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

April 7, 2024

[redacted]
ARDEN COURTS OF MONROEVILLE PA LLC
[redacted]
ATTN LICENSURE SUPPORT
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/13/2024 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 (MONROEVILLE)* **License #**: *43552* **License Expiration**: *05/23/2024*

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: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/14/2024*

Inspection Dates and Department Representative

02/13/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *54*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *whole license* **Capacity**: *56* **Residents Served**: *54*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *54*

Diagnosed with Mental Illness: *16*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *54*

Have Physical Disability: *0*

Inspections / Reviews

02/13/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/24/2024*

03/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/07/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/01/2024*

Inspections / Reviews *(continued)*

04/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/08/2024*

04/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2024*

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

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person A, hired [redacted], did not receive annual instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the [redacted] training year.

Plan of Correction ***Directed [redacted] - 04/01/2024)***

[redacted] - Staff person A received training on Meeting the Needs of the Resident, ADL's and ADL's for Dementia Care.
[redacted] - Annual training plan for 2024 and 2025 was developed by Executive Director on [redacted]. Training plan includes Meeting the Needs of the Resident per 2600.65f.
[redacted] - Executive Director began monthly training ,per the Annual Training Plan, with all staff . Executive Director/Designee will schedule all staff training monthly beginning Feb 2024 and ending 12/2024.
Copy of annual training plan will be submitted after POC is accepted.
[redacted] - Executive Director will be responsible for monitoring all staff training for 2024 and maintaining staff Record of Training through 12/2024 to remain in compliance with 2600.65

Proposed Overall Completion Date: 03/29/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all of the staff training through the quality management review to ensure compliance with Regulation 2600.65(f). 4/1/24 JK

Directed Completion Date: *03/29/2024*

Implemented [redacted] - 04/07/2024)

65g - Annual Training Content

2. 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:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
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

Direct care and maintenance director, staff person A, hired [redacted], did not receive annual training in Emergency preparedness procedures, Resident rights, The Older Adult Protective Services Act and Falls and accident prevention during the [redacted] staff training year.

Plan of Correction ***Accept [redacted] 04/01/2024)***

[redacted] - Staff person A received training on Resident Rights and Older Adult Protective Services / Abuse. Emergency Preparedness and Falls/Accident Prevention is scheduled for [redacted].

65g - Annual Training Content (continued)

[redacted] - *Annual training plan for 2024 and 2025 was developed by Executive Director. Training plan includes Emergency Preparedness, Resident Rights, Older Adult Protective Services Act and Falls and Accident Prevention per 2600.65g. Copy of plan will be submitted after POC is accepted.*

[redacted] - *Quality Mgt. Meeting was conducted by Executive Director. All violations from current LIS was discussed as well as the corrective action that would be taken to ensure all staff are trained per 2600.65.*

[redacted] - *Executive Director began executing the Annual Trainng plan. A monthly all staff training will be scheduled beginning with March and ending in Dec 24. The Executive Director/designee will be responsible for scheduling & monitoring the monthly training schedule. to remain in compliance with 2600.65. At the end of each month the Executive Director will review the training attendance and schedule a make-up training time for any staff member that did not attend that month's training.*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 04/07/2024)

141b1 - Annual Medical Evaluation

3. Requirements

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

Description of Violation

The most recent medical evaluation (DME) for resident [redacted], admitted [redacted], was completed [redacted] However, the resident's previous DME was completed [redacted].

The most recent DME for resident [redacted], admitted [redacted], was signed by a medical professional on [redacted]. However, the DME does not indicate the date that the resident was examined/evaluated. This section is blank on pages 1 and 2.

REPEAT VIOLATION 11/21/22 et al.

Plan of Correction ***Accept [redacted] - 04/01/2024)***

Resident [redacted] and Resident [redacted] were both deceased prior to this partial inspection, so no immediate correction was possible.

[redacted] - *Executive Director audited DME's of all current residents.*

[redacted] - *Executive Director educated Resident Services Coordinator on 2600.141.b.*

[redacted] - *Executive Director directed RSC to have all residents evaluated by PCP and updated Annual DME's created for each resident. This was completed 3/19.24*

[redacted] - *Executive Director created a spreadsheet to track due dates of annual DME's. A copy of the spreadsheet will be submitted upon acceptance of POC.*

[redacted] - *Executive Director will monitor spreadsheet weekly for 4 months beginning April 1 thru July 31, and notify RSC of resident annual DME's that will be due that current month. RSC will be responsible to notify PCP's and ensure the medical evaluations are completed to maintain compliance with 2600.141.b.*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 04/07/2024)

187b - Date/Time of Medication Admin.

