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

April 14, 2023

[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 02/07/2023, 02/08/2023 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.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARDEN COURTS (SUSQUEHANNA)* **License #**: *32431* **License Expiration**: *06/20/2023*

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: *333 NORTH SUMMIT ST, 16TH FLOOR, TOLEDO, OH, 43604*

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/08/2023*

Inspection Dates and Department Representative

02/07/2023 - On-Site: [redacted]

02/08/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Arden Courts* **Capacity**: *64* **Residents Served**: *42*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*

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

Have Mobility Need: *42* **Have Physical Disability**: *0*

Inspections / Reviews

02/07/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/20/2023*

Inspections / Reviews *(continued)*

03/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/09/2023*

03/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/07/2023*

04/14/2023 - Document Submission

Submitted [redacted] **Date Submitted:** *04/07/2023*

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 2/7/2023, the home's current violation report, dated 2/9/2022, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed (CR - 03/20/2023)***

Fixed onsite. ED immediately replaced the missing violation report on 2/7/2023 . ED was in-inserviced and educated on the importance of auditing binder in lobby to make sure violation report is posted by RDO on 2/9/2023. Moving forward, ED will audit survey binder weekly to ensure report is present and available to all.

(Directed)

- *Beginning 3/20/2023, the ED will complete weekly audits of the survey binder to ensure a a copy of the current license inspection summary issued by the Department is present and available to all.*

Directed Completion Date: *03/20/2023*

Implemented (CR - 04/10/2023)

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

The resident-home contract, dated 2/24/2021, for Resident #2 was not signed by the resident.

The resident-home contract, dated 7/26/2021, for Resident #1 was not signed by the resident.

Repeated Violation-2/9/2022, et al

Plan of Correction ***Directed (CR - 03/20/2023)***

On [redacted], ED reviewed resident-home contracts with Resident #1 and Resident #2. Due to the progression of their disease, neither residents were able to sign contract. ED noted and made attempt. ED indicated unable to sign on each contract.
All remaining resident contracts were reviewed by ED and Administrative Services Coordinator by 3/14/2023. All contracts that were missing signatures were either signed or it was notated that the resident was unable to sign.
In-serviced both Administrative Services Coordinator and Administrative Services Assistant on regulation and importance of auditing all new resident charts on 3/14/2023.
Attached is in-service document and attendance record.

(Directed)

- *The ED in-serviced both the Administrator Services Coordinator and Administrative Services Assistant on the*

25b - Contract Signatures (continued)

regulation and importance of auditing new resident charts on 3/14/23.

- *Beginning 3/20/2023, the ED or designee will audit all new admission contracts within 1 week of a resident's admission to ensure all required signatures are obtained.*

Directed Completion Date: *03/20/2023*

Implemented (CR - 04/12/2023)

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed (CR - 03/20/2023)***

On [redacted], ED reviewed resident-home contracts with Resident #1 and Resident #2. Due to the progression of their disease, neither residents were able to sign contract. ED noted and made attempt. ED indicated unable to sign on each contract.
All remaining resident contracts were reviewed by ED and Administrative Services Coordinator by 3/14/2023. All contracts that were missing signatures were either signed or it was notated that the resident was unable to sign.
In-serviced both Administrative Services Coordinator and Administrative Services Assistant on regulation and importance of auditing all new resident charts on 3/14/2023.
Attached is in-service document and attendance record.

(Directed)

- *The ED in-serviced both the Administrator Services Coordinator and Administrative Services Assistant on the regulation and importance of auditing new resident charts on 3/14/23.*
- *Beginning 3/20/2023, the ED or designee will audit all new admission documentation within 1 week of admission to ensure a statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.*

Directed Completion Date: *03/20/2023*

Implemented (CR - 04/10/2023)

42s - Privacy

4. Requirements

42s - Privacy *(continued)*

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has video monitoring and recording of the front exterior entrance, interior front lobby of the home and the entrances/exits to the home's courtyard; However, residents are not informed upon admission that this area is subject to video recording and signs are not posted in these areas indicating that images are being recorded.

Plan of Correction ***Directed (CR - 03/20/2023)***

-Signs were ordered on 2/8/2023 by the Building Services Coordinator
-Signs were delivered on 2/10/2023 via HD Direct Supply (vendor) and posted at all entrances and exits by Building Services Coordinator on 2/10/2023.
-All responsible parties (POA) were notified via email in November 2022 and again reiterated in an update email following violation on 2/13/2023.
-ED and Program Services Coordinator notified all residents at resident council meeting on 2/28/2023.
-Moving forward, this will be discussed by the ED in every new admission contract agreement until corporate legal department updates resident home contract.

