pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ARDEN COURTS OF MONROEVILLE PA LLC**
LEGAL ENTITY

To operate **ARDEN COURTS (MONROEVILLE)**
NAME OF FACILITY OR AGENCY

Located at **120 WYNGATE DRIVE, MONROEVILLE, PA 15146**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **56**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 56**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 28,** **2025** until **November 28,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **435521**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 28, 2025

[redacted], Executive Director
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: 435521

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 7, 2024, October 8, 2024, October 21, 2024, January 23, 2025, January 27, 2025, and February 10, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LISs) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 43552) dated May 23, 2025 – May 23, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 28, 2025 to November 28, 2025 .

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	X Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
65(f)	XX	54	$5	$270	calendar days from mailing date of this letter
65(g)	XX	54	$5	$270	calendar days from mailing date of this letter
187(d)	XX	54	$5	$270	calendar days from mailing date of this letter
225(a)	XX	54	$5	$270	calendar days from mailing date of this letter
225(c)	XX	54	$5	$270	calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *ARDEN COURTS (MONROEVILLE)* **License #:** *43552* **License Expiration:** *05/23/2025*

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:** *09/22/1998* **Issued By:** *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *106* **Waking Staff:** *80*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *10/21/2024*

Inspection Dates and Department Representative

10/07/2024 - On-Site: [redacted]
10/08/2024 - On-Site: [redacted]
10/21/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served:** *53*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire community* **Capacity:** *56* **Residents Served:** *53*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *53*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *53*
Have Physical Disability: *0*

Inspections / Reviews

10/07/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/19/2024*

12/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/24/2024*

12/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/06/2025*

05/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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 10/7/24 at approximately 10:45 a.m., there were unattended and accessible file folders setting in a wire rack on the desk in the Berry Ridge kitchen. The folder titled "Shower Sheets" included private resident information to include shower schedule, hospice involvement and/or body assessment forms for residents #1, #2, and #3.

Repeat Violation: 11/21/22 et al.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The immediate corrective action involved removing the unattended file folders from the Berry Ridge kitchen and securing them in a locked cabinet. This action was completed on 10/7/24 by the RSC(Resident Services Coordinator). Additionally, a memo was issued to all staff on 10/8/24, reminding them of the importance of maintaining the confidentiality of resident records and the proper storage procedures.

System Improvement Plan: To prevent recurrence, the facility will implement a comprehensive review of the record-handling policy. This includes mandatory training sessions for all staff on record confidentiality and secure storage practices, scheduled for 12/15/24. The training will be conducted by the Nursing Supervisor. Furthermore, the training will also review the locking requirement for all cabinets and the location of the keys for these cabinets for safe storage of resident information.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor adherence to the record-handling policy through weekly audits of all areas where resident records are stored. These audits will begin on 12/21/24 and continue for three months, after which they will be conducted monthly. The results of these audits will be reviewed in monthly staff meetings to ensure ongoing compliance and address any issues promptly.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Compliance Date: The facility will be in substantial compliance by 2/21/25.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

18 - Compliance With Laws *(continued)*

Description of Violation

According to the Care Facility Carbon Monoxide Alarms Standards Act Section 3. (b) (3) The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner." However, on 10/7/24 all the carbon monoxide detector batteries located in each of the home's four neighborhoods were dated "9/2023."

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The corrective action taken involved the immediate replacement of all carbon monoxide detector batteries in the home. This task was completed on 10/8/24 by the Building Services Coordinator.. Additionally, the Building Services Coordinator updated the maintenance log to reflect the new battery installation dates.

System Improvement Plan: To prevent recurrence, the facility has implemented a new policy requiring quarterly checks of all carbon monoxide detectors. The Building Services Coordinator and/or designee will conduct these checks, ensuring batteries are replaced annually or sooner if needed. Housekeeping Staff was trained on the new policy was conducted on 10/10/24.

Compliance Monitoring Plan: The Building Services Coordinator and/or designee will monitor compliance by conducting quarterly inspections of all carbon monoxide detectors and documenting the findings in the maintenance log. The results of these inspections will be reviewed quarterly by the Executive Director to ensure ongoing compliance. Any issues identified will be addressed immediately.

Compliance Date: The facility will be in substantial compliance by 2/19/2025

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented (- 04/14/2025)

25b - Contract Signatures

3. 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 #4 was admitted to the home on [redacted] However, the signatures of the home's memory care advisor and the resident's [redacted] were dated [redacted]

Repeat Violation: 11/21/22 et al.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The immediate corrective action taken included a thorough review and re-signing of

25b - Contract Signatures (continued)

Resident #4's contract to ensure all signatures are correctly dated. This action was completed on 10/15/24. The Memory Care Advisor was responsible for overseeing this corrective action to ensure compliance with the rule.

System Improvement Plan: To prevent recurrence, the facility has implemented a new protocol requiring a secondary review of all admission contracts by the Executive Director before finalization. Additionally, staff involved in the admission process, including the memory care advisor and administrative staff, will undergo mandatory training on proper contract documentation and date verification. This training was conducted on 10/15/24 by the Executive Director.

Compliance Monitoring Plan: The Executive Director/Designee will conduct monthly audits of all newly signed contracts for the next six months to ensure adherence to the new protocol. These audits will be documented, and any discrepancies will be addressed immediately. The results of these audits will be reviewed in monthly staff meetings to ensure continuous compliance.

Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

51 - Criminal Background Check

4. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The criminal history request for [redacted] the home's administrator, hired [redacted] was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes immediately initiating a new criminal background check for Staff Person A, which was completed on 10/18/24. Additionally, the Administrative Services Coordinator/HR has been tasked with ensuring that all new hires have their criminal background checks completed before their start date. This policy was implemented on 10/18/24.

System Improvement Plan: To prevent recurrence, the facility will revise its hiring policy to include a mandatory checklist that ensures all pre-employment requirements, including criminal background checks, are completed before the employee's start date. The Executive Director conducted a training session on 10/15/24 to educate the Administrative Services Coordinator/HR on the updated policy. The HR Manager/designee will review and approve all new hire documentation to ensure compliance.

Compliance Monitoring Plan: The Administrative Services Coordinator will conduct monthly audits of employee files to ensure all required documentation, including criminal background checks, is completed and up-to-date. These

51 - Criminal Background Check (continued)

audits will be documented and reviewed quarterly by the Executive Director to ensure ongoing compliance. Any discrepancies will be addressed immediately, and corrective actions will be documented.

Compliance Date: The facility will be in substantial compliance by 2/19/2025.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 10/8/24 the home served 52 residents. However, there was only one staff person present in the home who is trained in first aid and certified in obstructed airway techniques and CPR from 11:00 p.m. through 7:00 a.m. on 10/9/24.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: To address this deficiency, on 10/10/2024 we immediately requested copies of all CPR / First Aid cards from all staff that attended the CPR/First Aid training on 8/18/24. The Administrative Services Coordinator was responsible for obtaining all of these cards. The Executive Director was responsible for ensuring that all shifts are adequately staffed with trained personnel.

System Improvement Plan: Moving forward, on 10/10/2024 we implemented a new tracking system to ensure compliance with the first aid and CPR training requirements. This system will be used as a mandatory verification process to confirm that at least one trained staff member is present for every 50 residents at all times. The Human Resources Manager will review and update our staffing policies by 10/20/24,

Compliance Monitoring Plan: The Administrative Services Coordinator will monitor adherence to the new scheduling system. This will involve weekly audits of staff schedules and training records, starting from 11/30/24. The results of these audits will be reviewed in monthly management meetings to ensure ongoing compliance. Any discrepancies will be addressed immediately to prevent recurrence.

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

65a - FS Orientation 1st Day

6. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person B hired [redacted], did not receive orientation in the following topics:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation ...

(3) The designated meeting place outside the building or within the fire safe area in the event of an actual fire.

(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

(5) The location and use of fire extinguishers.

(6) Smoke detectors and fire alarms

(7) Telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: To address this deficiency that was identified during this survey period. 10/8/24, ED verified that employee B received training on 4/24/24 conducted by the Resident Services Coordinator on comprehensive fire safety and emergency preparedness. The orientation covered all required topics, including evacuation procedures, staff duties during fire drills, designated meeting places, smoking safety procedures, fire extinguisher locations, smoke detectors and fire alarms, and emergency services notification. The Director of Training was responsible for conducting this orientation.

System Improvement Plan: Moving forward, a new onboarding checklist has been implemented to ensure that all new hires receive the required fire safety and emergency preparedness orientation on their first day. This checklist will be reviewed and signed off by the Executive Director. Additionally, a quarterly audit of staff training records will be conducted to ensure compliance. The revised onboarding process and audit procedures were implemented on 11/01/24.

Compliance Monitoring Plan: The Administrative Services Coordinator will monitor compliance by reviewing the onboarding checklist for each new hire to ensure all required orientations are completed on the first day. This will be done on a weekly basis. Additionally, the quarterly audit of training records will be conducted by the Administrative Services Coordinator, with results reviewed during monthly staff meetings to ensure ongoing compliance. Compliance Date: 2/19/2025

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

65a - FS Orientation 1st Day *(continued)*

Not Implemented (- 04/14/2025)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person B, hired did not receive orientation in the following topics within 40 scheduled working hours:

(1) Resident rights.

(2) Emergency medical plan.

(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.

(4) Reporting of reportable incidents and conditions.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: 10/9/2024 The corrective action taken includes immediately verifying the required training for Direct Care Staff Person B was conducted for 2024. 10/20/24. The training covered all necessary topics, including resident rights, emergency medical plans, mandatory reporting of abuse and neglect, and reporting of reportable incidents and conditions. It was verified that Direct Care Staff Person B completed this training on 3/7 and 3/14/24. The Resident Services Coordinator was responsible for ensuring the completion of this orientation.

System Improvement Plan: To prevent recurrence, 6/1/24 the facility Administrative Services Coordinator implemented a new onboarding checklist that includes mandatory orientation topics to be completed within the first 40 scheduled working hours. This checklist will be reviewed and signed off by the Executive Director. Additionally, a policy review and revision will be conducted to ensure all new hires receive this training promptly.

Compliance Monitoring Plan: The Administrative Services Coordinator and/or designee will monitor compliance by reviewing the onboarding checklist for all new hires weekly for the next three months. Random audits will be conducted monthly to ensure ongoing adherence. The results of these audits will be documented and reviewed in monthly staff meetings to evaluate the effectiveness of the corrective actions and make any necessary adjustments.

