



pennsylvania
DEPARTMENT OF HUMAN SERVICES

AUG 08 2018

Ms. Betty Ulmer
Vice President-Legal Operations
Brookdale Senior Living Communities, Inc.
7151 Saltsburg Road
Pittsburgh, Pennsylvania 15235

RE: Brookdale Penn Hills
Certificate #: 431590

Dear Ms. Ulmer:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 17, 2018, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Rowe".

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

JUL 30 2018

Violation Report: 43159 - 05/17/2018 - Eveges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.65(e) - Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

2a. DESCRIPTION OF VIOLATION
Direct care staff person A, hired on 4/18/16, only received 7.5 hours of training during the 1/1/17 to 12/31/17 training year.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.65 (e)

All Department Managers were in-serviced by the Executive Director regarding the community policy on the annual training requirements for staff on July 10, 2018.

A tracking form for all associate's attendance at the mandatory monthly trainings has been developed. The Business Office Coordinator or designee will monitor training records every 2 weeks for 3 months then monthly thereafter. The Executive Director will review audit results for the next 3 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet, annual training schedule, tracking form

Completion Date: July 12, 2018

Staff A will complete 4.5 hours of extra training to give her 16.5 annual training hours for 2018.
See attached for total of 3hr 15 minutes - Remaining sign in sheets will be submitted as complete to reach total 4.5 hours

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba* Date *7-13-18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/18
(Date)

Plan of correction implementation status as of 8/1/18
(Date)

The above plan of correction was approved by BB
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 43159 - 05/17/2018 - Eveges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST PENNSYLVANIA COLLEGE
Division of Continuing Education

1. REGULATION 55 Pa.Code §2600

2600.65(f) - Training topics for the annual training for direct care staff persons shall include the following:

- (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.
- (7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired on 4/18/16, and direct care staff person B, hired on 5/28/15, did not receive training in the following areas during the 1/1/17 to 12/31/17 training year:

- * Medication self-administration
- * Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- * Personal care service needs of the resident

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.65 (e) *On 7/30/18, the home submitted training records, indicating staff person A received medication self-administration training on 7/30/18, instruction on meeting residents needs training on 8/25/18, and Personal care service needs of the resident training on 4/27/18. BB 8/1/18*

All Department Managers were in-serviced by the Executive Director regarding the community policy on the annual training requirements for staff on July 10, 2018.

A tracking form for all associate's attendance at the mandatory monthly trainings has been developed. The Business Office Coordinator or designee will monitor training records every 2 weeks for 3 months then monthly thereafter. The Executive Director will review audit results for the next 3 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet, annual training schedule, tracking form

Completion Date: July 12, 2018 *prior to use on staff person B's next workday - staff person B will receive training on the annual requirements not received during the 2017 training year. BB 8/1/18*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Judith Carmabha</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Judith Carmabha</i>	<i>7-13-18</i>

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>8/1/18</u> (Date)	Plan of correction implementation status as of <u>8/1/18</u> (Date)
The above plan of correction was approved by <u>BB</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not implemented

JUL 30 2018

Violation Report: 43159 - 05/17/2018 - Eveges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
- (3) Resident rights.
- (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired on 4/18/16, did not receive fire safety training completed by a fire safety expert during the 1/1/17 to 12/31/17 training year.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.65 (g)

All Department Managers were in-serviced by the Executive Director regarding the community policy on the annual training requirements on July 10, 2018.

A tracking form for all associates attendance at the mandatory monthly trainings has been developed. The Business Office Coordinator or designee will monitor training records every 2 weeks for 3 months then monthly thereafter. The Executive Director will review audit results for the next 3 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet, annual training schedule, tracking form

Completion date: July 13, 2018

Care staff person A attended Annual Fire Training on 5/18/18
(see attached sign in sheet)

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) *Judith Carrabbia*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Judith Carrabbia* Date *7-13-18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/18 (Date) Plan of correction implementation status as of 8/1/18 (Date)

The above plan of correction was approved by BB (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

JUL 19 2018

Violation Report: 43159 - 05/17/2018 - Evesges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST BERNARD FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION

There was a ball of lint, measuring approximately 3.5 inches in diameter, built up behind the lint trap in the far right clothes dryer in the home's laundry area.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.105 (g) (1)

Immediately, the ball of lint was removed from behind the lint trap at time of survey.

Appropriate associates were in-serviced on the community policy regarding lint removal from the second screen behind the actual lint trap from May 22-24th 2018.

The Maintenance Technician or designee will audit the dryer once weekly for 2 months then monthly thereafter for 6 months. The Executive Director will review audit results for the next 3 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet, environmental tracking form, signage for dryer

Completion date: July 13, 2018

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba, EP*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba* Date *7/19/18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/18
(Date)

The above plan of correction was approved by BB
(Initials)

Plan of correction Implementation status as of 8/1/18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 43159 - 05/17/2018 - Eveses, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST REGION FIELD OFFICE
Human Services Liaison

1. REGULATION 55 Pa.Code §2600

2600.144(c)(1) - Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

2a. DESCRIPTION OF VIOLATION

There were 2 seat cushions, which were not fire resistant, on chairs in the home's designated smoking area on the back porch.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.144(c) (1)

Immediately, the 2 cushions were removed from the designated smoking area and discarded by the Executive Director. The family member was immediately reminded not to bring in personal items for use in common areas that are not approved materials by Maintenance Tech/designee. The Maintenance Technician or designee will audit the smoking area weekly for 2 months then monthly thereafter for 6 months. The Executive Director will review audit results for the next 3 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence: Environmental Audit sheet.

