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Mt View Lake Retirement Village

Facility ID: P6102

Administrator: Philip Cleveland

Survey Exit Date: 6/26/2025

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1. **A305 420-5-20-.03 (2)(c) Administration:** The facility failed to notify ADPH of a change of Administrator.

2. When a new Administrator is hired, ADPH will be notified of the change of Administrator within 15 days of employment.

3. A new form will be included in the Administrator hiring packet by August 15, 2025, and will be used to notify ADPH of a change of administrator. Please see attached form.

4. The Governing Body will be responsible for ensuring that notification is made timely.

5. A copy of ADPH notification of a change of Administrator will be kept in the POC binder located in the Administrator's office.

CHANGE OF ADMINISTRATOR

Facility Information

Facility Name: _____

License Number: _____

Incoming Administrator Information

Full Name: _____

License/Certification Number (if applicable): _____

Effective Start Date: ___ / ___ / _____

Contact Phone Number: _____

Email Address: _____

Attachments:

☐ Copy of incoming administrator's license

Change of Administrator Request sent to ADPH:

Signature: _____

Date Submitted: _____

Mt View Lake Retirement Village
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1. A604 420-5.4-.06 (3)(a)(c)(d)(e) Care of Residents: Health Supervision: The facility failed to weigh a resident for three months due to the resident's inability to stand on a scale.

2. A wheelchair scale has been purchased and installed in the facility.

3. All residents will be weighed monthly during monthly assessments and weights recorded appropriately.

4. The Administrator or Designee will ensure that resident weights are taken and recorded monthly. The Administrator or Designee will audit all resident charts by August 10, 2025, to ensure that the resident weights have been taken and recorded.

5. The Administrator or Designee will audit weight reports monthly beginning September 2025 and ending December 2025 to ensure that all weights are being taken and recorded. Documentation of the audit will be placed in the POC binder located in the Administrator's office.

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1. **A621 420-5-20-.06 (9)(b) Care of Residents: Retention:** The facility failed to discharge two residents not meeting eligibility requirements.

2. All residents who do not meet eligibility requirements will be issued a 30-day notice to be moved from the facility.

3. All current residents have been reviewed. Two residents have been issued 30-day notices. The RN will assess all residents monthly or as necessary due to a change in condition. The Administrator and RN will determine if a resident does not meet eligibility requirements and if the condition is permanent or temporary. The Regional Executive Director will audit the monthly assessments quarterly beginning October 2025 ending March 2026.

4. The Administrator will issue a 30-day notice to any resident not meeting eligibility requirements. If the condition is temporary and the resident's condition returns to baseline, the 30-day notice will be rescinded.

5. The Administrator will place a copy of any 30-day notices issued in the Plan of Correction binder located in the Administrator's office.

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1. **A701 420-5-20-.07 (1) Food Service:** The facility failed to have a local employee who is a graduate of a Dietary Managers Course.

2. A local employee will be certified through a Dietary Managers Course or approved equivalent certification.

3. The local employee will be certified by September 1, 2025, and the certificate will be posted in the food service area.

4. The Regional Dietary Director will ensure that the employee's certification is kept up to date.

5. A copy of the certificate of a Dietary Managers Course or approved equivalent will be placed in the Plan of Correction binder located in the Administrator's office.

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1. **A702 420-5-20-.07 (2) Food Service:** The facility failed to monitor water temperatures and chemical concentrations prior to dishwashing for the period of June 21, 2025, through June 25, 2025, and testing strips were expired.

2. All expired test strips have been replaced. All kitchen staff will have refresher training on testing and recording water temperatures and chemical concentrations by August 15, 2025.

3. Kitchen staff will monitor and record chemical concentration daily prior to dishwashing.

4. The Regional Dietary Director will audit the records monthly beginning September 2025 ending December 2025 then quarterly beginning January 2026 ending December 2026.

5. Documentation of the audits will be placed in the Plan of Correction binder located in the Administrator’s office.

Mt View Lake Retirement Village
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1. **A702 420-5-20-.07 (2) Food Service:** The facility failed to properly label leftover food.

2. All kitchen staff have been reminded of the proper labeling and storage of leftover food. A complete refresher training on kitchen policies and procedures will be completed by August 15, 2025. Documentation of the training will be placed in the Plan of Correction binder.

3. The Administrator or Designee will audit the refrigerator and freezers weekly beginning September 2025 ending December 2025 to ensure leftovers are labeled and stored correctly.

4. The Regional Dietary Director will audit the records monthly beginning September 2025 ending December 2025 then quarterly beginning January 2026 ending December 2026.

