



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BRODHEAD SENIOR LIVING LLC**

LEGAL ENTITY

To operate **APPLE BLOSSOM SENIOR LIVING**

NAME OF FACILITY OR AGENCY

Located at **115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108**

(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 **40**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

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 **February 25, 2022** until **August 25, 2022**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450731**


ISSUING OFFICER


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 – 01/21



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: March 4, 2022
REPLACES LETTER DATED: February 25, 2022



Brodhead Senior Living LLC
115 Apple Blossom Way
Moon Township, Pennsylvania 15108

RE: Apple Blossom Senior Living
License/COC #: 450731

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 24, 2021, May 25, 2021, May 26, 2021, June 9, 2021, June 30, 2021, August 10, 2021, and August 11, 2021, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) 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 450730) dated November 19, 2021 – November 19, 2022 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 25, 2022 to August 25, 2022.

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.

[REDACTED]

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (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 or 2800	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
184.a	II	33	\$5	\$165	5 calendar days from mailing date of this letter
187.d	II	33	\$5	\$165	5 calendar days from mailing date of this letter
17	III	33	\$3	\$99	15 calendar days from mailing date of this letter
191	III	33	\$3	\$99	15 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.

[REDACTED]

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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,



Jamie Buchenauer
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: *APPLE BLOSSOM SENIOR LIVING* License #: *45073* License Expiration Date: *11/19/2021*
Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *4125396446* Email: [REDACTED]

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*
Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *60* Waking Staff: *45*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *06/30/2021*

Inspection Dates and Department Representative

05/24/2021 - On-Site: [REDACTED]
05/25/2021 - On-Site: [REDACTED]
05/26/2021 - Off-Site: [REDACTED]
06/09/2021 - Off-Site: [REDACTED]
06/30/2021 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* Residents Served: *30*

Secured Dementia Care Unit

In Home: *Yes* Area: *Home* Capacity: *40* Residents Served: *30*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30* Have Physical Disability: *0*

Inspections / Reviews

05/24/2021 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/08/2021*

9/21/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *09/28/2021*

10/20/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *10/28/2021*

16c - Written Incident Report

1. 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 4/26/21 at approximately 7:15 a.m., resident #1 was found

However, the home failed to report this incident to the Department.

Plan of Correction

Accept

on 4/26/2021 an initial incident report was sent to the department. The resident moved out of the facility so no final report was sent.

immediately on 8-9-2021 staff was educated on how and what is a reportable. documentation kept.

on 8-9-2-21 a designated person will review all incidents daily to ensure that all incidents are reported in a 24 hour period. documentation of fax confirmation will be kept.

Completion Date: 09/02/2021 Licensee's Proposed Date for POC Implementation

11/16/21

Not Implemented

23a - Activities of Daily Living Assistance

1. Requirements

2600.

- 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #2's annual assessment and support plan, dated 12/6/20, indicates [REDACTED] has a history of [REDACTED]. To meet this need, the home's staff will assist [REDACTED] in caring for [REDACTED], which is to be worn at all times, indefinitely. However, on or about 4/20/21 through 4/21/21, the resident's [REDACTED] was missing and could not be located. The resident was not wearing the [REDACTED] on these days.

23a - Activities of Daily Living Assistance (continued)

Plan of Correction

Directed

immediately on 5/26/21 Resident # 2 assessment and support plan were updated to include care needs and services which are provided to the resident, in addition to the frequency of all services provided.

on 5/26/21 the designated staff person started a review of all resident support plans to ensure each resident has an accurate support plan, completed in its entirety, to include care needs and services which are provided to the resident, in addition to the frequency of all services provided.

on 8/9/2021 the designated staff person implemented a tracking system weekly for 1 month then monthly for 6 months to ensure that all resident support plans are immediately updated as resident care needs change.

Immediately on 4/21/21 the nurse put a towel around [REDACTED] while looking for [REDACTED] the doctor was contacted for order of another [REDACTED] and back up [REDACTED] to be kept in medication room. a temporary [REDACTED] was purchased from Walmart to stabilize residents [REDACTED]

immediately on 8/9/21 staff was educated on importance of following annual assessment and support plan documentation on kept.

