

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

June 3, 2025

[REDACTED]
ARDEN COURTS OF MONROEVILLE PA LLC

[REDACTED]
ATTN LICENSURE SUPPORT
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/26/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ARDEN COURTS (MONROEVILLE) **License #:** 43552 **License Expiration:** 05/23/2025
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: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

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

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident **Exit Conference Date:** 02/26/2025

Inspection Dates and Department Representative

02/26/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

In Home: Yes **Area:** entire building **Capacity:** 56 **Residents Served:** 52

Hospice

Current Residents: 18

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 52
Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 52 **Have Physical Disability:** 0

Inspections / Reviews

02/26/2025 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/05/2025

04/18/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 04/25/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/25/2025

Inspections / Reviews *(continued)*

04/23/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/30/2025

06/03/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

On [REDACTED], staff person A reported an allegation of abuse of a resident by staff person B to [REDACTED] supervisor. The allegation was reported via chain of command on the same day to staff person C, the home's administrator. However, this incident was not reported to the local Area on Aging Protective Services until [REDACTED]

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] 04/23/2025)

All coordinators/managers were re-educated by the Executive Director or designee on Regulation 2600.15.a.. This training included that if there is an allegation of abuse of a resident involving a home's staff person, the coordinator/manger shall immediately suspend the staff person involved in the alleged incident, until a further investigation into the allegation is conducted, and immediately notify RSC or Executive Director to ensure the incident is reported timely to the Department.

Starting the week of 4/13 to 4/19/2025, the Executive Director, RSC or designee will audit staff training files weekly for four weeks and monthly for two subsequent months to ensure compliance with 2600.15(a). This includes, but not limited to: 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.

See Attachment

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 06/03/2025)

15b - Supervisor Plan

2. Requirements

2600.

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

Description of Violation

On [REDACTED], staff person A reported an allegation of abuse of a resident by staff person B to [REDACTED] supervisor. The allegation was reported via chain of command on the same day to staff person C, the home's administrator. However, the staff person accused of the abuse was not suspended until [REDACTED] nor was a plan of supervision submitted to the Department.

Plan of Correction

Accept [REDACTED] 04/23/2025)

All coordinators/managers were re-educated by the Executive Director or designee on Regulation 2600.15.b.. This training included that if there is an allegation of abuse of a resident involving a home's staff person, the coordinator/manger shall immediately suspend the staff person involved in the alleged incident, until a further investigation into the allegation is conducted, and immediately notify RSC or Executive Director to ensure the incident is reported timely and suspension occurs immediately.

15b Supervisor Plan (continued)

Starting the week of 4/13 to 4/19/2025, the Executive Director, RSC or designee will audit staff training files weekly for four weeks and monthly for two subsequent months to ensure compliance with 2600.15(b). This includes, but not limited to: If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

See Attachment

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] - 06/03/2025)

16c - Written Incident Report**3. Requirements**

2600.

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 [REDACTED], staff person A reported an allegation of abuse of a resident by staff person B to [REDACTED] supervisor. The allegation was reported via chain of command on the same day to staff person C, the home's administrator. However, this incident was not reported to the Department until [REDACTED].

Repeat Violation [REDACTED]

Plan of Correction

Accepted [REDACTED] - 04/18/2025)

Managers and nursing supervisors will be in serviced on the requirement for reporting incidents and conditions to the personal care home regional office within 24 hours. This training was conducted by the Executive Director/RSC 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). The administrator shall ensure all steps in the plan of correction have been initiated.

Licensee's Proposed Overall Completion Date: 04/16/2025

Implemented [REDACTED] - 06/03/2025)

65a - FS Orientation 1st Day**4. 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.

65a - FS Orientation 1st Day (continued)

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

Staff person B began working for the home on [REDACTED] However, staff person B did not receive training in general fire safety and emergency preparedness until [REDACTED] 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 firesafe 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.

Staff person D began working for the home on [REDACTED] However, staff person D did not receive training in general fire safety and emergency preparedness until [REDACTED] 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 firesafe 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] - 04/23/2025)

Staff person B is no longer employed by the facility on [REDACTED] Documentation of education shall be kept in accordance with Regulation 260.65(i) 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 Coordinator on or before March 20, 2025.

Starting the week of 4/13 to 4/19/2025, the Executive Director, Administrative Services Coordinator or designee will audit staff training files weekly for four weeks and monthly for two subsequent months to ensure compliance with 2600.65(a). This includes, but not limited to: 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

65a FS Orientation 1st Day (continued)

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.

These audits will be reviewed with the management team to evaluate compliance and identify areas of improvement.

The administrator shall educate staff persons D on the

required training topics in Regulation 2600.65(a). Documentation of education shall be kept in accordance with Regulation 260.65(i).

See Attachment

Licensee's Proposed Overall Completion Date: 04/23/2025

Implemented [REDACTED] 06/03/2025)

201 - Positive Interventions

5. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On [REDACTED] staff person A observed staff person B put [REDACTED] right hand on resident [REDACTED] back and shove [REDACTED] in order to deter [REDACTED] from approaching a resident toward whom [REDACTED] is often verbally abusive. The resident's support plan completed [REDACTED] indicates to use a calm, gentle approach with resident as the plan to meet [REDACTED] need for [REDACTED] diagnosis of [REDACTED].

Plan of Correction

Accept [REDACTED] - 04/18/2025)

Staff person "B" is no longer employed at the community as of [REDACTED]

All staff will be re educated and in serviced by RSC or designee by 4/18/25..

Executive Director/designee will audit staff interactions with residents 1x/week for 4 weeks to ensure positive interventions, including, but not limited to, improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence, prevention, praise, de escalation techniques and alternative techniques or methods to identify and defuse potential emergency situations, are being followed starting on the week of 4/16/25. The Executive Director or designee will be responsible for submitting and reviewing the findings with management team. Any issues identified will be addressed immediately to maintain compliance with 2600. 201.

Licensee's Proposed Overall Completion Date: 04/18/2025

Implemented [REDACTED] - 06/03/2025)

231b - Medical Evaluation

6. Requirements

231b - Medical Evaluation (*continued*)

2600.

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

Description of Violation

Resident [REDACTED] was admitted to the home (a secure dementia care unit) on [REDACTED]. However, the resident's medical evaluation was completed on [REDACTED] which is more than 60 days prior to admission.

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 04/18/2025)

Resident [REDACTED] was discharged from the facility [REDACTED]

All coordinators/managers involved with DME completion, were reeducated by the Executive Director or designee on Regulation 231(b) on 4/16/2025. An audit of all resident records will be conducted to ensure that all initial medical evaluations for residents admitted within the last year to indicate that medical evaluation was completed within 60 days prior to move-in. No discrepancies were found by the audit.

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

Licensee's Proposed Overall Completion Date: 04/16/2025

Implemented [REDACTED] 06/03/2025)