5. Documentation of the audits will be placed in the Plan of Correction binder located in the Administrator’s office.

Mt View Lake Retirement Village
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1. **A702 420-5-20-.07 (2) Food Service:** The facility failed to properly label freezer food contents with a “DO NOT USE BEYOND DATE”.

2. All kitchen staff have been reminded of the proper labeling and storage of food. Refresher training on kitchen policies and procedures will be completed by August 15, 2025. Documentation of the training will be placed in the Plan of Correction binder.

3. The Administrator or Designee will audit the refrigerator and freezers weekly beginning September 2025 ending December 2025 to ensure foods are labeled with contents and a “DO NOT USE BEYOND DATE”.

4. Kitchen staff will be responsible for ensuring that food is labeled properly with contents and a “DO NOT USE BEYOND DATE”.

5. Documentation of the audits will be placed in the Plan of Correction binder located in the Administrator’s office.

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1. **A702 420-5-20-.07 (2) Food Service:** The facility failed to have tight fitting lids on the garbage cans.

2. All garbage cans have been replaced and have tight fitting lids.

3. The Administrator or Designee will audit the kitchen weekly beginning September 2025 ending December 2025 to ensure garbage can lids are tightly on garbage cans. Documentation of the audits will be placed in the Plan of Correction binder.

4. Kitchen staff will be responsible for ensuring garbage cans have tight fitting lids and that the lids are always in place, and reporting to the Administrator or Designee when new garbage cans are needed.

5. Documentation of the audits will be placed in the Plan of Correction binder located in the Administrator’s office.

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1. **A1001 420-5-20-.10 (1) Sanitation and Housekeeping:** The facility failed to maintain water temperatures in the safe operating range.

2. Water temperatures have been adjusted to meet regulatory requirements.

3. The Administrator or Designee will conduct weekly testing of water temperatures in each resident room and record the temperatures on a Water Temperature Log. Temperatures outside of safe operating range will be adjusted. Documentation of the training will be placed in the Plan of Correction binder.

4. The Regional Executive Director will audit the Temperature Logs quarterly beginning October 2025 ending December 2026.

5. Documentation of the audits will be placed in the Plan of Correction binder located in the Administrator’s office.

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1. **A1002 420-5-20-.10(2) Sanitation and Housekeeping:** The facility failed to properly secure cleaning supplies and poisons.

2. All storage areas have been locked. All storage areas will remain locked at all times to ensure the safety of residents and visitors. All staff will have refresher training in policy requirements regarding the storage of chemicals. The training will be completed by August 10, 2025. Documentation of the training will be placed in the Plan of Correction binder located in the Administrator's office.

3. A check sheet will be attached to the storage room door to document that the door is always locked. Staff will initial the check sheet upon exit from the storage area to verify that it was locked back upon exit.

4. Care staff will be responsible for locking the storage door back upon exit from the storage area.

5. The Administrator or Designee will audit the check sheets beginning August 2025 and ending December 2025. Documentation of monthly audits will be placed in the Plan of Correction Binder located in the Administrator's office.

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1. **A1101 420-5-4-.11 (1) Fire and Safety:** The facility failed to have a semi-annual fire sprinkler and fire alarm inspections.

2. Safeguard provided semi-annual sprinkler and fire alarm inspections. Copies of the inspections have been requested. Semi-annual sprinkler inspection performed on 2/19/25 and semi-annual fire inspection performed on 3/21/25 were requested and placed in the Plan of Correction binder.

3. The Administrator will place all inspection reports in an inspection binder to be kept in the Administrator's office.

4. If a report is not received within a week after an inspection, the Administrator or Designee will reach out to Safeguard requesting the report for documentation that it occurred.

5. Documentation of the missing inspections will be placed in the Plan of Correction binder located in the Administrator's office.

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1. **A1101 420-5-4-.11 (1) Fire and Safety:** The facility failed to conduct a monthly fire drill in the month of May.

2. Fire drills will be conducted monthly and documented as required.

3. A Fire Drill Schedule has been created. A copy of the schedule will be placed in the Plan of Correction Binder.

4. The Administrator or Designee will conduct a monthly fire drill according to the schedule.

5. Documentation of fire drills will be placed in the Plan of Correction binder located in the Administrator’s office.

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1. **A1203 420-5-20-.12 (5) Physical Environment:** The facility failed to provide safe, smooth free of cracks flooring surface and had open flame heaters for emergency heat.

2. A contractor was engaged to repair the flooring surface. Open flame heaters will be removed.

3. All flooring surface repairs have been completed. A copy of the paid invoice will be placed in the Plan of Correction Binder.

4. The Governing Authority will conduct quarterly inspections of the flooring beginning January 2026 and ending December 2026.

5. Documentation of the inspections will be placed in the Plan of Correction binder located in the Administrator’s office.