Compliance Date: The facility will be in substantial compliance by 2/19/25

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Staff person B, hired [redacted] did not receive annual training in the following topics during the 1/1/23 – 12/31/23 staff training year:
(3)Care for residents with dementia and cognitive impairments.
(4)Infection control and general principles of cleanliness and hygiene …
(5)Personal care needs of the resident.
(6)Safe management techniques

Staff person C, hired [redacted], did not receive annual training in the following topics during the 1/1/23 – 12/31/23 staff training year:
(4)Infection control and general principles of cleanliness and hygiene …
(5)Personal care needs of the resident.
(6)Safe management techniques.

Repeat Violation: 2/13/24

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: To address this deficiency, ,on 10/22/24 the Executive Director verified 2024 mandatory training sessions covering the required topics for Direct Staff Person B and C have been completed. These trainings were conducted on 5/28/24, 7/18/24, 8/2/24, 10/29/2024, 11/20/24.

System Improvement Plan: Moving forward,1/1/2025, we will implement a robust tracking system to ensure all staff complete their required annual training. This system will include a centralized database to monitor compliance. Additionally, we will conduct quarterly reviews of training records by the Executive Direct to ensure no staff member falls behind. These audits will begin 4/1/2025 then quarterly.

Compliance Monitoring Plan: The Executive Director/designee will be responsible for conducting quarterly audits of training records. These audits will ensure that all staff have completed their required training. The results of these audits will be reviewed in monthly staff meetings, and any discrepancies will be addressed immediately. The first audit will take place on 4/1/2025, and subsequent audits will occur the first of each new quarter..
Compliance Date: We will be in substantial compliance by 2/19/2025.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024* ***Not Implemented ([redacted] - 04/14/2025)***

65g - Annual Training Content

9. 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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
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.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B, hired [redacted], did not receive annual training in the following topics during the 1/1/23 – 12/31/23 staff training year:

(1)Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

(3)Resident rights.

(4)The Older Adult Protective Services Act.

Staff person C, hired [redacted] did not receive annual training in the following topics during the 1/1/23 – 12/31/23 staff training year:

(1)Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

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

(5)Falls and accident prevention.

Repeat Violation: 2/13/24

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: To address this deficiency, 10/20/24 Executive Director verified the 2024 required annual training for Staff persons B & C . This training covered all mandated topics including fire safety, emergency preparedness, resident rights, the Older Adult Protective Services Act, falls and accident prevention, and any new population groups being served.

System Improvement Plan: To prevent recurrence, 10/20/24, we have implemented a new tracking system for staff training compliance.

Additionally, quarterly audits of training records by the Executive Director/designee to ensure all staff are up-to-date. These revisions and the new tracking system were implemented on 10/20/24

Compliance Monitoring Plan: The Executive Director/designee will monitor compliance by conducting monthly reviews of training records. Any discrepancies will be addressed immediately, and corrective actions will be documented. The first review under this new monitoring plan will occur on 1/10/2025.

Compliance Date: We will be in substantial compliance by 2/19/2025.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

65g - Annual Training Content *(continued)*

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

65i - Training Record

10. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The annual trainings for staff person B and staff person C did not include the dates, length of course, or who did the training for the following trainings:
**Meeting Resident Needs*
**Work orders – Emergency Preparedness – did not include length of training*
**Omnicare Pharmacy Training – did not include length of training.*
**Records provided for all classes completed on the legal entity's online training system.*

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: To address this deficiency, 10/20/24 Executive Director verified the 2024 required annual training for Staff persons B . This training covered all mandated topics including dementia, and cognitive impairment, infection control, personal care needs of the resident and safe mgt. tech needs.

System Improvement Plan: To prevent recurrence, 10/20/24, we have implemented a new tracking system for staff training compliance.
Additionally, quarterly audits of training records by the Executive Director/designee to ensure all staff are up-to-date. These revisions and the new tracking system were implemented on 10/20/24
Compliance Monitoring Plan: The Executive Director/designee will monitor compliance by conducting monthly reviews of training records. Any discrepancies will be addressed immediately, and corrective actions will be documented. The first review under this new monitoring plan will occur on 1/10/2025.
Compliance Date: We will be in substantial compliance by 2/19/2025.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

82c - Locking Poisonous Materials

11. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 10/7/24 at 12:10 p.m. the following poisonous items were in the unlocked and accessible cupboard above the empty space for medication cart storage in the Cloverdale kitchen:

82c - Locking Poisonous Materials (continued)

**3.75 oz tube of DermaPhor skin protectant moisturizing ointment with warning: In case of accidental ingestion, contact a physician or poison control center right away.*
**4 oz tube of Thera Calazinc body shield with warning: If swallowed, get medical help or contact a poison control center right away.*
**7 oz partially used tube of Remedy Prevent barrier ointment with warning; If swallowed, get medical help or contact a Poison Control Center right away.*

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: Immediate action was taken to lock the cupboard containing the poisonous materials. The items were relocated to a secure storage area that is only accessible to authorized staff. This corrective action was implemented on 10/7/24 by the Facility Manager.

System Improvement Plan: To prevent recurrence, the facility has revised its storage policy for poisonous materials. All staff were retrained on 10/10/24 regarding the importance of securing poisonous materials and the updated procedures. The training was conducted by the Resident Services Coordinator 5/28. Additionally, regular checks of storage areas will be incorporated into the daily routine of the housekeeping staff.

Compliance Monitoring Plan: Effect10/10 the Resident Services Coordinator will conduct weekly audits of all storage areas to ensure compliance with the new policy. These audits and any discrepancies will be addressed immediately. Results of the audits will be reviewed monthly by the Resident Services Coordinator to ensure ongoing compliance. Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

85e - Trash Outside Home

12. 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 10/21/24 at 9:00 a.m., the following items were on and around the home's fenced in dumpster:
** A translucent white bag of trash setting on top of the closed dumpster*
** A nearly emptied ripped-open translucent white trash bag hanging on the fence near dumpster*
** An opened bag behind dumpster exposing used briefs*
** Miscellaneous debris on the ground around dumpsters and outside of the gated area and in mulch to include: latex gloves, used wipes, small plastic dosing cups, straws, napkins, soda cans, plastic cups and plastic spoons.*

There was a piece of Styrofoam packing and warped cardboard lying behind the generator and a large, round, grey,

85e - Trash Outside Home (continued)

plastic trash can leaning against the fence between the generator and vinyl fencing.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The corrective action taken 10/8/24 included immediate cleanup of the trash and debris around the dumpster area. This was completed on 10/7/24 by the Building Services Coordinator. Additionally, all trash bags were properly disposed of in covered receptacles to prevent insect and rodent penetration. The Building Services Coordinator will ensure that all trash is properly contained and disposed of daily.

System Improvement Plan: To prevent recurrence, the facility will implement a daily inspection routine for the dumpster area. The Building Services Coordinator/designee will conduct these inspections and ensure that all trash is properly disposed of in covered receptacles. All maintenance and housekeeping staff was trained on the updated policy on 10/15/24. The training was conducted by the Executive Director.

Compliance Monitoring Plan: The Building Services Coordinator/designee will monitor the compliance of the corrective actions by conducting weekly inspections of the dumpster area for the next three months. Any issues will be documented and addressed immediately. The results of these inspections will be reviewed monthly in staff meetings to ensure ongoing compliance and to make any necessary adjustments to the procedures.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

86b - Bathroom

13. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 10/7/24 at approximately 4:00 p.m., the exhaust fan in the restroom on the right in Harvest Glen across from room #38 was not drawing in air from the bathroom. There is no window in this restroom.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The exhaust fan in the affected restroom was inspected and repaired to ensure proper ventilation. The repair was completed on 10/10/24 by the Maintenance Supervisor. Additionally, a check was conducted to ensure all other exhaust fans in the facility were functioning correctly.

System Improvement Plan: To prevent recurrence, a monthly inspection schedule for all bathroom exhaust fans has been implemented. The Maintenance Supervisor will conduct these inspections and document the findings. Any issues identified will be addressed immediately. Staff training on reporting maintenance issues promptly has been reinforced, work orders will be used as a reporting device

Compliance Monitoring Plan:12/15/24 The Maintenance Supervisor/ designee will monitor the functionality of all

86b - Bathroom (continued)

bathroom exhaust fans monthly. A log will be maintained to document the inspection dates and any actions taken. The Executive Director will review the log quarterly to ensure compliance and address any ongoing issues. The first review will occur on 1/15/25.

Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

88a - Surfaces

14. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The carpeting in several areas including the area leading to the kitchen and at the door to the administrative offices from the central interior area are darkened and dirty.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes a thorough cleaning of the affected carpeted areas. This cleaning was completed on 10/19/24 by our contracted cleaning service. Additionally, the Building Services Coordinator was tasked with inspecting all carpeted areas for any further cleaning needs or repairs, which was completed by 10/12/24.

System Improvement Plan: To ensure this deficiency does not recur, we have implemented a new cleaning schedule that includes weekly deep cleaning of high-traffic carpeted areas. . Additionally, quarterly inspections of all surfaces will be conducted by the Maintenance Supervisor/designee to identify and address any issues promptly.

Compliance Monitoring Plan: Building Services Coordinator/designee will monitor the cleanliness and condition of all surfaces through weekly inspections. Any issues identified will be documented and addressed immediately. The results of these inspections will be reviewed monthly by the Executive Director to ensure ongoing compliance. The first review will take place on 1/1/25.
Compliance Date: 2/19/25

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

89b - Hot Water Temperature

15. Requirements

89b - Hot Water Temperature *(continued)*

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 10/7/24 at approximately 11:25 a.m., the temperature of the hot water at the bathroom sink in resident room #4 in Berry Ridge Hall measured 133.5 degrees Fahrenheit.

On 10/7/24 at approximately 11:45 a.m., the temperature of the hot water at the sink in the common restroom/shower room to the left of the laundry room in Berry Ridge neighborhood measured 128.2 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken involved immediately adjusting the hot water heater settings to ensure temperatures do not exceed 120°F. This adjustment was completed on 10/8/24 by the Maintenance Supervisor. Additionally, all hot water outlets in resident-accessible areas were rechecked to confirm compliance.

System Improvement Plan: To prevent recurrence, we have implemented a daily monitoring system where the Building Services Coordinator/designee will check and record the hot water temperatures at various outlets throughout the facility. This process will be documented in a logbook. Staff training on the importance of maintaining safe water temperatures was conducted on 10/10/24 by the Facility Manager.