Directed:

Within 48 hours of receipt, once per shift for 1 week, and daily thereafter, a designated staff person shall check resident #2 to ensure [REDACTED] is wearing [REDACTED]. Documentation of checks shall be kept. **S.Q.**

10/20/21

Directed:

Within 7 days of receipt and at least monthly thereafter, the administrator shall meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the RASP, to include any medical equipment or assistive devices, to ensure all resident's needs are met. Reviews shall be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs.

Documentation of reviews shall be kept. **S.Q. 10/20/21**

 11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

42b - Abuse

1. 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.

42b - Abuse (continued)

Description of Violation

Resident #1's initial assessment and support plan, dated [REDACTED]/21, indicates [REDACTED] is independent in ambulating, transferring in/out of bed/chair and turning in bed/chair. However, on 2/25/21 [REDACTED] was prescribed physical therapy and on [REDACTED]/21 [REDACTED] was prescribed occupational therapy to address multiple needs to include: unsteady gait, functional performance of walking and transfers, and high fall risk and functional mobility. [REDACTED] physical therapy intake on [REDACTED]/21 indicates [REDACTED] has unsteadiness and has had 1-2 falls with bruising injury since moving onto the memory care unit.

On 4/9/21, resident #1 sustained an unwitnessed [REDACTED]. Staff interviews indicate on 4/23/21 [REDACTED] sustained another unwitnessed [REDACTED]

[REDACTED] The home's fall policy indicates, "Initiate Neuro checks if resident has an unwitnessed fall or hits their head,"... "Seventy two (72) hour follow up charting form will be initiated and documented on shift for 72 hours." On [REDACTED]/21 and [REDACTED]/21, the home failed to follow its fall policy and did not implement neuro checks or conduct follow up charting.

Multiple staff interviews indicate that staff working between [REDACTED] 21 and [REDACTED]/21 were not aware that resident #1 [REDACTED] [REDACTED]/21 and performed no additional continence or wellness checks on [REDACTED] through the night of [REDACTED] 21 into [REDACTED] 21.

42b - Abuse (continued)

Plan of Correction

Directed

42b █ acknowledge but do not agree with this violation.

At the time of inspection on 5/24/21 & 5/25/21 the inspector found Resident #1 support plan █/21 did not reflect the start of PT/OT on █/21.

Immediately on 5/25/21 an addendum was added to the █/21 support plan to reflect that █ had PT/OT for previous unsteady gait when █ was still able to ambulate independently. Resident mobility baseline was unsteady gait.

Follow-up: charting not documented per fall policy. bed put against wall and bed alarm ordered.

From █/21 to █/21 no staff reported to the nurse on duty or management that the resident was "declining" resident care tracking showed resident was checked on every 2 hours. There was no need for additional checking. immediately on 10/12/2021 staff was educated on the importance of reporting to nurse on duty any changes that occur with a resident and documentation of that information. documentation kept.

immediately starting on 10/12/21 a designated person will meet weekly with the PT/OT/SP team to review current resident's on their service and updates for those residents. Will also review any potential residents that may need service. Those residents will be screened for services. any support plans that need updated will be done at this time. documentation kept.

Directed:

Any significant changes identified as a result of weekly reviews shall be documented on the resident assessment with support plan revisions within 24 hours. **S.Q. 10/20/21**

Directed:

Within 5 days of receipt, all direct care staff shall be reeducated on the homes fall policy. Documentation of education shall be kept. **S.Q. 10/20/21**

Directed:

Within 7 days of receipt and at least monthly thereafter, the administrator shall meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the RASP, to include any medical equipment or assistive devices, to ensure all resident's needs are met. Reviews shall be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs.

Documentation of reviews shall be kept. **S.Q. 10/20/21**

 11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

57c - 2 Hours/Day

1. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

57c - 2 Hours/Day (continued)

Description of Violation

On 5/2/21, there were 28 residents in the home, all of whom had mobility needs. The home was required to provide a minimum of 56 hours of direct care. However, only 52 hours of direct care were provided.