4. Requirements

187b - Date/Time of Medication Admin. *(continued)*

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On [redacted], resident [redacted] was ordered [redacted] every 3 hours and every 1 hour as needed. Resident [redacted] ceased to breathe on [redacted] at [redacted] However, the [redacted] dose of this medication was signed off as being administered on the resident's December 2023 medication administration record.

Plan of Correction ***Accept [redacted] 03/25/2024)***

[redacted] - Executive Director directed the Resident Services Coordinator to conduct med cart audits to ensure discontinued meds had been removed and destroyed. Audit completed [redacted] The agency that employed the LPN that signed off on the incorrect date of med administration was notified of her error.
[redacted] - Executive Director directed RSC to re-educate all med techs' and agenct LPN's on med administration policy and procedure and also pain management per pysician orders. Training completed [redacted]
[redacted] - Executive Diretor directed a med administration refresher course to be scheduled with a Train the Trainer for all current med techs. [redacted] All med techs have been registered.
[redacted] - RSC/LPN will be responsible to monitor and audit monthly MARS and conduct a monthly med cart audit.

Licensee's Proposed Overall Completion Date: *03/24/2024*

Implemented [redacted] 04/07/2024)

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

On [redacted], resident [redacted] was ordered [redacted] every 3 hours and every 1 hour as needed. However, according to the resident's December 2023 medication administration record (MAR), this medication was not administered to the resident on [redacted] at [redacted] and on [redacted] at [redacted] and [redacted]

On [redacted], resident [redacted] was ordered [redacted] every 6 hours. However, according to the resident's December 2023 MAR, this medication was not administered on [redacted] at [redacted] and [redacted]

On [redacted], resident [redacted] was ordered [redacted] – give 1 ml by mouth every 4 hours by mouth for anxiety. However, according to the resident's December 2023 MAR, this medication was never administered to the resident. Resident ceased to breathe on [redacted] at approximately [redacted]

REPEAT VIOLATION 12/12/23

Plan of Correction ***Accept [redacted] 04/01/2024)***

[redacted] - Resident Services Coordinator and scheduler were instructed by Executive Director to ensure an LPN and/or a certified Med Tech was present to administer mediations at all times per prescribers orders.
[redacted] - Executive Diretor directed a med administration refresher course to be scheduled with a Train the Trainer for all current med techs. Training will be completed on 4/12 and the Trainer will finalize the training requirements at that time.
[redacted] All med techs and LPN's have been re-educated by the Resident Services Coordinator on the home's

187d - Follow Prescriber's Orders (continued)

policies and procedures in relation to med administration and monitoring pain.control ..

[redacted] *- Resident Services Coordinator will be responsible to monitor monthly, beginning April 1 and continue for 6 months, all med techs and MAR's to ensure medications are being administered per prescribers orders. Any errors identified will be reported to Executive Director who will determine what corrective action is needed.*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 04/07/2024)

225c - Additional Assessment

6. Requirements

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

Description of Violation

The most recent assessment for resident [redacted], admitted [redacted], was completed [redacted]. The resident was discharged [redacted]

The most recent assessment for resident [redacted], admitted [redacted], was completed [redacted]. The signature page indicates it was signed on [redacted]. The assessment did not indicate that resident had been admitted to hospice. The resident ceased to breathe on [redacted].

REPEAT VIOLATION 12/12/23; 11/21/22 et al.

Plan of Correction ***Accept [redacted] - 04/01/2024)***

Resident [redacted] and Resident [redacted] had ceased to breathe prior to this partial inspection so no corrective action for these residents could be made.

[redacted] *- Executive Director audited all resident files for current RASP's. Executive Director coached and educated Resident Services Coordinator on RASP's and regulation 2600.225.1. Audit completed 3/19/24.*

[redacted] *- Executive Director created a spreadsheet to track due dates of annual RASP's. A copy of the spreadsheet will be submitted upon acceptance of POC.*

[redacted] *- Executive Director will monitor spreadsheet weekly and notify RSC of resident annual RASP's that will be due that current month. Executive Director will also audit RASP's at the end of each month for 4 months beginning April 1 to ensure compliance of 225.c is maintained.*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 04/07/2024)

231b - Medical Evaluation

7. 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.

231b - Medical Evaluation *(continued)*

Description of Violation

The medical evaluation (DME) completed [redacted] for resident [redacted] admitted [redacted], did not include the resident's height, weight, pulse rate and temperature. These sections are blank.

REPEAT VIOLATION 12/12/23

Plan of Correction ***Accept [redacted] - 04/01/2024)***

Resident [redacted] had ceased to breathe prior to this partial inspection so no correction could be made for this specific resident.