Compliance Monitoring Plan: The Building Services Coordinator/designee will monitor hot water temperatures weekly for the first three months and then monthly thereafter. Any deviations will be addressed immediately. The results will be reviewed monthly by the Executive Director to ensure ongoing compliance. The monitoring logs will be maintained and reviewed during quarterly safety meetings.
Compliance Date: The facility will be in substantial compliance by 2/19/25

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

91 - Telephone Numbers

16. 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 10/7/24 at 11:40 a.m., the list of emergency telephone numbers attached to the phone on the desk in the Berry Ridge kitchen was torn, folded and stuck to the laminate which prevented being able to decipher what phone number was for which entity.

Repeat Violation: 11/21/22 et al.

91 - Telephone Numbers *(continued)*

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The torn and illegible list of emergency telephone numbers was immediately replaced with a new, clearly printed list on 10/8/24. The new list was laminated to prevent future damage and securely attached to the phone. The Building Services Coordinator was responsible for this corrective action.

System Improvement Plan: To prevent recurrence, a monthly inspection schedule has been implemented to ensure all emergency telephone number lists are legible and intact. The Building Services Coordinator will conduct these inspections and replace any damaged lists as needed. Additionally, staff will be trained on the importance of maintaining these lists during the next staff meeting on 12/30/24.

Compliance Monitoring Plan: Building Services Coordinator/designee will monitor compliance by reviewing the condition of emergency telephone number lists during weekly walk-throughs. Any issues identified will be addressed immediately. and reviewed monthly during management meetings to ensure ongoing compliance.
Compliance Date: The facility will be in substantial compliance by 2/19/2025.

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

95 - Furniture and Equipment

17. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/7/24 at approximately 10:30 a.m., the under-layer of the lampshade in room #33 was cracked in several places.

On 10/7/24 at approximately 12:30 p.m., the fire pull station by room #25 in Cloverdale neighborhood was broken/inoperable. The top bar of the "T" with the arrow indicting to pull down was broken off. The battery was missing from the pull station.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The cracked lampshade in room #33 was replaced with a new one on 10/8/24. The fire pull station by room #25 was repaired. The Building Services Coordinator was responsible for these corrective actions.

System Improvement Plan: To prevent recurrence, a monthly inspection has been implemented for all furniture and equipment. The housekeeping staff will conduct these inspections and document any issues found.

Compliance Monitoring Plan: The housekeeping staff will conduct weekly checks for the next three months, then transition to monthly checks to ensure all furniture and equipment remain in good repair.
Compliance Date: The facility will be in substantial compliance by 2/19/2025.

Documentation of monitoring will be maintained by the administrator.

95 - Furniture and Equipment (continued)

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

96a - First Aid Kit

18. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 10/7/24 there was not a complete first aid kit in the home. At approximately 10:55 a.m., the first aid kit in the kitchen cupboard in Harvest Glen did not contain a thermometer, breathing shield, or eye coverings. At approximately 12:00 p.m., the first aid kit in Cloverdale kitchen did not include a thermometer or eye coverings. At approximately 2:15 p.m., the first aid kit in nurse's office did not include a thermometer or eye coverings.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The corrective action taken involved immediately restocking all first aid kits to ensure they contain all required items. This was completed on 10/25/24. The Resident Services Coordinator was responsible for verifying the contents of each first aid kit and ensuring they were fully stocked.

System Improvement Plan: To prevent recurrence, a new policy has been implemented requiring monthly checks of all first aid kits. The Resident Services Coordinator/ Nursing will oversee these checks, and a checklist will be used to document the presence of all required items. Additionally, staff training sessions on the importance of maintaining complete first aid kits were conducted on 10/25/24. The training was led by the Resident Services Coordinator.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance by conducting random weekly audits of the first aid kits for the next three months, followed by monthly audits thereafter. The results of these audits will be reviewed during the monthly staff meetings to ensure ongoing compliance. Any deficiencies found during audits will be addressed immediately.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

102i - Soap Dispenser

19. 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 10/7/24 at 11:50 a.m., there was a purple bar of soap lying on the floor of the shower stall in the shared shower

102i - Soap Dispenser (continued)

room to the left of the laundry room in Berry Ridge neighborhood.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The immediate corrective action taken was the removal of the bar soap from the shared shower room. On 10/8/24, liquid soap dispensers were installed in all shared bathrooms, including the one in Berry Ridge neighborhood. The Building Services Coordinator was responsible for this task. Additionally, staff were instructed to ensure that bar soaps are not used in shared bathrooms unless individually labeled for each resident.

System Improvement Plan: To prevent recurrence, the facility will implement a policy review and update to ensure compliance with soap dispenser regulations. Training sessions for all housekeeping and caregiving staff will be conducted by the Resident Services Coordinator on 10/15/24 to reinforce the importance of using liquid soap dispensers in shared bathrooms.

Compliance Monitoring Plan: The Housekeeping Supervisor will conduct weekly inspections of all shared bathrooms to ensure compliance with the soap dispenser rule. These inspections will be documented, and any issues will be addressed immediately. Monthly audits will be performed by the Resident Services Coordinator and results will be reviewed during the monthly staff meetings to ensure sustained compliance.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented (- 04/14/2025)

103f - Refrigerator/Freezer Temps

20. 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 10/7/24 at 11:05 a.m. the refrigerator section of the refrigerator/freezer in the Dockside kitchen measured 44 degrees Fahrenheit.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The refrigerator in the Dockside kitchen was immediately adjusted to ensure it maintains a temperature at or below 40°F. A new thermometer was installed to provide accurate readings. This corrective action was implemented on 10/7/24. The Dietary Manager is responsible for these corrective actions.

System Improvement Plan: To prevent recurrence, we have implemented a daily temperature log for all refrigerators and freezers. Staff will be trained on the importance of maintaining proper temperatures and how to record and respond to temperature deviations. This training will be completed by 12/15/24. The Dietary Managerr will review and revise the relevant policies to ensure clarity and compliance.

Compliance Monitoring Plan: The Dietary Manager will monitor refrigerator and freezer temperatures daily and

103f - Refrigerator/Freezer Temps (continued)

review the logs weekly. Any deviations will be addressed immediately, and corrective actions will be documented. Monthly audits will be conducted by the Dietary Manager to ensure ongoing compliance. The results will be evaluated during monthly staff meetings to ensure sustained compliance.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

103g - Storing Food

21. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 10/7/24 at approximately 10:50 a.m., there was an opened, undated bag containing three waffles in the freezer section of the refrigerator/freezer in the Harvest Glen kitchen.

On 10/7/24 at approximately 11:10 a.m., there was an opened, undated bag containing eight waffles in the freezer section of the refrigerator/freezer in Dockside kitchen.

On 10/7/24 at approximately 11:20 a.m., there was an opened, undated bag containing seven waffles in the freezer section of the refrigerator/freezer in the Berry Ridge kitchen.

On 10/7/24 at approximately 12:15p.m., there was an opened, undated bag containing nine waffles in the freezer section of the refrigerator/freezer in the Cloverdale kitchen.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

The Corrective Action Plan: Immediate corrective action was taken to ensure compliance with the cited rule. All opened and undated bags of waffles were discarded on 10/7/24. The Dietary Manager was responsible for overseeing this action. Additionally, staff were instructed to ensure all food items are stored in sealed containers and properly dated moving forward. This directive was implemented on 10/8/24.

System Improvement Plan: To prevent recurrence, a comprehensive review of food storage policies was conducted. The policy was revised to include mandatory labeling and dating of all food items upon opening. Staff training sessions were held on 10/9/24 and 10/10/24 to educate kitchen staff on the updated procedures. The Dietary Manager was responsible for these actions.

Compliance Monitoring Plan: The Dietary Manager will conduct weekly inspections of all kitchen areas to ensure compliance with food storage policies. These inspections will be documented, and any non-compliance will be addressed immediately. Monthly audits will be performed by the Dietary Manager to verify the effectiveness of the weekly inspections. Results will be reviewed during monthly staff meetings to ensure ongoing compliance.

103g - Storing Food (continued)

Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

107a - Emergency Preparedness

22. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

On 10/21/24, staff person A, the home's administrator, did not have a copy of the local municipality's emergency preparedness plan.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: 10/21/24 The administrator has obtained a copy of the local municipality's emergency preparedness plan.. The administrator has reviewed the plan thoroughly to ensure familiarity. The Executive Director is responsible for ensuring that the facility maintains an updated copy of the plan.

System Improvement Plan: To prevent recurrence, a new policy has been implemented requiring the administrator to review and update the emergency preparedness plan annually. This policy was reviewed management team on 11/05/24. Additionally, all administrative staff will undergo annual training on emergency preparedness, with the first session scheduled for 12/01/24.

Compliance Monitoring Plan: The Director of Operations will conduct quarterly audits to ensure that the emergency preparedness plan is current and that the administrator is familiar with its contents. These audits will be reviewed during monthly management meetings. Any discrepancies will be addressed immediately, and corrective actions will be taken as necessary.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

132c - Fire Drill Records

23. Requirements

2600.

132c - Fire Drill Records *(continued)*

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 home's fire drill records do not indicate the exit routes used for several fire drills. The records only indicate the name of one of four neighborhoods in the "exit routes used" column. They do not indicate if this is "from where" or "to where" the residents evacuated as follows:

** 9/6/24 "Harvest"*

** 8/17/24 "Berry"*

** 4/10/24 "Dockside"*

** 5/3/24 "Cloverdale"*

** 4/6/24 "Berry Ridge"*

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: 10/8/24 To address this deficiency, we have revised our fire drill documentation process to ensure comprehensive recording of all required details. Effective immediately, starting from 12/14/2024, the Executive Director will oversee the accurate completion of fire drill records. The revised documentation will include clear indications of both the starting and ending points of the evacuation routes.

System Improvement Plan: To prevent recurrence, we have implemented a standard that fire drill record all required information, including detailed exit routes. Additionally, all staff involved in fire drills will undergo mandatory training on the new documentation process by 12/18/2024.

Compliance Monitoring Plan: The Executive Director will conduct monthly audits of fire drill records to ensure compliance with the updated documentation standards. These audits will begin on 12/20/2024 and will be reviewed during the monthly safety meetings. Any discrepancies or omissions will be addressed immediately, and corrective actions will be documented.
Compliance Date: The facility will be in substantial compliance by 2/19/2025.

