programmed with correct date and time. Additionally, the Resident Services Coordinator is mplementing a monthly check on all glucometers beginning in January 2023 to ensure that they are accurately programmed with ate and time. Any identified issues will be addressed. This monthly check will be conducted by the Resident Services Coordinator or designated Resident Services Supervisor.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *01/31/2023*

Implemented [redacted] 03/15/2023)

225a Assessment 15 Days

8. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department s assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #7's medical evaluation, dated [redacted]/22, indicates that the resident is prescribed a [redacted]; however, the [redacted] is not indicated on resident #7's assessment, dated [redacted]/22.

Plan of Correction ***Accept [redacted] - 12/23/2022)***

Resident #7 had a change in diet between the time the initial DME was completed and when [redacted] arrived at the residence. Resident #7's diet on the assessment matches the current diet order. The Executive Director and Resident Services Coordinator will check for any changes in diet that may occur between the initial DME and when resident moves-in to ensure the diet on the assessment is current. The Resident Services Coordinator will conduct a monthly audit on 10% of the residents to make sure that the current diet order is on the assessment/support plan. Any dentified issues will be immediately addressed. The first audit will be conducted by 1/31/23 and continue for at least three months or until sustained compliance is maintained.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Implemented [redacted] - 03/15/2023)

225c Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #8's most recent assessment was completed on [redacted]22; however, resident #8's previous assessment was completed on [redacted]/20.

Resident #9's most recent assessment was completed on [redacted]22; however, resident #9's previous assessment was completed on [redacted]20.

Plan of Correction ***Accept ([redacted] 12/23/2022)***

Resident #8 and #9 had assessments due prior to the current Executive Director and Resident Services Coordinator being in place. The Resident Services Coordinator has identified late assessments and had updated all resident assessments. The Resident Services Coordinator has implemented a tracking system to ensure all assessments are

225c - Additional Assessment (continued)

completed in compliance with this regulation. The Resident Services Coordinator will conduct a monthly audit of all assessment due that month to ensure all assessments were completed timely. Any issues of non-compliance will be addressed. The first monthly audit will be conducted by 1/31/23 with a review of the assessments due in the previous month. This audit will be conducted monthly for at least 3 months or until sustained compliance is maintained.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Implemented (- 03/15/2023)