[redacted] - Executive Director coached and educated Memory Care Advisor and Resident Services coordinator on DME's, and monitoring the completion of DME sections for required information on the day the form is received from the PCP.

[redacted] - Executive Director directed Resident Services Coordinator to have all residents evaluated by PCP and updated Annual DME's created for each resident. RSC reviewd all new DME's for accurate completion of form. This was completed [redacted].

[redacted] - RSC or ED will monitor all new and annual DME's for completion prior to filing in resident chart. Any omission of information identified will be directed back to the PCP for completion. ED will review again when returned by PCP.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 04/07/2024)

231c - Preadmission Screening

8. 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 [redacted] was admitted to the home on [redacted]. However, the resident's cognitive screening was completed on [redacted].

REPEAT VIOLATION 12/12/23

Plan of Correction ***Accept [redacted] - 03/25/2024)***

[redacted] - Executive Director coached and educated Memory Care Advisor on completing the Pre-Admission Screening form within 72hrs. of admission and obtaining the cognitive screening form from the physician or geriatric assessment team in conjuction with the Pre-screening.

[redacted] - All current resident records were audited for completed Pre-Screening and Cognitive Screening forms. Audit was completed [redacted]

[redacted] - All new resident move-in records will be reviewed by the Executive Director or designee for correct completion of Pre-Admission and Cognitive Screening forms. This will be on going for each new resident move in file.

Licensee's Proposed Overall Completion Date: *03/24/2024*

Implemented [redacted] - 04/07/2024)

231e - No Objection Statement

9. 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

Only resident [redacted] representative signed the Medical Evaluation Attachment form indicating that [redacted] did not object to the resident's placement in a secured Memory Care Community. However, the record does not include documentation that the resident did not object to admission to the secured dementia care unit.

REPEAT VIOLATION 12/12/23

Plan of Correction ***Accept [redacted] 04/01/2024)***

Resident [redacted] had ceased to breathe prior to this partial insoection so no corretion could be made for this specific resident,

[redacted] - Executive Director coached and educated the Memory Care Advisor on 2600.231.e.

[redacted] - Memory Care Advisor and Administrative Services Assistant audited all the current resident files to verify that the objection statement was in the chart and had both signatures as required. This audit was completed [redacted]

[redacted] - All new resident files will be reviewed by the Executive Director within 24hrs of admission for the next 4 months, beginning April 1, to ensure the objection statement is part of the file and has been acknowledged by both the responsible party and the reisdent.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 04/07/2024)

234a - Admission Support Plan

10. 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 [redacted] was admitted to the home on [redacted] and ceased to breath on [redacted]. However, a support plan was not developed for the resident.

REPEAT VIOLATION 12/12/23

Plan of Correction ***Accept [redacted] 03/25/2024)***

[redacted] - Executive Director audited all current resident charts to ensure each resident had a current RASP that was properly executed and completed in a timely manner. Audit was completed [redacted].

[redacted] - Executive Director educated Resident Services Coordinator on 2600.234a .3/4/24 - Executive Director will be responsible for completion of initial assessment and support plan for all new resident move-ins. Resident Service Coordinator will be responsible for initiating and completing all change in condition and annual RASP's. Executive Director will be responsible for updating the audit spreadsheet that will be used as a monthly tracker for completing annual resident RASP's. A copy of this audit tool will be submitted after POC is accepted.

Licensee's Proposed Overall Completion Date: *03/24/2024*

234a - Admission Support Plan *(continued)*

Implemented [redacted] 04/07/2024)

234b - Support Plan Needs Elements

11. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The assessment for resident [redacted], admitted to the home [redacted] and discharged [redacted] was completed [redacted] indicated that the resident wears glasses. However, the support plan did not indicate what type of assistance the resident required nor what assistance would be provided to make sure resident [redacted] had [redacted] glasses and that they were clean.

Plan of Correction ***Accept[redacted] 03/25/2024)***

[redacted] *- Executive Director with the assistance of med techs began auditing all resident charts and enusring that each resident RASP had the detail of assistance needed for he direct care staff to meet the needs of the resident.*
[redacted] *- Audit of resident charts was completed. All staff 2024 annual training plan includes training on Pre-screeneing/RASPs/DMEs.*
[redacted] *- Executive Director will be responsible for completion of initial assessment and support plan for all new resident move-ins. Resident Service Coordinator will be responsible for initiating and completing all change in condition and annual RASP's. Executive Director will be responsible for updating the audit spreadsheet that will be used as a monthly tracker for completing annual resident RASP's. A copy of this audit tool will be submitted after POC is accepted.*

3/22/24 -

Licensee's Proposed Overall Completion Date: *03/24/2024*

Implemented[redacted] 04/07/2024)