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

141b1 - Annual Medical Evaluation

24. Requirements

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

Description of Violation

Resident #1's annual medical evaluation (DME) completed 2/28/24 does not include if the resident has any special health or dietary needs, body positioning or movement needs, or the status of the resident's immunizations. The DME does not include the medical professional's license number. These sections are blank. Resident #1's annual DME also does not indicate that the resident needs to be served in a secured dementia care unit.

141b1 - Annual Medical Evaluation (continued)

Resident #4's annual medical evaluation completed 3/26/24 did not include the resident's height and if the resident's immunizations are current.

Repeat Violation: 5/1/24, 2/13/24, 12/12/23, 11/21/22 et al.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The facility will ensure that all sections of the annual medical evaluations are thoroughly completed. For Resident #1, (this resident has been discharged Resident #4, the missing information has been obtained and documented by 12/20/24. The Resident Services Coordinator will oversee this process to ensure completeness and accuracy.

System Improvement Plan: To prevent recurrence, the facility will revise its medical evaluation form to include mandatory fields that cannot be left blank. Staff training sessions on the importance of comprehensive medical evaluations will be conducted by the Resident Services Coordinator on 12/2/24. Additionally, a checklist will be implemented to verify all required information is included before finalizing the evaluations.

Compliance Monitoring Plan: The Executive Director/designee will conduct monthly audits of a random sample of medical evaluations to ensure compliance. These audits will begin on 11/5/24 and will be documented in a log. The results will be reviewed quarterly by the facility's management team to identify any trends or areas needing further improvement.

Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented (- 04/14/2025)

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4 is ordered metoprolol Succ ER 50mg tab – 0.5 tab (25mg) by mouth at bedtime. However, on 10/8/24 at 1:25 p.m., the pharmacy label on the blister pack of this medication indicates Metoprolol Succ ER 25mg – Give 1.5tabs (37.5mg) by mouth every day.

184a - Resident's Meds Labeled (continued)

Resident #5 is ordered Lidocaine 5% patch – Apply topically to back daily. Wear for 12 hours on 12 hours off. However, on 10/8/24 at 2:15 p.m., the pharmacy label on the bag containing this medication indicated Lidocaine patch 5% - Apply topically 1 patch to affected area every 12 hours.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken included immediately contacting the pharmacy to correct the labeling errors for Resident #4 and Resident #5. The corrected labels were received and verified by the nursing staff on 10/9/24. The Resident Services Coordinator was responsible for overseeing this corrective action.

System Improvement Plan: To prevent recurrence, the facility will implement a new protocol where all medication labels are double-checked by two licensed nurses upon receipt from the pharmacy. Additionally, a monthly audit of medication labels will be conducted by the Resident Services Coordinator. Staff training on the new protocol was completed on 10/15/24, led by the Resident Services Coordinator

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance by conducting weekly spot checks of medication labels for the next three months, then monthly thereafter. Results of these checks will be documented and reviewed in monthly staff meetings to ensure ongoing compliance. Any discrepancies will be addressed immediately.
Compliance Date: The facility will be in substantial compliance by 2/19/25

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

185a - Implement Storage Procedures

26. 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

Resident #4 is ordered atropine sulfate 1% drops – give 2-drops sublingually every 4 hours as needed for secretions. However, on 10/8/24 at approximately 2:00 p.m., this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes immediately ordering and ensuring the delivery of atropine sulfate 1% drops for Resident #4. The medication was received and logged into the medication administration record (MAR) on 10/9/24. The Resident Services Coordinator was responsible for this corrective action.

System Improvement Plan: To prevent recurrence, the following measures will be implemented:
• A comprehensive review and update of the medication storage and inventory procedures will be conducted by the Resident Services Coordinator by 12/20/24.

185a - Implement Storage Procedures (continued)

• Staff training sessions on the updated procedures will be held on 12/22/24, led by the Resident Services Coordinator
• A new policy requiring weekly inventory checks of all medications will be instituted, with immediate reordering protocols for any missing or low-stock items.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance with the new medication storage procedures. Weekly audits of medication inventory will be conducted by the Nursing Supervisor, starting 12/23/24. The results of these audits will be reviewed monthly by the Resident Services Coordinator to ensure ongoing compliance and to address any issues promptly.
Compliance Date: The facility will be in substantial compliance by 2/19/25

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

186a - Authorized Prescriber

27. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 10/8/24, the home did not have physician orders for the following medications that were on the medication cart, but not included on resident #4's medication administration record (MAR):
Furosemide 40mg – take 1 tablet by mouth every day as needed for secretions or volume overload
Prochlorperazine 10mg tab – take 1 tablet by mouth under tongue or rectally every 6 hours as needed for nausea or vomiting.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes obtaining written prescriptions from an authorized prescriber for all medications found on the medication cart. This action was completed on 10/9/24. The Resident Services Coordinator was responsible for ensuring that all medications have corresponding written prescriptions and are accurately reflected in the MAR.

System Improvement Plan: To prevent recurrence, the facility will implement a new protocol requiring a weekly audit of the medication carts and MARs by the nursing staff. This protocol includes a checklist to verify that all medications have current written prescriptions. Additionally, staff will receive training on this new protocol and the importance of maintaining accurate MARs. The training will be conducted by the Resident Services Coordinator and completed by 12/20/24.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance with the new protocol through bi-weekly audits for the first three months, then monthly audits thereafter. The results of these audits will be reviewed during monthly staff meetings to ensure ongoing compliance. Any discrepancies will be addressed

186a - Authorized Prescriber (continued)

immediately, and corrective actions will be documented.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

187a - Medication Record

28. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

On 10/8/24, the medication administration records (MAR) for several residents included medical abbreviations as follows:
**Resident #4's Multaq 400mg tab - "i PO after brkt and supper."*
**Resident #4's tramadol hcl 50mg tablet - "one tab PO Q8H PRN."*
**Resident #5's Eliquis [Apixaban] 5mg tablet – "PO BID."*

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes revising the MAR to eliminate the use of medical abbreviations and ensure all required information is clearly documented. This action was implemented on 10/15/24. The Resident Services Coordinator was responsible for overseeing this revision and ensuring compliance with the documentation standards.

System Improvement Plan: To prevent recurrence, the facility will implement a comprehensive review and update of the medication administration policy. This includes mandatory training sessions for all nursing staff on proper MAR documentation, emphasizing the prohibition of medical abbreviations. The training will be conducted by the Resident Services Coordinator and completed by 12/20/24.

187a - Medication Record (continued)

Compliance Monitoring Plan: The Resident Services Coordinator will conduct weekly audits of the MARs for the next three months, followed by monthly audits thereafter. These audits will verify that all medication records are complete and free of abbreviations. The results of these audits will be reviewed in monthly staff meetings to ensure ongoing compliance and address any issues promptly.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

187b - Date/Time of Medication Admin.

29. Requirements

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

Description of Violation

The October 2024 medication administration record (MAR) for resident #6 includes an entry for Vitamin B-12 500mcg tablet – take 1 tab by mouth every day. The MAR has not been initialed indicating that the medication was administered from 10/1/24 – 10/8/24.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes an immediate review and update of Resident #6's MAR to ensure all entries are accurately completed. This was implemented on 10/9/24. The Resident Services Coordinator was responsible for this corrective action, ensuring that all staff are aware of the importance of documenting medication administration in real-time.

System Improvement Plan: To prevent recurrence, the facility will implement a new electronic MAR system that prompts staff to record the date and time of medication administration before moving to the next task. Additionally, a policy review and revision will be conducted to reinforce the importance of timely documentation. Staff training sessions on the updated policy and new system will be held on 10/15/24 and 10/16/24, led by the Resident Services Coordinator

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance by conducting weekly audits of MARs for the next three months, then monthly audits thereafter. Any discrepancies will be addressed immediately with retraining as necessary. The results of these audits will be reviewed in monthly staff meetings to ensure continuous compliance and to discuss any further improvements.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

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

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented (- 04/14/2025)

191 - Resident Right to Refuse

30. 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

There was no documentation that resident #7, admitted was educated on the right to question or refuse a medication if the resident believes there may be a medication error.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The corrective action taken includes immediate education of Resident #7 on their right to question or refuse medication. This education was provided on 10/8/24 by the Executive Director. Documentation of this education has been added to Resident #7's file. Moving forward, all new residents will be educated on this right upon admission, and this will be documented in their files.

System Improvement Plan: To prevent recurrence, the facility will revise its admission process to include mandatory education on the right to question or refuse medication. This will be incorporated into the admission checklist. The Resident Services Coordinator will conduct a training session for all nursing staff on 11/15/24 to ensure they understand the importance of this education and the documentation process. The facility's policy on resident rights will be reviewed and updated by 11/20/24 to reflect these changes.

Compliance Monitoring Plan: Monthly audits of new resident files will be conducted by the Executive Director/designee to ensure documentation of education on the right to refuse medication. Any discrepancies will be addressed immediately to ensure ongoing compliance.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented (- 04/14/2025)

224a - Preadmission Screen Form

31. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

A preadmission screening was not completed for resident #4 who was admitted to the home on

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The facility has immediately implemented a policy to ensure that all preadmission screening forms are completed and documented within the required 30-day period prior to any resident's admission. As of 12/14/2024, the Admissions Coordinator is responsible for verifying the completion of these forms before admission. Resident #4's preadmission screening form was completed retroactively on 12/14/2024.

System Improvement Plan: To prevent recurrence, the facility has revised its admissions protocol to include a mandatory checklist that requires the completion of the preadmission screening form. This checklist will be reviewed and signed off by the Admissions Coordinator and the Resident Services Coordinator

Compliance Monitoring Plan: The Executive Director will conduct monthly audits of all new admissions to ensure compliance with the preadmission screening form requirement. These audits will be documented and reviewed during the monthly management meetings. Any discrepancies will be addressed immediately, and corrective actions will be implemented as necessary.
Compliance Date: The facility will be in substantial compliance by 2/19/2025

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented (- 04/14/2025)

225c - Additional Assessment

32. 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 #4's annual assessment completed 6/14/24 did not indicate if the resident has any dietary or sensory (vision, hearing, communication, olfactory and tactile) needs. These sections were blank.

Resident #7's annual assessment completed 1/27/24 did not indicate if the resident has any dental, dietary, or sensory needs. These sections were blank.
Repeat Violation: 5/1/24, 2/13/24, 12/12/23, 11/21/22 et al.

