





# Pennsylvania Department of Human Services

Emailing Date: November 4, 2025

[REDACTED]  
Arden Courts of Monroeville PA LLC

RE: Arden Courts (Monroeville)  
License #: 435520

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on August 20, 2025, August 21, 2025 and October 28, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

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

**Facility Information**

Name: *ARDEN COURTS (MONROEVILLE)* License #: *43552* License Expiration: *11/28/2025*  
Address: *120 WYNGATE DRIVE, MONROEVILLE, PA 15146*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *ARDEN COURTS OF MONROEVILLE PA LLC*  
Address: *120 WYNGATE DRIVE, [REDACTED], MONROEVILLE, PA, 15146*  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *09/22/1998* Issued By: *Labor and Industry*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *112* Waking Staff: *84*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint* Exit Conference Date: *08/21/2025*

**Inspection Dates and Department Representative**

08/20/2025 - On-Site: [REDACTED]  
08/21/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

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

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *23*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *56*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *56* Have Physical Disability: *0*

**Inspections / Reviews**

**08/20/2025 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/17/2025*

09/18/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/01/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/24/2025

09/22/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/01/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/01/2025

10/29/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/01/2025

Reviewer: [REDACTED]

Follow-Up Type: Exception

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The entire home is licensed as a secured dementia care unit (SDCU). On 8/20/25 and 8/21/25, there were 56 residents present in the home, including 56 residents with mobility needs. Of the 56 residents with mobility needs, 8 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. According to the most recent documentation from a fire safety expert, dated 3/11/25, the maximum evacuation time to the home's numerous internal fire-safe areas is 15 minutes. The home routinely schedules 5 staff persons in the home during the 11:00 PM through 7:00 AM shift, which is not adequate to evacuate all residents in an emergency. Additionally, the home conducted a fire drill using only 5 staff persons on 6/10/25 at 6:30 AM; however, the evacuation time for that fire drill was completed in 15 minutes, 35 seconds, which exceeds the current maximum evacuation time.

Plan of Correction

Directed [redacted] - 09/22/2025)

Correction: On 8/22/25, facility added hiring and recruiting efforts to hire additional staff for 11:00 PM - 7:00 AM shift. Effective 9/17/25, overnight staffing has been increased from 5 to 6 direct care staff to ensure safe evacuation within the fire expert's 15-minute timeframe. Staffing patterns will be adjusted based on need to maintain adequate coverage for resident mobility needs. The Resident Services Supervisor (RSC) and all facility supervisors have been educated on 2600.60.a; that staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan, on 9/17/25 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

Monitoring: The Administrator/RSC or designee will review staffing schedules Daily ensure adequate staffing to meet the needs of residents to evacuate all residents in an emergency. (DIRECTED: The daily reviews of the direct care staffing schedule shall begin within 24 hours of receipt of the plan of correction. [redacted] 9/22/25). Also, the Building Service Coordinator will continue to conduct quarterly overnight (11:00 pm - 7:00 am) evacuation drills to ensure evacuation time for the fire drill does not exceed the current maximum evacuation time. The Building Service Coordinator will conduct an unannounced fire drill using 6 staff persons to ensure all residents are able to evacuate within the time specified by the fire safety expert. Said fire drill has been scheduled for 10/1/2025. (DIRECTED: Documentation of the 10/1/25 fire drill shall be kept in accordance with 260.132c. [redacted] 9/22/25). An additional QAPI review meeting was added on 9/24/25 at 9:00 AM. During this meeting, all items specified in 2600.26b (including "licensing violations and plans of correction) will be reviewed and that documentation will be kept in the QAPI meeting minutes binder.

Responsible Party: RSC, BSC or Designee

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date: 10/01/2025

Implemented [redacted] - 10/29/2025)

65f - Training Topics

2. Requirements

65f - Training Topics (continued)

2600.

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

- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

**Description of Violation**

Direct care staff person A, hired on [REDACTED]/17, did not receive training on 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 training year.

REPEAT VIOLATION: 1/23/2025, et. al.

**Plan of Correction**

Accept [REDACTED] - 09/22/2025)

Correction: On 9/17/2025, staff person A was educated by Resident Services Coordinator (RSC) on 2600.65.f., specifically "Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan." This education will be documented and kept in employee's records for 2025 required annual training.

Monitoring: Administrative Services Coordinator, Executive Director or Designee will continue to follow the Plan of Correction from June 2025 annual education (2600.65f) violation. This includes: The ASC will created an in-service matrix to monitor compliance with annual training components of (1) Medication self-administration training; (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan; (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 and (7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

Executive Director or designee reviewed staff trainings weekly x4 weeks starting the week of 6/8/2025.