Plan of Correction**Accept**

on 5/25/21 the inspector reviewed the daily staffing sheets and found insufficient staff on 5/2/21.

immediately on 7/1/21 the ED reviewed staffing sheets for the following 2 weeks to ensure adequate staffing hours are provided to meet resident needs

immediately on 7/1/21 staff was educated on importance of having adequate staff on each shift the red square policy documentation kept.

immediately on 10/12/2021 A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing is provided to meet the needs of the residents in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. If it is determined staffing levels will fall below minimum requirements, a designated staff person shall immediately attempt to schedule substitute personnel or contact a staffing agency in accordance with 2600.61. Documentation of the daily reviews shall be kept, which includes the date, number of residents in the home on each day, the number of resident's with mobility needs, any additional assistance needed in accordance with 2600.60a and the number of direct care staffing hours provided.



11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

57d - Waking Hours

1. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 5/2/21, there were 28 residents in the home, all of whom had mobility needs. The home was required to provide a minimum of 45 hours of direct care during waking hours. However, only 42 hours of direct care were provided during waking hours.

57d - Waking Hours (continued)

Plan of Correction

Accept

on 5/25/21 the inspector reviewed the daily staffing sheets and found insufficient staff on 5/2/21 immediately on 7/1/21 the ED reviewed staffing sheets for the following 2 weeks to ensure adequate staffing hours are provided to meet resident needs

immediately on 7/1/21 staff was educated on importance of having adequate staff on each shift the red square policy documentation kept.

immediately on 10/12/2021 A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing is provided to meet the needs of the residents in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. If it is determined staffing levels will fall below minimum requirements, a designated staff person shall immediately attempt to schedule substitute personnel or contact a staffing agency in accordance with 2600.61. Documentation of the daily reviews shall be kept, which includes the date, number of residents in the home on each day, the number of resident's with mobility needs, any additional assistance needed in accordance with 2600.60a and the number of direct care staffing hours provided.

 11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Multiple staff interviews and the home's observation notes indicate that prior to 4/23/21, Resident #4 used a pressure pad bed alarm to alert staff if the resident had fallen out of [REDACTED] bed. However, on [REDACTED]/21, the resident was found [REDACTED]

Plan of Correction

Accept

At time of inspection 5/25/21 all bed alarms were checked to ensure that each bed alarm was property working by testing pad and changed battereies

on 7/1/21 staff was educated on importance of checking all bed alarms to make sure bed alarms works, documentation kept

on 7/1/21 a tracking system was developed and implemented to ensure that all bed alarms are working. A designated person will change batteries monthly in all bed alarms. every bed alarm, documentation kept for 1 month then discarded.

a designated person on each shift will check each bed alarm to ensure that it is working and will check off if on or off on that shift. documentation will be kept for 1 month then discarded.

 11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

82c - Locking Poisonous Materials**1. 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 5/24/21 at 4:10 p.m. a cleaning cart was unsecured, unattended and accessible in the hallway outside of bedroom #126.

The cart contained the following poisonous materials:

** One 32 ounce spray bottle of Array all-purpose cleaner with bleach labeled "If swallowed call poison control or a physician"*

** One 32 ounce spray bottle of Mr. Clean multi surface spray labeled "If swallowed call poison control center or physician"*

The home is a secured dementia care unit and all residents are assessed unsafe to handle poisons or hazardous materials.

Plan of Correction**Accept**

at time of inspection 5/24/21 inspector found cleaning cart was unlocked and unattended.

at time of inspection 5/24/21 med cart was locked and put in locked housekeeping closet

on 7/1/21 staff was educated on importance of keeping poisonous material locked in the housekeeping cart. documentation kept.

on 10/12/21 a tracking system was implemented to ensure the housekeeping cart is kept locked if not in use or in visual sight of the person using it.

on 10/12/2021 a designated person will check housekeeping cart at the beginning of the shift and at the end of the shift to ensure that cart is locked. documentation kept kept for 1 month then discarded. This will be done for 6 months.

 11/16/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

Not Implemented**187d - Follow Prescriber's Orders****1. Requirements**

2600.

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

Description of Repeat Violation

Resident #2's annual medical evaluation, dated 12/5/20 indicates the resident has a history of [REDACTED] and is ordered to wear a [REDACTED]. On or about 4/20/21 through 4/21/21, the resident's [REDACTED] was missing and the resident was not wearing the [REDACTED] on these days.