Plan of Correction ***Accept (- 12/30/2024)***

Corrective Action Plan: The corrective action taken includes a comprehensive review and completion of the missing sections in the assessments for Resident #4 and Resident #7. This action was implemented on 10/15/24. The Resident Services Coordinator was responsible for ensuring the assessments were updated accurately and completely.

System Improvement Plan: To prevent recurrence, we have revised our assessment procedures to include a mandatory checklist that ensures all sections are completed. Staff training sessions on the importance of thorough assessments were conducted on 10/20/24. The training was led by the Director of Nursing and attended by all

225c - Additional Assessment (continued)

nursing staff. Additionally, we have updated our electronic health record system to flag incomplete assessments for review.

Compliance Monitoring Plan: The Director of Nursing will monitor compliance by conducting monthly audits of resident assessments to ensure all sections are completed. These audits will be documented and reviewed during monthly staff meetings. Any discrepancies will be addressed immediately, and corrective actions will be taken as necessary. The results of these audits will be evaluated quarterly to ensure sustained compliance.
Compliance Date: 2/19/2025

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

227g -Support Plan Signatures

33. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #7's annual support plan completed 1/27/24 was not signed by the assessor.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The previous Administrator is no longer with the company so obtaining the missing signature from the assessor for Resident #7's support plan was not possible 11/1/2024 A new RASP was completed for Resident $7 and signed by current assessor.

System Improvement Plan: To prevent recurrence, a new policy has been implemented requiring that all support plans be reviewed for signatures before being finalized. The Executive Director is responsible for these actions.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor compliance by conducting monthly audits of all newly completed support plans to ensure they are signed and dated by all participants. These audits will be documented and reviewed during monthly staff meetings. Any discrepancies will be addressed immediately, and corrective actions will be taken as necessary. The results of these audits will be evaluated quarterly to ensure sustained compliance.

Compliance Date: The facility will be in substantial compliance by 2/19/25

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

233c - Key-Locking Devices

34. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 10/7/24 at 10:46 a.m., the code to enter into the keypad to unlock the gate near the dumpster had a code posted on the metal pole to the right of the gate. However, there were two keypads on the wall of the building perpendicular and to the left of the gate. There was no way to identify which of the two keypads operates the lock to the gate and which one operates the door to the Harvest Glenn neighborhood of the home.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes clearly labeling both keypads to indicate their specific functions. The keypad that operates the gate will be labeled "Gate Keypad," and the one that operates the door to the Harvest Glenn neighborhood will be labeled "Door Keypad." This labeling was completed on 10/15/24 by the Housekeeping Staff.

System Improvement Plan: A monthly inspection checklist has been updated to include verification of proper labeling of all key-locking devices. Staff training on the new policy and inspection checklist was conducted on 10/20/24 by the Executive Director.

Compliance Monitoring Plan: The Executive Director/designee will conduct weekly inspections to ensure that all key-locking devices and keypads remain properly labeled.

Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Not Implemented ([redacted] - 04/14/2025)

234d - Support Plan Revision

35. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #7's annual support plan, completed 1/27/24. did not include a plan to meet the medical need of any of the resident's medical diagnoses including: hyperlipidemia, pleural effusion, unsteadiness on feet, diabetes mellitus, essential hypertension, Gastro-esophageal reflex, and cognitive communication disorder.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The corrective action taken includes an immediate review and update of Resident #7's support plan to ensure all medical needs are addressed. This was completed on 12/01/24 by the Resident Services Coordinator. Additionally, all other residents' support plans will be reviewed and updated as necessary to ensure compliance.

234d - Support Plan Revision (continued)

System Improvement Plan: To prevent recurrence, the facility will implement a new protocol requiring quarterly reviews of all residents' support plans by the Resident Services Coordinator and the nursing staff. A checklist will be developed to ensure all medical diagnoses and needs are addressed in the support plans. Staff training on the new protocol will be conducted by 12/15/24, led by the Resident Services Coordinator

Compliance Monitoring Plan: The Resident Services Coordinator will monitor the support plans monthly to ensure they are up-to-date and comprehensive. This will involve random audits of 10% of the support plans each month. The results of these audits will be reviewed in monthly staff meetings, and any deficiencies will be addressed immediately.
Compliance Date: The facility will be in substantial compliance by 2/19/25.

Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

236 - Staff Training

36. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, hired [redacted], did not receive six hours of annual training related to dementia care and services during the 1/1/23 – 12/31/23 staff training year.

Plan of Correction ***Accept ([redacted] - 12/30/2024)***

Corrective Action Plan: The facility has scheduled immediate training sessions to ensure compliance. Direct care staff person B will complete the required six hours of dementia care training by 12/20/24. The Director of Nursing will oversee the training sessions and ensure all materials are covered comprehensively. This action was initiated on 12/10/24 and will be completed by 12/20/24.

System Improvement Plan: To prevent recurrence, the facility will implement a new tracking system for staff training requirements. This system will include automated reminders for upcoming training deadlines and a centralized database accessible by management. The Administrative Services Coordinator will review the training policy by 12/15/24, ensuring all staff are aware of their training obligations.

Compliance Monitoring Plan: The Resident Services Coordinator will monitor the completion of required training through monthly audits of training records. These audits will be conducted on the first Monday of each month, starting 1/6/25. The results of these audits will be reviewed in monthly management meetings, and any discrepancies will be addressed immediately .

Compliance Date: The facility will be in substantial compliance by 2/19/25

236 - Staff Training (continued)

Documentation of education will be kept in accordance with Regulation 2600.65(i) Documentation of monitoring will be maintained by the administrator.

Licensee's Proposed Overall Completion Date: *12/23/2024*

Implemented ([redacted] - 04/14/2025)

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

Facility Information

Name: *ARDEN COURTS (MONROEVILLE)* **License #:** *43552* **License Expiration:** *05/23/2025*

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

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date:** *02/11/2025*

Inspection Dates and Department Representative

01/23/2025 - On-Site: [redacted]
01/27/2025 - On-Site:
02/10/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire PCH* **Capacity:** *56* **Residents Served:** *54*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *54*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *54*
Have Physical Disability: *0*

Inspections / Reviews

01/23/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2025*

03/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/24/2025*

03/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/07/2025*

05/15/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/07/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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 1/17/25 at approximately 6:28 a.m., staff person [redacted] a nurse, observed resident #1 on the floor of [redacted] room. Resident #1 told the nurse "[redacted] [another resident] punched me." The allegation of physical abuse against resident #1 was not reported to the local Area Agency on Aging until 1/18/25 at 10:55 a.m.

On 2/8/25, at approximately 8:45 p.m., staff person B witnessed an incident of resident-to-resident physical abuse against resident #2. However, the incident was not reported to the local Area Agency on Aging until 2/9/25 at 12:45 p.m.

Repeat Violation: 1/10/23

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

All staff were previously educated during the period of February 17 to March 4, 2025. The facility will be re-educating all staff on the requirement for immediate reporting to the local Area Agency on Aging for all suspected abuse cases. This training will be conducted by the Executive Director or designee on or before April 11, 2025. The Resident Service Coordinator or designee will conduct a review of all incidents occurring between February 15 – March 14, 2025 to ensure proper reporting. Executive Director or Resident Services Coordinator will conduct a weekly audit of incident reports for 4 weeks to ensure that incidents are reported within the required time frame. The results of these will be reviewed weekly with the management team. Following the 4 weeks an audit will be conducted and reviewed with the management team monthly for two months to evaluate compliance and identify areas of improvement. The administrator will review all allegations of abuse to ensure compliance with Regulation 2600.15(a). Allegheny County Area Agency on Aging was contacted on March 18 and March 20, 2025 to provide additional staff training. Date to be determined.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall review all allegations of abuse to ensure compliance with Regulation 2600.15(a). [redacted] *3/26/25*

Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

16c - Written Incident Report

2. 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 Violation

On 2/8/25, at approximately 8:45 p.m., staff person B witnessed an incident of resident-to-resident physical abuse against resident #2. However, the incident was not reported to the Department until 2/10/25 at 11:13 a.m.

On 2/10/25 at 8:55 a.m. when Department representatives arrived on-site, two fire department vehicles were in front of the building. A fire fighter told licensing representative that a toaster set off the alarm. However, the home did not submit an incident report to the Department regarding this incident.

Repeat Violation: 1/10/23

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

Managers and nursing supervisors will be inserviced on the requirement for reporting incidents and conditions to the personal care home regional office within 24 hours. This training will be conducted by the Executive Director or designee on or before April 11, 2025. The Resident Service Coordinator or designee will conduct a review of all incidents occurring between February 15 – March 14, 2025 to ensure proper reporting. Executive Director, Resident Services Coordinator or designee will conduct a weekly audit of incident reports for 4 weeks to ensure that incidents are reported within the required time frame. The results of these will be reviewed weekly with the management team. Following the 4 weeks an audit will be conducted and reviewed with the management team monthly for two months to evaluate compliance and identify areas of improvement. The administrator will review all reportable incidents and conditions to ensure compliance with Regulation 2600.16(c).

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall review all reportable incidents and conditions to ensure compliance with Regulation 2600.16(c). [redacted] 3/26/25

Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

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 12/9/24 at approximately 3:30 p.m., staff person K opened the door to resident #3's room and saw resident #4 lying across the bed with [redacted] shirt and [redacted] exposed. Resident #5 (not this resident's room) was sitting on the bed sideways and fondling resident #4 [redacted] and when [redacted] stood up, [redacted] was fixing [redacted] zipper. Resident #3 was not present in the

42b - Abuse (continued)

room. Resident #5 got upset with the staff person K who walked into the room and told the staff person that resident #4 was [redacted] Resident #4 has a history of wandering into the various neighborhoods and going into other resident rooms.

On 1/17/25 at approximately 6:28 p.m., staff person C had walked some residents to the living room of Harvest Glenn. Then staff person C heard resident #1 scream and say something like "[redacted] you!" Staff person C went to resident #1's room to find resident #1 sitting on the floor facing resident #6. Resident #6 had both fists up and was facing resident #1. Resident #6 had toothpaste on [redacted] mouth because [redacted] was brushing [redacted] teeth in resident #1's room. Staff person C asked resident #1 what happened, and [redacted] said that resident #6 hit [redacted] Staff person C asked resident #6 what happened and [redacted] kept saying "[redacted] shoved me." Resident #1 admitted that [redacted] shoved [redacted] because [redacted] wanted [redacted] out of the room. Resident #6 admitted to hitting [redacted] but kept saying "[redacted] was hitting me." Resident #1 was bleeding on [redacted] nose. It is unknown if the bleeding was from being hit or from hitting [redacted] nose on something.