For continued long-term monitoring; utilizing the in-service matrix, ASC or designee will continue to review all training documents and the home's staff training plan at least quarterly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. The first quarterly reviewed was completed on 6/16/25. Next quarterly review is scheduled for 10/9/2025.

Responsible Party: Resident Services Coordinator (RSC), Administrative Services Coordinator (ASC), or designee.

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [REDACTED] - 10/29/2025)

88a - Surfaces

**3. 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**

On 8/20/25, numerous doors to fire-safe areas in the hallways did not completely close when disengaged from the magnetic door holder and had to be physically pushed shut, to include the doors in the following areas:

- The door in the hallway leading to Dockside

**88a - Surfaces (continued)**

- The door in the hallway leading to Cloverdale
- The door in the hallway leading to Berry Ridge

**Plan of Correction**

Accept (█) - 09/22/2025)

*Correction: The fire-safe doors were repaired/replaced on Dockside, Cloverdale, and Berry Ridge by contractor "Scherer Lock & Supply" on 8/28/25 to ensure they latch and close independently. Building Safety Coordinator (BSC) and all managers were educated on 2600.88.a Surfaces, to ensure they understand that all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards, on 9/16/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.*

*Monitoring: █ or designee will perform safety checks weekly x1 month (starting 9/1/2025), and then monthly indefinitely to confirm proper function of all doors/magnetic latches. The checks will include verifying proper functioning and closure/latching of all exterior doors and fire doors. Documentation of checks will be stored in █ office.*

*Responsible Party: Maintenance Director (BSC)*

**Licensee's Proposed Overall Completion Date: 09/19/2025**

Implemented (█) - 10/29/2025)

**101j7 - Lighting/Operable Lamp****4. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*On 8/20/25, resident #2's bedside lamp was unplugged. No other operable lamp or other source of lighting was present at resident #2's bedside.*

**Plan of Correction**

Accept (█) - 09/22/2025)

*Correction: Resident #2's lamp was immediately plugged in and verified operable on 8/20/25. Spare bedside lamps are in storage for emergencies. Building Safety Coordinator (BSC) and all managers were educated on 2600.101j7, Lighting/Operable Lamp and that each resident shall have the following: an operable lamp or other source of lightning that can be turned on at bedside, on 9/15/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.*

*Monitoring: █ or designee will perform lighting checks weekly x4 weeks (starting 9/1/2025), and then monthly x1 month to confirm proper function of ensure all residents have working bedside lighting. All 54 rooms/56 bedside lights will be checked during each check.*

*Responsible Party: Building Service Coordinator*

101j7 - Lighting/Operable Lamp (continued)

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [REDACTED] - 10/29/2025)

102h - Toilet Paper

5. Requirements

2600. 102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 8/20/25 at approximately 11:00 AM, no toilet paper was present in residents #3 and #4's shared bathroom.

Plan of Correction

Accept [REDACTED] 09/22/2025)

Correction: Toilet paper was replenished in residents #3 and #4's bathroom on 8/20/25. Building Services Coordinator and all Housekeeping staff were re-trained on restocking responsibilities and 2600.102.h, toilet paper shall be provided for every toilet, on 9/15/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

Monitoring: [REDACTED] or designee will perform toilet paper checks weekly x4 weeks (starting 9/1/2025), and then monthly x1 month to confirm toilet paper shall be provided for every toilet. All 54 resident toilets will be included during each check.

Responsible Party: Building Services Coordinator and Housekeeping Staff

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [REDACTED] - 10/29/2025)

102k - No Common Towel

6. Requirements

2600. 102.k. Use of a common towel is prohibited.

Description of Violation

On 8/20/25, there was an unlabeled towel rack containing towels in residents #3 and #4's shared bathroom.

Plan of Correction

Accept [REDACTED] - 09/22/2025)

Correction: Unlabeled towel rack was immediately and correctly labeled with appropriate resident's name on 8/20/2025. [REDACTED] were educated on 2600.102.k., Use of a common towel is prohibited, on 9/16/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

Monitoring: BSC or designee will perform towel rack label audits weekly x4 weeks (starting 9/1/2025), and then monthly x1 month to confirm each towel rack is appropriately labeled with correct resident's name in the two suites (two residents per one room). All shared suites (2 rooms only) will be checked during each audit check.

Responsible Party: Building Services Coordinator or Designee

Licensee's Proposed Overall Completion Date: 09/19/2025

102k - No Common Towel (continued)

Implemented [redacted] - 10/29/2025)

132c - Fire Drill Records

7. 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 records do not include the exit route used during the following fire drills:

- On 4/22/25 at 9:35 PM, which indicates "N/A" as the exit route used
- On 6/10/25 at 6:30 AM, which indicates "0" as the exit routes used

The home's fire drill record for the fire drill conducted on 4/22/25 at 9:35 PM does not include the number of staff persons that participated. This section of the fire drill record is blank.