Repeat Violation: 6/17/20

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Directed

Immediately on 4/21/21 the nurse put a towel around [REDACTED] to stabilize [REDACTED] while looking for the [REDACTED] the doctor was contacted for order of another [REDACTED] and back up [REDACTED] to be kept in medication room. a temporary [REDACTED] was purchased from Walmart to stabilize residents [REDACTED]

On 5/25/21 resident #2 AA and SP were updated with addendum stating resident will have 2 [REDACTED] at all times to ensure compliance with doctor order.

on 8/9/2021 staff was educated on importance of following doctors order and their support plan to meet their needs. documentation kept.

on 5/25/21 resident #2 AA and SP were updated with addendum stating resident will have 2 [REDACTED] at all times to ensure compliance with dr order

immediately on 8/9/21 staff was educated on importance of following annual assessment and support plan documentation on kept.

Directed:

Within 48 hours of receipt, once per shift for 1 week, and daily thereafter, a designated staff person shall check resident #2 to ensure [REDACTED] is wearing [REDACTED] prescribed [REDACTED]. Documentation of checks shall be kept. S.Q.

10/20/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

11/16/21
Not Implemented

225c - Additional Assessment

1. Requirements

$$\overline{2600.}$$

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

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On 2/25/21, resident #1 was prescribed physical therapy and on 3/2/21 [REDACTED] was prescribed occupational therapy to address multiple needs to include: unsteady gait, functional performance of walking and transfers, and high fall risk and functional mobility. [REDACTED] physical therapy intake on 2/25/21 indicates [REDACTED] [REDACTED] [REDACTED]. In addition, resident #1 sustained unwitnessed [REDACTED] [REDACTED] /21 and [REDACTED] /21. However, [REDACTED] assessment and support plan, dated 1/29/21, has not been updated to include these significant changes.

Multiple staff interviews and the home's observation notes indicate that prior to 4/23/21, Resident #4 was assessed as a fall risk and used a pressure pad bed alarm to alert staff if [REDACTED] fell out of [REDACTED] bed. However, [REDACTED] assessment and support plan, dated 11/10/21, has not been updated to include these significant changes.

225c - Additional Assessment (*continued*)**Plan of Correction****Directed**

immediately Pressure bed alarm was ordered on 4/23/21

support was not updated due to the fact the resident did not return to the facility.

immediately on 10/12/2021 staff was educated on the importance of reporting any changes in the resident's condition so it can be assessed and support can be updated within the 5 days for a significant change.

documentation kept.

Immediately on 10/12/2021 a designated staff person shall review the support plans weekly for 1 month then monthly for 6 months. documentation kept.

Directed:

Any significant changes identified as a result of reviews shall be documented on the resident assessment with support plan revisions within 24 hours. S.Q. 10/20/21

Completion Date: 10/12/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Not Implemented

233c - Key-Locking Devices

1. 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 5/24/21, the directions for operating the home's front door locking mechanism were not conspicuously posted near the front door.

Plan of Correction**Accept**

at the time of inspection on 5/24/21 sign was placed beside the keypad.

immediately on 8/7/21 staff was educated on the keypad system and the importance of sign posted at door.

on 8/7/21 a checklist was implemented by the designated person to check each entrance BID (daily for 1 month, then weekly for 1 month) to ensure sign with code is by the keypad

Completion Date: 09/02/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Not Implemented

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

Facility Information

Name: *APPLE BLOSSOM SENIOR LIVING* License #: *45073* License Expiration Date: *11/19/2021*
Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *4125396446* Email: [REDACTED]

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*
Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *08/27/2019* Issued By: *Twp. of Moon*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *66* Waking Staff: *50*

Inspection

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *08/11/2021*

Inspection Dates and Department Representative

08/10/2021 - On-Site: [REDACTED]

08/11/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* Residents Served: *33*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire home* Capacity: *40* Residents Served: *33*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *33*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33* Have Physical Disability: *0*

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 Repeat Violation

On 8/10/21, the privacy coding document, which contained the names of residents #1, #2, #3 and #4, was attached to the licensing inspection summary, dated 2/28/20, and was posted on the main lobby bulletin board.

REPEAT VIOLATION: 2/28/2020

Plan of Correction

Accept

At the time of inspection 8/10/21 document was removed from the main lobby bulletin board

on 8/15/21 staff was educated on the the importance of confidentiality. documentation kept

Immediately on 8/15/21, a tracking system was implemented to ensure that confidentiality is kept. documentation kept.