On 2/8/25 at approximately 8:45 p.m., staff person B observed resident #2 leaving [redacted] room and witnessed resident #1 swinging [redacted] fists at resident #2. Resident #2 told staff person B that resident #1 was beating [redacted] up and threw water on [redacted] Resident #2's bed was wet from the water being thrown on [redacted] by resident #1.

Repeat Violation: 11/21/22 et al.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

Executive Director/designee will educate nursing staff on Resident Rights by 04/11/25. Allegheny County Area Agency on Aging was contacted on March 18 and March 20, 2025 to provide additional staff training. Date to be determined.

Executive Director/designee will audit staff interactions with residents 1x/week for 4 weeks to ensure residents rights are being followed starting on the week of 3/17/25. Private interviews of four residents will occur weekly for three months beginning March 20, 2025. Three resident interviews will then be conducted monthly for three months thereafter. The Executive Director will be responsible for submitting and reviewing the findings with management team. Any issues identifed will be addressed immediately to maintain compliance.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

63a - First Aid/CPR Training

4. Requirements

2600.

63a - First Aid/CPR Training *(continued)*

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 10/31/24, the home served 51 residents. However, from 11:00 p.m.– 7:00 a.m. on 11/1/24, there was only one person certified in obstructed airway techniques and CPR present in the home; no staff persons were trained in first aid.

According to staff person D, the home's administrator, the home served more than 50 residents on 11/17/24. However, from 7:00 a.m.– 3:00 p.m., there was only one staff person trained in first aid and certified in obstructed airway techniques and CPR and two staff persons who were certified in obstructed airway techniques and CPR but not trained in first aid present in the home.

According to staff person D, the home's administrator, the home served more than 50 residents on 12/25/24. However, from 3:00 p.m.– 11:00 p.m., there was only one staff person trained in first aid present in the home.

According to staff person D, the home's administrator, the home served more than 50 residents on 12/25/24. However, from 11:00 p.m. – 7:00 a.m. on 12/26/24, there was only one staff person trained in first aid present in the home.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

All employee files were audited by the Administrative Services Coordinator on February 27, 2025 for obstructed airway techniques and CPR and First Aid certification. Obstructed airway techniques and CPR and First Aid trainings will be conducted at the community on March 21 and the week of March 24, 2025 to ensure compliance with Regulation 2600.63(a).

The Resident Services Coordinator will develop and implement a biweekly schedule to include at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR will be in the home at all times. This schedule will be implemented by March 31, 2025.

The Administrative Services Coordinator of designee will complete a weekly review of actual staff persons who worked in the home to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR was in the home at all times, including vacations of call offs. This weekly review will begin the week of March 31, 2025

After April 18, 2025 Executive Director or Administrative Services Coordinator will conduct an audit of the schedule weekly for 4 weeks and monthly for 2 months to ensure compliance with Regulation 2600.63 (a)

Licensee's Proposed Overall Completion Date: *03/31/2025*

Not Implemented ([redacted] - 04/14/2025)

65a - FS Orientation 1st Day

5. Requirements

2600.

65a - FS Orientation 1st Day *(continued)*

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person E, hired [redacted] whose first day of work was [redacted], did not receive general orientation in general fire safety and emergency preparedness until 1/9/25 that included the following:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

(5) The location and use of fire extinguishers.

(6) Smoke detectors and fire alarms.

(7) Telephone use and notification of emergency services.

Direct care staff person F, hired [redacted], did not receive general orientation in general fire safety and emergency preparedness until [redacted] that included the following:

(1) Evacuation procedures.

(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

(5) The location and use of fire extinguishers.

(6) Smoke detectors and fire alarms.

(7) Telephone use and notification of emergency services.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

Hiring managers will be re-educated by the Executive Director or designee on the state specific Day 1 required training by April 11, 2025. The next General Orientation for new staff is scheduled for March 18, 2025 and will include the state specific Day 1 topics.

An audit of staff files was conducted by the Administrative Services Coordinator. Any staff that did not have general fire safety and emergency preparedness training on Day 1 were re-educated by the Building Services Coorodinator on or before March 20, 2025.

The Executive Director and Administrative Services Coordinator will audit staff training files monthly throughout 2025 to ensure compliance with 2600.65(f). These audits will be reviewed with the management team to evaluate compliance and identify areas of improvement.

65a - FS Orientation 1st Day (continued)

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 5 days of receipt of the plan of correction: The administrator shall educate staff persons E and F on the required training topics in Regulation 2600.65(a). Documentation of education shall be kept in accordance with Regulation 260.65(i). [redacted] *3/26/25*

Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] ***- 04/14/2025)***

65f - Training Topics

6. 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.
6. Safe management techniques.

Description of Violation

Direct care staff person G, hired on [redacted]*, did not receive instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2024 staff training year.*

Direct care staff person H, hired on [redacted]*/*[redacted] *did not receive training on safe management techniques during the 2024 staff training year.*

Repeat Violation: 2/13/24

Plan of Correction ***Directed (*** [redacted] ***- 03/26/2025)***

The Administrative Services Coordinator will be inserviced by the Executive Director or designee on Regulation 2600.65(f) by April 11, 2025.

The 2025 training calendar has been developed and will be implemented by April 18, 2025 to ensurse that all required trainings for 2600.65(f) will be completed for the 2025 training and calendar year.

The Executive Director and Administrative Services Coordinator will audit staff training files monthly throughout 2025 to ensure compliance with 2600.65(f). These audits will be reviewed with the management team to evaluate compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/11/2025

DIRECTED

65f - Training Topics (continued)

Within 5 days of receipt of the plan of correction: The administrator shall educate staff persons G and H on the required training topics in Regulation 2600.65(f). Documentation of education shall be kept in accordance with Regulation 260.65(i). [redacted] *3/26/25*

Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)

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:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
5. Falls and accident prevention.

Description of Violation

Direct care staff person G, hired on [redacted]*, did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2024 staff training year.*

Direct care staff person I, hired on [redacted] *did not receive training in falls and accident prevention during the 2024 staff training year.*

Repeat Violation: 2/13/24

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Staff person G will be in-serviced by fire safety expert on March 31st, 2025. The Building Services Coordinator will be trained as a fire safety expert on April 9, 2025. Staff person I will be trained in falls and accident prevention by the Executive Director or designee by March 31, 2025.

The 2025 training calendar has been developed and will be implemented by March 21, 2025 to ensure that all required trainings for 2600.65(g) will be completed for the 2025 training and calendar year.

The Executive Director, Administrative Services Coordinator or designee will audit staff training files monthly throughout 2025 to ensure compliance with 2600.65(g). These audits will be reviewed with the management team to evaluate compliance and identify areas of improvement.

Proposed Overall Completion Date: 03/31/2025

Licensee's Proposed Overall Completion Date: *03/31/2025*

Not Implemented ([redacted] - 04/14/2025)

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 1/23/25 at 8:55 a.m. and at 11:45 a.m., the entire lid on the home's dumpster on the right of two dumpsters was flipped all the way open. The dumpster was filled with trash including a desk chair, boxes and trash bags.

Plan of Correction ***Directed (- 03/26/2025)***

The Maintenance/Housekeeping team and the Management team will be inserviced by the Building Services Coordinator or designee before April 11, 2025 on regulation 85(e) and the need for trash outside the home to be kept in covered receptacles. Daily checks of outdoor receptacles began on 3/3/2025 and will continue to be conducted by the Building Services Coordinator or designee to ensure receptacles are covered and logs will be maintained to document compliance. These checks will be conducted daily for one month and weekly for two months. These checks will be reviewed weekly with the management team to evaluate compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. 3/26/25

Directed Completion Date: *04/06/2025*

Not Implemented (- 04/14/2025)

89a - Water Pressure

9. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 1/23/25 at approximately 1:40 p.m., the hot water at the sink in the kitchen of Harvest Glen reached a maximum temperature of 49.7 degrees Fahrenheit, and the hot water temperature at the sink in the common bathroom across from Room #38 reached a maximum temperature of 50.1 degrees Fahrenheit.

Plan of Correction ***Directed (- 03/26/2025)***

The Building Services Coordinator inspected the mixing valve on 1/24/2025. Upon resetting mixing valve, the hot water temperature in Harvest rose to 116 degrees.

The Houskeeping/Maintenance Team and Management Team will be re-educated by the Building Services Coordinator or designee by April 11, 2025 on the importance of maintaining water pressure and temperature to accommodate residents of the community.

Water temperatures are monitored daily by the Building Services Coordinator/designee throughout the facility to ensure that hot and cold water is available to accommodate the needs of the residents. A new log form was implemented on 3/13/2025 to routinely document water temperatures throughout the community. The Building Services Coordinator will monitor the water temperature logs daily for the first month and weekly for 2 months. Any deviations will be addressed immediately. The results will be discussed with the management team weekly to

89a - Water Pressure (continued)

evaluate for compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

100b - Removal Snow/Obstructions

10. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 1/23/25, at 9:59 a.m., the home's fire alarm sounded due to a malfunction and leak in the sprinkler system. There had been no accumulation of snowfall for the past few days in the area. However, during the evacuation, there was approximately 2 inches of snow along the following sidewalks in the home's courtyard which serves as an emergency evacuation route in the event that evacuation from the areas of refuge is needed:
** Exit from Central Station to the courtyard.*
** Exit from the Studio to the courtyard.*
** Egress path beginning just beyond the end of the building from the Dockside and Harvest dining rooms towards the courtyard gates near the dumpster.*
** The sidewalk outside of the exit door from Dockside neighborhood into the courtyard leading to the gates near the dumpster.*

On 1/23/25, at approximately 12:00 p.m., the sidewalk leading from the exit door across from the beauty shop into the courtyard was cleared to the perimeter fencing. The sidewalk to the gate that exits to parking lot near Berry Ridge was clear of snow. However, the sidewalk to the left (toward rear of building) is cleared of snow for approximately 20 feet, but the remaining sidewalk toward the rear of the building along the Clover Dell neighborhood and the sidewalk around the rear of the building was covered with 1½ inches of snow. The emergency exit at the end of Clover Dell hallway leading to the courtyard was covered with 1½ inches of snow.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

The Building Services Coordinator immediately shoveled the snow on 1/23/2025.