REPEAT VIOLATION: 1/23/2025, et. al.; 10/7/2024, et. al.

Plan of Correction

Accepted [redacted] - 09/22/2025)

Correction: Staff that are responsible for Fire Drills and Fire Drill documentation (Building Services Coordinator) were re-educated 2600.132c, specifically including the need to document fire drill exit route and staff persons that participated. All facility managers were also educated on Fire Drills and Fire Drill documentation to function as a backup incase the Building Services Coordinator is unavailable. All education occurred on 9/17/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

Monitoring: Executive Director will monitor and audit all monthly fire drills, on a monthly basis, for both completion and proper documentation. Executive Director will conduct Fire Drill audit on a monthly basis indefinitely to ensure long-term success of Fire Drills. Audit had begun on 9/17/25 with the September fire drill that was conducted on 2nd shift.

Responsible Party: Executive Director and Building Services Coordinator (BSC).

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented [redacted] - 10/29/2025)

## 132d - Evacuation

**8. 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**

According to the most recent documentation from a fire safety expert, dated [REDACTED]/25, the maximum evacuation time to the home's numerous internal fire-safe areas is 15 minutes; however, the evacuation time for the fire drill conducted on 6/10/25 at 6:30 AM was completed in 15 minutes, 35 seconds.

The home's fire drill records for the fire drills conducted on the following dates/times do not include the number of residents in the home at the time of the fire drills, so it is unable to be determined if all residents were evacuated to a public thoroughfare or to an internal fire-safe area:

- 5/14/25 at 8:00 PM
- 2/10/25 at 8:41 AM
- 1/30/25 at 11:33 AM

According to the home's fire drill records, not all of the residents were evacuated to a public thoroughfare or to an internal fire-safe area during the following fire drills:

- On 8/1/25 at 9:20 AM, 54 residents were present in the home; however, only 13 residents were evacuated
- On 7/16/25 at 1:30 PM, 50 residents were present in the home; however, only 11 residents were evacuated
- On 6/10/25 at 6:30 AM, 54 residents were present in the home; however, 0 residents were evacuated
- On 4/22/25 at 9:35 PM, 51 residents were present in the home; however, 0 residents were evacuated
- On 3/11/25 at 3:40 PM, 46 residents were present in the home; however, only 13 residents were evacuated
- On 3/4/25 at 1:44 PM, 47 residents were present in the home; however, only 14 residents were evacuated

REPEAT VIOLATION: 1/23/2025, et. al.

**Plan of Correction**

Directed [REDACTED] - 09/22/2025)

Correction: Staff that are responsible for Fire Drills and Fire Drill documentation ([REDACTED]) were re-educated on 2600.132d, specifically including the need to document number of residents in the home at the time of the fire drills, that all of the residents were evacuated to a public thoroughfare or to an internal fire-safe area during the following fire drills, and maximum evacuation time of 15 minutes. All facility managers were also educated on Fire Drills and Fire Drill documentation to function as a backup incase the Building Services Coordinator is unavailable. All education occurred on 9/17/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

**132d - Evacuation (continued)**

*Monitoring: Executive Director will monitor and audit all monthly fire drills, on a monthly basis, for both completion and proper documentation. Executive Director will conduct Fire Drill audit on a monthly basis indefinitely to ensure long-term success of Fire Drills. Audit had begun on 9/17/25 with the September fire drill that was conducted on 2nd shift. (DIRECTED: The monthly fire drill record reviews shall also include ensuring all residents were able to evacuate to a fire-safe area within the time specified by a fire safety expert within the past year. If any fire drill exceeds the maximum evacuation time, the administrator shall immediately determine the root cause and conduct an additional unannounced fire drill within 5 calendar days from the unsuccessful fire drill. Documentation of all fire drills shall be kept in accordance with 2600.132c. [REDACTED] 9/22/25).*

*Responsible Party: Executive Director and Building Services Coordinator (BSC).*

*Proposed Overall Completion Date: 09/19/2025*

**Directed Completion Date: 09/22/2025**

**Implemented [REDACTED] - 10/29/2025)**

**132e - Fire Drill Sleeping Hours**

**9. Requirements**

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

**Description of Violation**

*The most recent fire drill conducted during sleeping hours was held on 6/10/25 at 6:30 AM; however, there is no documentation present in the home indicating a fire drill was conducted during sleeping hours between 5/3/24 and 6/10/25.*

**Plan of Correction**

**Accept [REDACTED] - 09/22/2025)**

*Correction: Staff that are responsible for Fire Drills and Fire Drill documentation ([REDACTED]) were re-educated on 2600.132.e, specifically including the need that a fire drill shall be held during sleeping hours once every 6 months. All facility managers were also educated on Fire Drills and Fire Drill documentation to function as a backup incase the Building Services Coordinator is unavailable. All education occurred on 9/17/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.*