Completion date: May 17, 2018

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Judith Carrabbia

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

Judith Carrabbia

Date

7-13-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of

8/1/18
(Date)

Plan of correction implementation status as of

8/1/18
(Date)

The above plan of correction was approved by

BS
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 43159 - 05/17/2018 - Evages, Joseph
 PCH Name: BROOKDALE PENN HILLS

WEST REGION FIELD OFFICE
 Human Services Licensing

1. REGULATION 55 Pa.Code §2600

144(c)(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

2a. DESCRIPTION OF VIOLATION

The home's designated smoking area on the back porch is approximately 4 feet from the home's rear exit.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.144 (c)(2)

The designated smoking area was relocated to another location which is a safer distance from the community. The furniture was relocated to this new area. A designated smoking area sign has been purchased and placed at area. The Executive Director retrained the management staff regarding the new smoking area designation on July 10, 2018. The Executive Director or/designee will audit the smoking area for compliance weekly for 2 months then monthly thereafter and determine if any further action is warranted.

Evidence: Photo of purchased sign, audit sheet, training attendance sheet.

Completion date: July 13, 2018

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Judith Carrabba*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Judith Carrabba</i>	Date <i>7-13-18</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>8/1/18</u> (Date)	Plan of correction implementation status as of <u>8/1/18</u> (Date)
The above plan of correction was approved by <u>BS</u> (Initials)	<input checked="" type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

RECEIVED

JUL 13 2018

Violation Report: 43159 - 05/17/2018 - Eveges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST REGIONAL OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.183(b) - Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2a. DESCRIPTION OF VIOLATION

There was an unlocked, unattended bottle of Polyethylene Glycol on top of resident #1's dresser in bedroom #18.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.185 (b)

Immediately, the Health and Wellness Director removed and secured the medication brought in by the family. The Health and Wellness Director re-educated the family about leaving medications out in the resident's room.

The Resident care Coordinator or designee will check 3 random rooms weekly for two months then monthly thereafter for any medication that are not secured according to the community policy. The Health and Wellness Director or/designee will review the audit results weekly for 2 months to determine if any further action is warranted.

Evidence: Audit Sheet.

Completion date: July 27, 2018

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba* Date *7-13-18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/18
(Date)

Plan of correction implementation status as of 8/1/18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by BB
(Initials)

Violation Report: 43159 - 05/17/2018 - Eveges, Joseph
PCH Name: BROOKDALE PENN HILLS

WEST PHILADELPHIA FIELD OFFICE
Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

Resident #2 is prescribed Guaifenesin AC syrup 100-10mg/5ml (Guaifenesin-Codeine) - take 10 ml four times daily as needed for cough. However, this medication was not available in the home for administration.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.185 (a)

Immediately, the Health and Wellness Director clarified the order with the prescriber and the medication was discontinued day of inspection.

The Health and Wellness Director retrained the appropriate staff on July 13, 2018 regarding the community policy on Medication Administration. The Resident Care Coordinator or/designee will audit MAR orders to cart to verify needed medications are available weekly for 2 months then monthly thereafter. The Health and Wellness Director will review audit results and to verify if any further action is warranted.

Evidence: Physician order to discontinue, In-service training sheet, Audit form

Completion date: May 17, 2018

During the next quality management plan review and evaluation - The administrator will place an increased emphasis on this plan of correction. *BB 8/1/18*

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/05/2017 <i>et. al.</i>
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Signature of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Judith Carrabba* Date *7-13-18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of *8/1/18*
(Date)

Plan of correction Implementation status as of *8/1/18*
(Date)

The above plan of correction was approved by *BB*
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 43159 - 05/17/2018 - Evegges, Joseph
PCH Name: BROOKDALE PENN HILLS

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

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

2a. DESCRIPTION OF VIOLATION

Resident #2 is prescribed Senexon 8.6-50 mg – take two tablets (17.2-100 mg) at bedtime as needed and 3 tablets (25.8-150 mg) at bedtime as needed and 4 tablets (34.4-200 mg) at bedtime as needed. However, the resident's May 2018 medication administration record (MAR) only includes Senexon 8.6-50 mg – take 2 tablets at bedtime as needed for constipation. Neither the prescription or the MAR indicates the frequency of administration.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

(See attached POC) Page 11A

Repeat Violation: Yes Date(s) of Previous Violation(s): 06/05/2017 et. al.

Signature of Legal Entity Representative
(Required on EVERY Page) *Judith Carrubba, ED*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Judith Carrubba* Date *7/19/18*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/2/18
(Date)

The above plan of correction was approved by BB
(Initials)

Plan of correction Implementation status as of 8/2/18
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

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AUG 02 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Regulation 2600.187 (a)

Health and Wellness Director showed the surveyor the most current order which matched MAR. The Health and Wellness Director clarified the order with the prescriber. The package had a green change in order sticker but entered orange sticker for further clarification. The Health and Wellness Director and Resident Care Coordinator were retrained by the Executive Director on July 10, 2018 on the Medication Administration Policy regarding change in prescriber orders. The Resident Care Coordinator or designee will audit the orders to MAR weekly for 2 months then monthly thereafter. The Health and Wellness Director will review the audit results to verify if any further action is required.

Evidence: Training log

Completion Date: July 12, 2018

Judy Carrabba Executive Director 8/2/18
Judy Cavallo ED 8/2/18

BB 8/2/18