The snow removal protocol has been reviewed, which includes regular monitoring of weather conditions and preemptive snow removal measures. Staff training on snow removal procedures and the use of snow removal equipment. Training sessions will be conducted by the Building Services Coordinator by April 11, 2025 for coordinators, supervisors and housekeepers.
The Building Services Coordinator will conduct daily inspections of all walkways and emergency routes during the winter months to ensure they are free of snow and obstructions. Inspections will be documented, and any issues

100b - Removal Snow/Obstructions (continued)

will be addressed immediately. The results of these inspections will be reviewed weekly by executive director and building services coordinator to ensure compliance and effectiveness of the snow removal protocol.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

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 home's fire drill record for the 1/23/25 incident involving a frozen pipe in the sprinkler system indicate the exit routes used as "Berry to Dockside." The record does not indicate where residents in the other areas of the building were evacuated to.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

All staff will be re-educated on the fire drill procedures, including focusing on the importance of detailed documentation. This training will be conducted by the Building Services Coordinator/designee and will be completed by 04/11/25.

The Executive Director or designee shall audit the fire drill record monthly for 3 months to ensure the home's written fire drill record accurately includes 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. Documentation of audits will be kept. Ongoing compliance with regulation 132(c) will be monitored at the monthly safety committee meeting.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)

132d - Evacuation

12. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's safe evacuation time to areas of refuge as determined by a fire safety expert on 3/15/24 is 15 minutes. However, on 1/23/25, the fire alarm sounded at 9:59 a.m. and the "all clear" was not called until 10:18 a.m.

Several interviews indicate that not all residents are evacuated from individual rooms in unaffected areas of the home during fire drills. Residents are permitted to remain in their rooms.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

A fire drill was conducted on 3/4/25 and the evacuation time was 6 minutes 47 seconds.

All staff will be re-educated on the fire drill procedures, including focusing on documentation of time for evacuation in compliance with 2600.132(d). This training will be conducted by the Building Services Coordinator/designee and will be completed by 04/11/25.

The Executive Director or designee shall audit the fire drill record monthly for three months to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. Documentation of audits will be kept. Ongoing compliance will be monitored monthly by the facility's safety committee.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator shall complete the following steps to reduce the safe evacuation to a time less than 2 minutes and 30 seconds, if the home is unable to obtain a safe evacuation time specified in writing by a fire safety expert within the past year:
• Provide resident and staff education on evacuation policies and procedures. Documentation will be kept.
• Conduct additional fire drills.
• Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.
• Add additional staff (at all times) to meet the 2 minute and 30 second evacuation time or the safe evacuation time specified by the fire safety expert within the past year. [redacted] 3/26/25

Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

184a - Resident's Meds Labeled

13. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #7 is prescribed Atorvastatin 80 mg tablet - give 0.5 tab (40 mg) by mouth at bedtime. The label on this medication indicates Atorvastatin Calcium 40 mg take one tablet by mouth at bedtime.

Resident #7 is prescribed Eliquis 5 mg tablet - give 1 tablet by mouth twice daily (blood thinner). However, the label for this medication only includes Apixaban 5 mg tablet take one tablet by mouth twice a day for blood thinner.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

A direction change sticker was applied to the label of the Atorvastatin. The MAR was updated to read Apixaban instead of Eliquis. This was compled immediately by the Resident Services Coordinator.

An audit of all medication carts and MAR's was completed on 1/30/2025 for compliance with medication labeling.

All nurses and medication techs will be re-educated by the Resident Services Coordinator or designee by April 11, 2025 on the requirements for medication labeling including the name of the the medication, date prescription was issued, and prescribed dosage and instructions for administration.

The Resident Services Coordinator or designee will conduct weekly medication cart and MAR audits to include medication labels for all residents to ensure compliance with labeling requirements, and any discrepancies will be addressed immediately. These audits will be reviewed by the management team weekly for one month and monthly for two months to evaluate the effectiveness of the corrective measures and make any necessary adjustments.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] *3/26/25*

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)

187a - Medication Record

14. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #6's January 2025 medication administration record (MAR) did not include a diagnoses or purpose for

187a - Medication Record (continued)

medications to include:
** Melatonin 3 mg tablet 1 tablet by mouth at bedtime.*
** Ezetimibe 10 mg tablet give 1 tab by mouth every day.*
** Pantoprazole Sodium F/C 40 mg tablet give 1 tablet every day.*
** Prednisone 20 mg tablet give 1 tablet by mouth every day.*
** Memantine HCL F/C 5 mg tablet give 1 tablet by mouth twice daily.*
** Mutlaq 400 mg tablet give 1 tablet by mouth after breakfast and after supper.*
** Clotrimazole-Beta met 1-0.05% cream apply topically to bilateral lower extremities twice daily for 14 days.*

Resident #7 is prescribed Donepezil HCL F/C 10 mg tablet give 1.0. The medication prescription order was changed on 1/21/24 from 15 mg take every day to 5 mg take every day.
This medication is written 3 additional times on the January 2025 MAR. However, the diagnosis or purpose is not included on any of the order changes.

Resident #8's January 2025 Medication Administration Record did not include diagnoses or purpose for medications to include:
** Omeprazole 20 mg capsule DR give 2 caps (40 MG) by mouth every morning prior to breakfast (give 30 mins before meal).*
** Quetiapine Fumarate 25 mg tablet give 1 tablet by mouth at bedtime.*

Resident #8 is prescribed Escitalopram Oxalate F/C 10 mg tablet - give 1.5 tabs by mouth every morning. On 1/27/25, according to the resident's January 2025 MAR, Escitalopram was discontinued on 1/19/25. The residents 2025 MAR indicates "D/C 1/19/25 see change" and a new entry was written on the MAR indicating Escitalopram 10mg – Give 1 tab (10mg) by mouth every day and documented as administered from 1/20/25-1/23/25 at 9:00 a.m. However, according to staff person [redacted] a nurse, this medication was not changed.

Resident #9's January 2025 Medication Administration Record did not include diagnoses or purpose for medications to include:
** Quetiapine Fumarate 50 mg tablet 1 tablet by mouth three times daily.*
** Donepezil HCL F/C 10 mg tablet give 1 tablet by mouth every day.*
** Melatonin 3 mg tablets give 2 tablets at bedtime.*
** Melatonin 1 mg tablets give 2 tablets at bedtime.*

Resident #10's January 2025 MAR did not include diagnoses or purpose for numerous medications to include:
** Lorazepam 0.5mg tablet Lk: Ativan give 1 tablet by mouth twice daily.*
** Ropinirole HCL 1mg tablet give 1 tablet by mouth twice daily*
** Polyethylene Glycol 3350 17gm (1 capful) in 8 ounces of liquid*
** Senna 8.6mg tablet give 1 tablet by mouth every day as needed.*

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

An audit of all medication carts and MAR's was completed by the Resident Services Coordinator and Resident Services Supervisor by 1/30/2025 for compliance with the complete medication order including dosage, diagnosis or indication for use. All resident MAR's were updated for February 1, 2025 to include dose, diagnosis and indication for use.

All nurses and medication techs will be re-educated by the Resident Services Coordinator or designee by April 11,

187a - Medication Record (continued)

2025 on the requirements for complete medication order including dose, diagnosis or indication for use.

The Resident Services Coordinator or designee will conduct weekly medication cart and MAR audits for all residents to ensure compliance with complete medication orders including dosage, diagnosis and indication for use, and any discrepancies will be addressed immediately. These audits will be reviewed by the management team weekly for one month and monthly for two months to evaluate the effectiveness of the corrective measures and make any necessary adjustments.

Proposed Overall Completion Date: 04/11/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #6 is prescribed the following medications that were not administered on the noted dates and times because the medications were not available in the home to include:
** Ezetimibe 10 mg tablet give one tablet by mouth every day - 1/24/25 at 8:00 a.m.*
** Donepezil HCL F/C 10 mg tablet 0.5 tablet by mouth at bedtime - 1/30/25 at 8:00 p.m.*
** Doxepin HCL 3 mg tablet 1 tablet by mouth at bedtime - 1/23/25, 1/24/25, 1/30/25 at 8:00 p.m.*
** Clotrimazole-Betamet 1-0.05% cream apply topically to bilateral lower extremities twice daily for 14 days - 1/25/25, 1/26/25 and 1/27/25 at 8:00 p.m.*

Resident #7 is prescribed the following medications that were not administered because the medications were not available in the home on the noted dates and times:
** Risperidone F/C 0.5 mg tablet - give 0.5 tab by mouth every evening on 1/2/25 at 5 p.m. (not available)*
** Acetaminophen 500 mg tablet - give 2 tablets by mouth three times daily beginning 1/12/25 on 1/14/25 at 9:00 p.m., 1/16/25 at 9:00 a.m. and 2:00 p.m. (medication unavailable)*
** Cefuroxime F/C 250 mg - give 1 tablet by mouth twice daily for 7 days on 1/18/25 at 9:00 p.m.*

Resident #8 is prescribed Escitalopram Oxalate F/C 10 mg tablet - give 1.5 tabs by mouth every morning. The incorrect dose of this medication - 10 mg tablet 1 tab (10 mg) was administered at 9:00 a.m. on 1/20/25, 1/21/25 and 1/22/25.

Resident #8 is prescribed the following medications that were not administered according to the resident's January 2025 medication administration record (MAR) on the noted dates and times:
** Melatonin 3 mg capsule – give 1 capsule by mouth at bedtime on 1/19/25, 1/20/25, 1/22/25, 1/23/25, 1/24/25 and 1/25/25 at 9:00 p.m.*
** Escitalopram Oxalate F/C 10 mg tablet - give 1.5 tablets (15 MG) on 1/1/25 and 1/3/25 at 9:00 a.m. (no exception*

187d - Follow Prescriber's Orders (continued)

indicating why)
** Simvastatin F/C 80 mg tablet - give 0.5 tablet (40 mg) by mouth at bedtime on 1/17/25, 1/18/25, 1/19/25, 1/20/25, 1/22/25, 1/23/25, 1/24/25 and 1/25/25.*

Resident #9 is prescribed the following medications that were not administered according to the resident's January 2025 medication administration record (MAR) on the following dates because they were not available in the home to include:
** Vitamin B-12 500mg tablet – give 1 tablet by mouth every day was not administered on 1/25/25.*
** Melatonin 4mg tablet – give 2 tablets by mouth at bedtime. (8mg) was not administered on 1/4/25 and 1/5/25.*
Repeat Violation: 2/13/24, 12/12/23

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

An audit of all medication carts and MAR's were completed by 1/30/2025 by RSC for compliance with the complete medication order including dosage, diagnosis or indication for use.
With regard to Resident #6, all meds were acquired through the pharmacy and available for administration in the community on the following dates:
Ezetimibe on January 26th 2025
Donepezil on January 31st 2025
Doxepin on January 26th 2025
Clotrimazole-Betamet on 1/28
This was corrected by RSC.