Designated person checks bulletin board a the beginning of each shift for 6 months to ensure that all resident info is kept. documentation kept.

 11/16/21

Completion Date: 09/02/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

96a - First Aid Kit

1. 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 8/10/21, the first aid kit located at the nurses' station did not include antiseptic, a thermometer, adhesive tape, breathing shield or eye coverings.

On 8/10/21, the first aid kits located in the laundry room near bedroom #113 and the laundry room near bedroom #137, did not include eye coverings.

96a - First Aid Kit (continued)

Plan of Correction

Accept

At the time of inspection on 8/11/21, the inspector found 1st the aide kit at the nurse's station did not have an antiseptic, thermometer, adhesive tape, breathing shield, or eye coverings. 1st aid kit in the laundry room did not have eye coverings.

At time of inspection 8/11/2021 the missing items were added to the 1st aid kit.

Immediately on 8/15/21 staff was educated on the importance of 1st aid and their content

immediately on 8/15/21, a tracking system was implemented to ensure that each 1st aid kit includes regular equipment.

immediately on 8/15/21, the designated person checks each 1st aid kit to ensure compliance 1st aide kit will be checked by the designated person weekly for 1 month then monthly for 6 months documentation kept.  11/16/21

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

103g - Storing Food

1. Requirements

2600.

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

Description of Violation

On 8/10/21, there was an opened and unsealed bag of Lays kettle cooked potato chips on the dry storage shelf in the kitchen.

Plan of Correction

Accept

At the time of inspection on 8/10/21. Inspector found an unstored bag of potato chips.

Immediately on 8/10/21 Lays Potato chips were placed in plastic sealed bags and labeled with the date.

on 8/15/21 staff was educated on food storage and labeling. documentation kept.

starting on 8/15/2021 The designated person will monitor all food storage areas, including refrigerators, daily for 1 month, then weekly thereafter to ensure safe food storage practices are being followed, including all food items being labeled and dated. Documentation kept.

Completion Date: 09/02/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Implemented

Document Submission

documents attached

183d - Prescription Current

1. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current (*continued*)**Description of Violation**

On 8/11/21, resident #5's Timolol 0.5% eye drops was dated as opened on 6/7/21; however, was still present in the home. According to the manufacturer's instructions, the medication is to be discarded 4 weeks after opening.

Plan of Correction**Accept**

at the time of inspection on 8/11/21 inspector found that medications for resident #5 was expired according to manufacturer's instructions.

At time of inspection on 8/11/2021 resident #5 eye drops were discarded and new ones ordered from pharmacy.

on 8/15/21 nurses were educated on checking for dates and labeling when opened documentation kept.

on 8/15/21 a medication audit was done on all residents. documentation kept.

on 8/15/21 a tracking system was implemented for medication audit. A medication audit by a designated person will be done weekly for 1 month then monthly for 6 months. documentation kept.

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Document Submission**Implemented**

documents attached

184a - Labeling OTC/CAM

1. 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 Repeat Violation

The pharmacy label for resident #4's Bio-Dk Musion indicates to administer 5 drops under the tongue each day; however, resident #4 is prescribed Bio-Dk-Mulsion-Administer 2 drops under tongue in the morning.

REPEAT VIOLATION: 6/17/2020

Plan of Correction**Accept**

at the time of inspection on 8/11/2021 inspector found the dosage incorrect on the label of resident #4.

At time of inspection 8/11/2021 pharmacy label was correct. obtained doctor order to administer 5 drops daily. order sent to pharmacy.

on 8/15/21 nurses were educated on the five rights of medication administration. documentation kept

on 8/15/21 a medication audit was done on all resident's medications. documentation kept.

on 8/15/21 a tracking system was implemented for medication audit. A medication audit by a designated person will be done weekly for 1 month then monthly for 6 months. documentation kept.

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Not Implemented

187a - Medication Record**1. 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).