(Directed)

- *Beginning 3/20/2023, the ED will verbally discuss the home's video recording with new admissions until contracts are updated.*

Directed Completion Date: *03/20/2023*

Implemented (CR - 04/10/2023)

65d - Initial Direct Care Training

5. 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 Member A, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, Staff Member A did not complete and pass the Department-approved direct care training course and pass the competency test as of 2/7/2023.

Plan of Correction ***Directed (CR - 03/20/2023)***

Staff Member A completed the Department-approved direct care training course and passed the competency test on 2/7/2023.
Beginning on 2/10/2023, the Direct Care Staff Training and competency test was added to the training process and is completed on or before day 2 of orientation. No new staff member will be able to start training on the floor until

65d - Initial Direct Care Training (continued)

competency test is passed.
On 3/17/2023, formal in-service was completed with Administrative Services Coordinator (HR designee) to complete training process to ensure training plan is followed through with incompliance with Regulation 65d.
Internal audit was completed by 3/1/2023 and all current staff members are in compliance with regulation and up to date on competency test.

(Directed)

- *On 3/17/2023, a formal in-service was completed by the ED with the Administrative Services Coordinator (HR designee) to complete training process to ensure training plan is followed through in compliance with regulation 2600.65(d)*
- *The home has an orientation checklist for all new hires. The orientation checklist is in the process of being revised by the ED to include all required trainings in 2600.65(d). The checklist will be completed by the new hire and signed off on by the supervisor prior to the new hire working unsupervised with residents. Checklist will be updated and implemented by 3/24/2023.*
- *Internal audit was completed by 3/1/2023 by the Administrator Services Coordinator and all current staff members are in compliance with regulation and up to date on competency test.*

Directed Completion Date: *03/24/2023*

Implemented (CR - 04/12/2023)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct Care Staff Member B did not receive training in medication self-administration training; instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan; personal care service needs of the resident; and safe management techniques during training year 2022.

Plan of Correction ***Directed (CR - 03/20/2023)***

• An audit of all remaining direct care staff staff member records will be completed by 4/1/2023 by the ED and the Administrative Services Coordinator.
• Following that audit, the Administrative Services coordinator will begin auditing training records monthly (April 2023 – onward).
• Director of Nursing and Administrative Services Coordinator were in-serviced on 3/17/2023 on the importance of training hours.
• Administrative Services Coordinator and ED will develop annual training plan that satisfies both the Corporate Training Requirements and regulation 65f.

65f - Training Topics (continued)

(Directed)

- *Staff Member B is scheduled to complete required trainings on* [redacted].
- *An audit of all remaining direct care staff staff member records will be completed by 4/1/2023 by the ED and the Administrative Services Coordinator.*
- *Beginning 4/1/2023, the Administrative Services Coordinator will complete monthly staff training audits.*
- *Director of Nursing and Administrative Services Coordinator were in-serviced on 3/17/2023 on the importance of training hours and content by the ED.*

Directed Completion Date: *04/01/2023*

Implemented (CR - 04/14/2023)

65g - Annual Training Content

7. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff Person B did not receive training in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102); resident rights; and falls and accident prevention during training year, January 1, 2022 to January 31, 2023.

Plan of Correction ***Directed (CR - 03/20/2023)***

• Staff member B will have all required trainings complete by 4/15/2023.
• An audit of all remaining direct care staff staff member records will be completed by 4/1/2023 by the ED and the Administrative Services Coordinator.
• Following that audit, the Administrative Services coordinator will begin auditing training records monthly (April 2023 – onward).
• Administrative Services Coordinator were in-serviced on 3/17/2023 on the importance of training hours.
• Administrative Services Coordinator and ED will develop annual training plan that satisfies both the Corporate Training Requirements and regulation 65g.

(Directed)

- *Staff member B will have all required trainings complete by* [redacted]
- *Administrative Services Coordinator was in-serviced on 3/17/2023 on the importance of training hours by the ED.*
- *An audit of all remaining direct care staff staff member records will be completed by 4/1/2023 by the ED and the Administrative Services Coordinator. Any trainings found to be missing from the staff record will be completed by 4/30/2023.*
- *Beginning 4/1/2023, the Administrative Services coordinator will begin auditing staff member's training*

65g - Annual Training Content (continued)

records monthly

- *The Administrative Services Coordinator and ED will develop an annual training plan that satisfies both the Corporate Training Requirements and regulation 65g by 3/31/2023. The annual training plan will be implemented by 4/1/2023.*

Directed Completion Date: *04/01/2023*

Implemented (CR - 04/12/2023)

85e - Trash Outside Home

8. 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 2/7/2023 at approximately 10:15 AM, the outside dumpster was not covered and not actively in use at the time of the observation.