With regard to Resident #7, resident is deceased.

With Regard to Resident #8, the Physician order and the corresponding MAR for Escitalopram Oxalate was updated with corrected dosage on 1/24/25 by RSC.
With regard to the Melatonin , Escitalopram Oxalate and Simvastatin missed doses, the MAR was audited and reviewed by RSC. The appropriate meds were administered on the correct dates and times on 1/26 and subsequently thereafter.

With regard to Resident #9, all meds were acquired through the pharmacy by the RSC and available for administration in the community on the following dates:
Vitamin B-12: 1/26
Melatonin: 1/6

Resident #6's Power of Attorney was notified on 3/21/25 by RSC. Prescriber of the medication errors was notified 3/21/25 by RSC. If any direction from the prescriber is received, RSC and staff will follow accordingly. An incident report for the medication errors was completed on 3/21/25 by RSC. The medication errors were made part of the resident's permanent records error by RSC on 3/21/25.

Resident #8's Power of Attorney was notified by RSC on 3/20/25. Prescriber of the medication errors was notified 3/21/25 by RSC. If any direction from the prescriber is received, RSC and staff will follow accordingly. An incident report for the medication errors was completed on 3/21/25 by RSC. The medication errors were made part of the resident's permanent records error by RSC on 3/21/25.

187d - Follow Prescriber's Orders (continued)

Resident #9's Power of Attorney was notified by RSC on 3/21/25. Prescriber of the medication errors was notified 3/21/25 by RSC. If any direction from the prescriber is received, RSC and staff will follow accordingly. An incident report for the medication errors was completed on 3/21/25 by RSC. The medication errors were made part of the resident's permanent records error by RSC on 3/21/25.

All nurses and medication techs will be re-educated by the Resident Services Coordinator or designee by April 11, 2025 on the requirements for administering medications according to the prescriber's orders.

The Resident Services Coordinator or designee will conduct weekly medication cart and MAR audits for all residents to ensure compliance with medication administration according to prescriber's orders and any discrepancies will be addressed immediately. These audits will be reviewed by the management team weekly for one month and monthly for two months to evaluate the effectiveness of the corrective measures and make any necessary adjustments.

Proposed Overall Completion Date: 03/21/2025

Licensee's Proposed Overall Completion Date: *03/21/2025*

Not Implemented ([redacted] - 04/14/2025)

191 - Resident Right to Refuse

16. 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 #8's contract completed [redacted] was not signed by the resident. The contract indicates in Section III, B, 3 that Addendum E serves as acknowledgement of having been made aware of the Resident Rights on which the home includes education of the resident's right to refuse or question a medication if the resident believes there may be a medication error. Addendum E was not included with resident #8's contract.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

On March 13, 2025 Resident #8 signed the contract and the notification of Resident Rights, and the resident was made aware of the right to refuse medications if the resident feels there is an error.

The Memory Care Advisor will be re-eduated by the Executive Director or designee on 2600.191 by April 11, 2025.

An audit will be conducted of all resident files will be conducted to ensure that Addendum E is signed and attached to the contract in compliance with 2600.191. Any discrepancies will be corrected immediately. This audit will be completed by April 11, 2025. An audit of any new resident files will be conducted by the Executive Director or designee weekly for one month and monthly for two months to ensure compliance with 2600.191.

Proposed Overall Completion Date: 04/11/2025

DIRECTED
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

191 - Resident Right to Refuse *(continued)*

Directed Completion Date: *04/06/2025*

Not Implemented (- 04/14/2025)

225a - Assessment 15 Days

17. 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 #1's medical evaluation (DME), dated 4/17/24, includes diagnoses of schizophrenia, insomnia, HTN, constipation, and pain. These diagnoses are not included on the resident's assessment completed 6/5/24.

Resident #5's DME, dated 11/14/24, includes diagnoses of spinal stenosis, agitation, cholesterol and an illegible diagnosis (perhaps neuralgia). However, these diagnoses are not included on the resident's assessment completed 11/20/24.

Repeat Violation: 12/12/23, 11/21/22 et al.

Plan of Correction ***Directed (- 03/26/2025)***

Resident #1 was sent to the hospital on and did not return to the community and resident #5 was discharged on

Resident Services Coordinator and Executive Director will be reeducated by the Regional Director of Operations or designee on Regulation 225(a) by March 21, 2025.

An audit of all resident records has started an will be completed to ensure that all diagnoses on the medical evaluation are also on the resident assessment. Any addendums will be added to the RASP for any discrepancies found on the audit and will be completed by April 18, 2025.

After completion of this audit, the Executive Director or designee will review any new or updated medical evaluations to ensure the inclusion of all diagnoses on the resident assessment. This audit will be completed weekly for 4 weeks and monthly for 2 months. The results will be discussed with Mangement Team to evaluate for compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/18/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. 3/26/25

Directed Completion Date: *04/06/2025*

Not Implemented (- 04/14/2025)

225c - Additional Assessment

18. Requirements

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

Description of Violation

The medical evaluation (DME), dated [redacted], for resident #6, admitted [redacted] includes diagnoses of BPH, DM, A-Fib, hyperlipidemia, pain, constipation, rash, itch, SOB, inflammation, depression, sleeplessness. However, these diagnoses are not included on the resident's annual assessment dated 6/14/24.

Repeat Violation: 5/1/24, 2/13/24, 12/12/23, 11/21/22 et al.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

Resident #6 will have a new medical evaluation and assessment completed by April 4, 2025.

Resident Services Coordinator and Executive Director will be reeducated by the Regional Director of Operations or designee on Regulation 225 (c) by March 21, 2025.

An audit of all resident records has started an will be completed to ensure that all diagnoses on the medical evaluation are also on the resident assessment. Any addendums will be added to the RASP for any discrepancies found on the audit and will be completed by April 18, 2025.

After completion of this audit, the Executive Director or designee will review any new or updated medical evaluations to ensure the inclusion of all diagnoses on the resident assessment. This audit will be completed weekly for 4 weeks and monthly for 2 months. The results will be discussed with Mangement Team to evaluate for compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/18/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)

227i - Support Plan Accessible

21. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

The resident's assessments and support plans (RASPs) accessible to direct care staff are kept in the ribbed binders in each of the home's four neighborhoods. However, on 1/23/25, the ribbed binder labeled "Cloverdale Care Plans" did not include current support plans for residents #12, #13, #14 and #15. Licensing representatives were told that the current RASPs for all residents are kept in the business files which are locked in the administrator's office and not accessible to staff after business hours.

227i - Support Plan Accessible *(continued)*

Plan of Correction ***Directed (- 03/26/2025)***

On March 19, a binder containing the assessments and support plans for each resident in that neighborhood was placed in each neighborhood in an area accessible to all direct care staff.

Beginning March 20, 2025 direct care staff will be educated by the Resident Services Coordinator or designee on the contents and location of the RIB binder (which contains the RASP's). Training will be completed by April 11, 2025.

The Resident Services Coordinator or designee will conduct a weekly audit of the RIB book for 4 weeks then monthly for two months to ensure updated and accurate information for each resident. These audits will be reviewed by the management team weekly for one month and monthly for 2 months to evaluate the effectiveness of the corrective measures and make any necessary adjustments.

Proposed Overall Completion Date: 04/11/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. 3/26/25

Directed Completion Date: *04/06/2025*

Implemented (- 04/14/2025)

231b - Medical Evaluation

22. 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

The annual medical evaluation (DME) for resident #17, completed 1/24/24, did not indicate that the resident requires a secure dementia care unit (SDCU).

Repeat Violation: 2/13/24, 12/12/23

Plan of Correction ***Directed (- 03/26/2025)***

The medical evaluation for Resident #17 was updated on 1/24/2025.

Resident Services Coordinator and Executive Director were reeducated by the Regional Director of Operations or designee on Regulation 231(b) by March 21, 2025.

An audit of all resident records will be conducted to ensure that all medical evaluations indicate that the resident requires a secure dementia unit in compliance with state requirements . Any discrepancies will be addressed with the resident's physician. The audit and any discrepancies found will be completed by April 18, 2025

After completion of this audit, the Executive Director or designee will review any new or updated medical evaluaitons to ensure compliancew. This audit will be completed weekly for 4 weeks and monthly for 2 months. The results will

231b - Medical Evaluation (continued)

be discussed with Mangement Team to evaluate for compliance and identify areas of improvement.

Proposed Overall Completion Date: 04/18/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Implemented ([redacted] - 04/14/2025)

233c - Key-Locking Devices

23. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 1/23/25 at 11:32 a.m., the code posted for the keypad near the dining room exit door in the Harvest Glen neighborhood did not unlock the magnetically secured door. The correct code which was verbally provided to the licensing representative unlocked the door.

On 1/23/25 at approximately 12:00 p.m., the code posted for the keypad at the door across from the beauty shop in the core of building leading to the courtyard did not unlock the magnetically secured door. However, the code provided to licensing representative by staff in the Harvest Glenn neighborhood did unlock the door.

Plan of Correction ***Directed ([redacted] - 03/26/2025)***

The keypads in deficiency were immediately corrected and labeled with the appropriate codes. The Housekeeping/Maintenance and Management Team will be in-serviced by the Executive Director or designee on the requirement for conspicuous posting of correct codes near the key pads. This in-service will occur by April 11, 2025. The Building Services Coordinator or designee will monitor the codes and key pads daily for 1 month and weekly for 2 months to ensure compliance. These audits will be discussed weekly with the mangement team. Any discrepancies will be addressed immediately.

Proposed Overall Completion Date: 04/11/2025

DIRECETD
Within 10 days or receipt of the accepted plan of correction: The administrator shall ensue all steps in the plan of correction have been initiated. [redacted] 3/26/25

Directed Completion Date: *04/06/2025*

Not Implemented ([redacted] - 04/14/2025)