Description of Violation

Resident #4's August 2021 medication administration record (MAR) does not include a diagnosis or purpose for the following medications:

- *Acetaminophen 325 mg tablet-Take two tablets (650mg) by mouth three times daily*
- *Bio-Dk-Mulsion-Administer 2 drops under tongue in the morning*
- *Clearlax Powder-Mix 17 grams (one capful) into 4-8 oz. of beverage of choice by mouth twice daily*

Resident #5's August 2021 MAR does not include a diagnosis or purpose for the following medications:

- *Alendronate Sodium 70 mg tablet-Take 1 tablet by mouth once weekly*
- *Aripiprazole 2mg tablet-Take two tablets (4mg) by mouth once daily*
- *Levothyroxine 100mcg tablet-Take one tablet daily*
- *Mirtazapine 7.5mg tablet-Take one tablet by mouth at bedtime*

Resident #6's August 2021 MAR does not include a diagnosis or purpose for the following medications:

- *Acetaminophen 325mg tablet-Take two tablets (650 mg) by mouth three times daily*
- *Donepezil HCL 10 mg tablet-Take one tablet by mouth daily at bedtime*
- *Memantine HCL ER 28mg capsules-Take one capsule by mouth daily*
- *Sertraline HCL 50mg tablet-Take one tablet by mouth daily*

Resident #7's August 2021 MAR does not include a diagnosis or purpose for the following medications:

- *Buspirone HCL 5mg tablet-Take 1.5 tablet (2.5mg) by mouth twice daily*
- *Levothyroxine 25mcg tablet-Take one tablet by mouth daily*

187a - Medication Record (continued)

Plan of Correction

Directed

at time of inspection on 8/11/2021 the inspector found that resident #4 said [REDACTED] wasn't educated on right to refuse medication.

At time of inspection diagnosis for resident #4, #5, #6, #7 were added to e-mar for all medications.

on 8/15/21 staff and residents were educated on the right to refuse medications. documentation kept.

on 8/15/21, a tracking system was implemented to ensure that residents' right to refuse medication is discussed in October for resident right month during the resident council. documentation kept.

DIRECTED: Within 7 days of receipt of the plan of correction, then monthly thereafter: A designated staff person shall review the medication administration records for all residents to ensure all items specified in 2600.187a are present, including a diagnosis or purpose for each medication. LM 9/20/21

DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated that all items specified in 2600.187a are present on each resident medication administration record, including a diagnosis or purpose for each medication. Documentation of the education shall be kept. LM 9/20/21

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

 11/16/21
Not Implemented

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

Description of Repeat Violation

Resident #4 is prescribed Acetaminophen 325mg tablet-Take two tablets by mouth three times daily. However, this medication was not administered to the resident on 8/11/21 at 6:00 a.m., because the medication was not available in the home.

Resident #4 is prescribed Ibuprofen 600mg tablet-Take one tablet by mouth three times daily. However, this medication was not administered to the resident on 8/11/21 at 6:00 a.m., because the medication was not available in the home.

REPEAT VIOLATION: 6/17/2020

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Accept

at the time of inspection on 8/11//21 inspector found that medications for resident #4 was not admin because was not available by pharmacy.

At time of inspection on 8/11/2021 the medication was ordered from the pharmacy.

on 8/15/21 nurses were educated on getting meds from pharm on time. documentation kept.

on 8/15/21 a medication audit was done on all residents medications. documentation kept.

on 8/15/21 a tracking system was implemented for medication audit. A medication audit by a designated person will be done weekly for 1 month then monthly for 6 months. documentation kept.

 11/16/21

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

Not Implemented

191 - Resident Right to Refuse

1. 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 Repeat Violation

Resident #4, admitted [REDACTED]/19, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

REPEAT VIOLATION: 2/28/2020

Plan of Correction

Directed

at time of inspection on 8/11/2021 the inspector found that resident #4 said [REDACTED] wasn't educated on right to refuse medication.

At time of inspection 8/11/2021 resident was education on the right to refuse medication.

immediately on 8/15/21 staff and residents were educated on the right to refuse medications. documentation kept.

immediately on 8/15/21 a tracking system was implemented to ensure that residents' right to refuse medication is discussed in October for resident right month during resident council. documentation kept. (DIRECTED: The tracking system shall be used for all new admissions to ensure each newly-admitted resident is notified in writing of their right to refuse or question a medication if they believe there is a medication error. LM 9/20/21

DIRECTED: Within 7 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure each resident has been notified in writing of their right to refuse or question a medication if they believe there is a medication error. LM 9/20/21

 11/16/21

Completion Date: 09/17/2021 Licensee's Proposed Date for POC Implementation

Not Implemented