Plan of Correction ***Accept (CR - 03/20/2023)***

-Fixed immediately onsite on 2/7/23 by Maintenance Director.
-Maintenance Director was educated by ED on importance of keeping lid closed when not actively in use on 2/7/2023. Staff also made aware with in service by ED on 2/7/23.
-Maintenance Director confirmed this inspection is part of [redacted] daily round checklist on 2/7/23 and will continue to monitor with an additional exterior round schedule on Tuesday and Friday morning, which is our trash day.

Licensee's Proposed Overall Completion Date: *03/14/2023*

Implemented (CR - 04/12/2023)

91 - Telephone Numbers

9. 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 2/8/2023, there were no emergency telephone numbers including the nearest hospital and fire department on or by the telephone in Resident #3's bedroom.

Plan of Correction ***Accept (CR - 03/20/2023)***

Fixed on site on 2/8/23 by Executive Director and placed emergency telephone numbers on resident #3's phone.
On 2/16/2023, Audit completed of all resident rooms to check phones by Executive Director. Tags added to phones by Building Services Coordinator on 2/17/2023.
On 2/17/2023, we added checking the phones for emergency numbers on the rounding checklist for all housekeepers to check phones for appropriate and secured tags weekly.
ED in-serviced housekeeper and building services staff on plan on 2/17/2023. In-service attached.

91 - Telephone Numbers *(continued)*

Licensee's Proposed Overall Completion Date: *03/14/2023*

Implemented (CR - 04/12/2023)

132a - Monthly Fire Drill

10. Requirements

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

Description of Violation

An unannounced fire drill was not held during the months of May 2022 and June 2022.

Plan of Correction ***Directed (CR - 03/20/2023)***

Beginning March 2023, the ED, BSC, and ASC will audit fire drills monthly to ensure completion in the monthly safety committee meeting.
At QA meeting on 4/5/2023, fire drills will be prescheduled for the remainder of 2023.
QA meetings are the first Wednesday of the month following the completion of a quarter, so 1st Quarter QA meeting is schedule for 4/5/2023 where fire drill completion and records will be reviewed and audited for completion and compliance of regulation 132a.

(Directed)

- *Beginning March 1, 2023, monthly audits of fire drills will be completed by the ED, BSC and ASC to ensure completion during the monthly safety committee meeting.*

Directed Completion Date: *04/05/2023*

Implemented (CR - 04/10/2023)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 3/21/2022 does not include the time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

The fire drill record for the drills conducted on 4/29/2022, 7/13/2022 and 8/25/2022, do not include the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records (continued)

The fire drill record for the drills conducted on 9/5/2022 and 1/130/2023 do not include the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill or the number of residents evacuated.

The fire drill record for the drills conducted on 10/7/2022, 11/30/2022 and 12/28/2022 do not include the number of residents in the home at the time of the drill, the number of residents evacuated and whether the fire alarm or smoke detector was operative.

Plan of Correction ***Directed (CR - 03/20/2023)***

Started using DHS approved fire drill log for February 2023 drill (see attached).
Building Services Coordinator was trained on new form on 2/20/2023 when we transposed internal fire drill log information onto DHS approved document.
Administrative Services Coordinator (Safety Committee Co-Chair) will assist ED in oversight to ensure these fire drills are logs appropriately.
Fire Drill logs will be reviewed at the quarterly QA meetings.
ASC and BSC in-serviced formally on 3/16/2023 with ED to ensure this compliance with 132c.

(Directed)

- *On 2/3/2023, the home implemented the DHS approved fire drill log for all future monthly fire drill documentation.*
- *Building Services Coordinator was trained on new form by the ED on 2/20/2023 when we transposed internal fire drill log information onto DHS approved document.*
- *Beginning 3/1/2023, the Administrative Coordinator (Safety Committee Co-Chair) will assist the ED with auditing monthly fire drill documentation to ensure the logs contain the required information.*
- *Beginning 4/5/2023, fire drill documentation will be reviewed at the home's QA meetings.*

Directed Completion Date: *04/05/2023*

Implemented (CR - 04/10/2023)

144b - Policy on Smoking

12. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The Clean Indoor Air Act requires that the home post a sign at each entrance that states, "Smoking Permitted in Designated Areas Only" or "No Smoking." On 2/7/2023 signs were not posted at the home's entrance to the building.

Plan of Correction ***Accept (CR - 03/20/2023)***

-Signs were ordered on 2/8/2023 by the Building Services Coordinator
-Signs were delivered on 2/10/2023 via HD Direct Supply (vendor) and posted by Building Services Coordinator on 2/10/2023.
-Beginning 2/13/2023 and moving forward, Building Services Coordinator will ensure signs are still posted during his daily building and ground walk through.