*Monitoring: Executive Director will monitor and audit all monthly fire drills, on a monthly basis, for both completion and proper documentation. Executive Director will conduct Fire Drill audit on a monthly basis indefinitely to ensure long-term success of Fire Drills. Audit had begun on 9/17/25 with the September fire drill that was conducted on 2nd shift.*

*Responsible Party: Executive Director and Building Services Coordinator (BSC).*

**Licensee's Proposed Overall Completion Date: 09/19/2025**

**Implemented ([REDACTED] 10/29/2025)**

132g - Fire Drills Days/Times

10. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 5 staff persons in the home during the 11:00 PM through 7:00 AM shift. The most recent fire drill that was conducted using only 5 staff persons was held on 6/10/25 at 6:30 AM; however, no other fire drills were conducted using only 5 staff persons between 5/3/24 through 6/10/25.

Plan of Correction

Directed [REDACTED] - 09/22/2025)

Correction: Staff that are responsible for Fire Drills and Fire Drill documentation (Building Services Coordinator) were re-educated on 2600.132g, specifically including fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. All facility managers were also educated on Fire Drills and Fire Drill documentation to function as a backup incase the Building Services Coordinator is unavailable. All education occurred on 9/17/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder. The Building Service Coordinator will conduct an unannounced fire drill using 6 staff persons to ensure all residents are able to evacuate within the time specified by the fire safety expert. Said fire drill has been scheduled for 10/1/2025. (DIRECTD: Documentation of the 10/1/25 fire drill shall be kept in accordance with 260.132c. [REDACTED] 9/22/25). An additional QAPI review meeting was added on 9/24/25 at 9:00 AM. During this meeting, all items specified in 2600.26b (including "licensing violations and plans of correction) will be reviewed and that documentation will be kept in the QAPI meeting minutes binder.

Monitoring: Executive Director will monitor and audit all monthly fire drills, on a monthly basis, for both completion and proper documentation. Executive Director will conduct Fire Drill audit on a monthly basis indefinitely to ensure long-term success of Fire Drills. Audit had begun on 9/17/25 with the September fire drill that was conducted on 2nd shift.

Responsible Party: Executive Director and Building Services Coordinator (BSC).

Proposed Overall Completion Date: 09/19/2025

Directed Completion Date: 10/01/2025

Implemented [REDACTED] - 10/29/2025)

162c - Menus Posted

11. Requirements

2600.

162c - Menus Posted (continued)

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 8/20/25, the menus posted in a conspicuous and public place in the home ended on 8/23/25.

Plan of Correction

Accept ( ) - 09/22/2025)

Correction: On 8/20/2025, menus were immediately updated and posted, including menus posted 1 week in advance in a conspicuous and public place in the facility. Dietary staff were re-trained/educated to post menus one week in advance without lapse. This education included 2600.162.c, menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home. The education occurred on 9/15/2025 by Executive Director. A copy of the staff education will be kept in both the staff education binder and the Plan of Correction Credible Evidence Binder.

Monitoring: Culinary Services Coordinator (CSC) or designee will conduct weekly audits of menus; weekly x2 months (starting 9/1/2025), ensuring all menus are posted in a conspicuous and public place and posted 1 week in advance.

Responsible Party: Culinary Services Coordinator (CSC) or Designee

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented ( ) - 10/29/2025)

236 - Staff Training

12. 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 A, hired on ( ) 7, only received 3.5 hours of training related to dementia care during the 2024 training year. The entire home is licensed as a SDCU.

REPEAT VIOLATION: 5/19/2025; 10/7/2024, et. al.

Plan of Correction

Accept ( ) - 09/22/2025)

Correction: To date, employee has received 8 hours of annual training related to dementia care and services in 2025. This training occurred on 3/30/2025 and 6/26/2025

Monitoring: Administrative Services Coordinator, Executive Director or Designee will continue to follow the Plan of Correction from June 2025 annual education (2600.236 - Training) violation. This includes: The ASC will created an in-service matrix to monitor compliance with annual training components of "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)."

**236 - Staff Training (continued)**

*Executive Director or designee reviewed staff trainings weekly x4 weeks starting the week of 6/8/2025.*

*For continued long-term monitoring; utilizing the in-service matrix, ASC or designee will continue to review all training documents and the home's staff training plan at least quarterly to ensure all direct care staff persons receive training on all topics specified in 2600.236 during each training year. The first quarterly reviewed was completed on 6/16/25. Next quarterly review is scheduled for 10/9/2025.*

*Responsible Party: Administrative Services Coordinator (ASC), Executive Director or Designee*

**Licensee's Proposed Overall Completion Date: 09/19/2025**

**Implemented [REDACTED] - 10/29/2025)**