144b - Policy on Smoking *(continued)*

Licensee's Proposed Overall Completion Date: *03/14/2023*

Implemented (CR - 04/10/2023)

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

On 2/8/2023 at approximately 10:54 AM, Resident #4's glucometer was not calibrated to the correct time.

Resident #4 is prescribed blood glucose checks weekly. The blood glucose check on the glucometer did not match the number transcribed on the Medication Administration Record (MAR). On 2/7/2023, at 6:30 AM, Resident #4's MAR was 137; the glucometer reading was 132.

Plan of Correction ***Directed (CR - 03/20/2023)***

- *Resident #4's glucometer was recalibrated to AM on 2/8/2023 by the Director of Nursing.*
- *All nursing staff were in-serviced by the Director of Nursing on 2/10/2023.*
- *All glucometers were audited to ensure appropriate calibration on 2/8/2023.*
- *Beginning 4/1/2023, weekly calibration audits will be completed by the 11pm-7am shift supervisor.*

(Directed)

- *All glucometers were audited to ensure appropriate calibration on 2/8/2023 by the Director of Nursing.*
- *DON will in-service nursing staff on checking the transcriptions by 4/1/23.*
- *Beginning 4/1/2023 the Director of Nursing will complete weekly checks on glucometers and the blood glucose transcription forms.*

Directed Completion Date: *04/01/2023*

Implemented (CR - 04/10/2023)

191 - Resident Right to Refuse

14. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1 admitted [redacted], has not been educated of the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #2 admitted [redacted], has not been educated of the resident's right to refuse medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse (continued)

Plan of Correction ***Directed (CR - 03/20/2023)***

• On [redacted], Resident #1 and Resident #2 were educated on the resident's right to refuse medication if the resident believes that there may be a medication error. Please also provide the staff member's title who provided this education and be prepared to submit documentation.
• All remaining resident records will be audited for compliance and education will be done by ED for each resident by 3/31/2023.
• Beginning 3/17/2023 and moving forward, ED will review new admissions within 3 days to ensure proper education was provided and we are in compliance of 191.

(Directed)

- *On 2/15/2023, Resident #1 and Resident #2 were educated on the resident's right to refuse medication if the resident believes that there may be a medication error by the ED.*
- *ED will in-service Administrative Team as well as nursing team to ensure these signatures are completed on all contracts moving forward by 4/1/23.*

Directed Completion Date: *04/01/2023*

Implemented (CR - 04/12/2023)

227h - Support Plan Refuse Sign

15. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #4 participated in the development of the support plan on [redacted]. The resident did not sign the support plan, nor did the home make a notation regarding the resident's inability or refusal to sign.

Plan of Correction ***Directed (CR - 03/20/2023)***

On [redacted], Resident #4 reviewed the RASP with ED. They were unable to sign, so ED indicated that on the support plan.
All resident records were audited for completion and compliance on 2/17/2023.
ED in-serviced Administrative Support Staff on this plan on 3/14/2023. Please see attached in-service and policy.

(Directed)

- *All resident records were audited for completion and compliance on 2/17/2023 by the ED.*
- *Beginning 4/1/2023, the Admin Services Assistant will audit resident RASP's monthly. If a signature is not present, the ED will attempt to review and receive signatures or note the resident was unable to refused to sign.*

Directed Completion Date: *04/01/2023*

Implemented (CR - 04/10/2023)

231e - No Objection Statement

16. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident has not objected to the admission.

Repeated Violation-2/9/2022, et al

Plan of Correction ***Directed (CR - 03/20/2023)***

-The Administrative Services team, Memory Care Advisor, and Director of Nursing were in-serviced by the ED on 2/22/2023. (In-serviced again on 3/14/2023 with documentation)
-The current residents documentation that the resident and designated responsible party have not objected to the residents' admission to a SDCU were audited by the Executive Director on 2/22/2023.
-The Executive Director will review documentation that the resident and the resident's designated responsible party have not objected to the admission to a SDCU to ensure compliance beginning 3/14/2023 and ongoing.
-Semi annual audits will be instituted by the administrative services team and ED to ensure compliance with 231e going forward.

(Directed)

- *Resident #4 and Resident #5 reviewed and signed the no objection statement as well as the designated contact on [redacted] with the ED.*
- *Beginning 3/20/2023, the ED will review the new resident's admission paperwork within 1 week of admission to ensure the home obtained documentation that the resident and designated contact do not object to the admission to the SDCU.*

Directed Completion Date: *03/20/2023*

Implemented (CR - 04/10/2023)