



MAILING DATE: April 25, 2019

Ms. Stacey Meyer
Assistant Secretary
Brookdale Senior Living Communities, Inc.
7151 Saltsburg Road
Pittsburgh, Pennsylvania 15235

RE: Brookdale Penn Hills
Certificate #: 431590

Dear Ms. Meyer:

As a result of the Department's Bureau of Human Services Licensing inspection on February 25, 2019, of the above facility, the citations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Janine Wenzig". The signature is written in a cursive, flowing style.

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
Violation Report

**VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: BROOKDALE PENN HILLS		License Number: 43159
Address: 7151 SALTSBURG ROAD, PITTSBURGH, PA 15235		County: Allegheny
Administrator: JUDY CARRABBIA		Region: WEST
Legal Entity Name: BROOKDALE SENIOR LIVING COMMUNITIES INC		
Legal Entity Address: 7151 SALTSBURG ROAD, PITTSBURGH, PA 15235		
Certificate(s) of Occupancy C-2 LP 09/22/1997 L&I		RECEIVED APRIL 9 2019 WEST REGION FIELD OFFICE Human Services Licensing
Staffing Hours		
Resident Support: 0	Total Daily Staff: 27	Waking Staff: 20
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s)		
Complaint		
On-Site Inspections Dates and Department Representatives On-Site		
02/25/2019: Flinner-Alman, Lisa; Pfaff, Vicki		
Off-Site Inspection Dates and Inspectors, if Applicable		
Other Details		
Partial or Full Triggers:		Random Indicators:
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 26 Number of Residents Served: 18 Secured Dementia Care Unit in Home: No Area: Secured Dementia Unit Capacity, if Applicable: Number of Residents Served in Secured Dementia Care Unit, if applicable: Number of Current Hospice Residents: 3 Number of Hospice Residents in past year: 8	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 17 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 9 Have a Physical Disability: 0	

Brookdale Penn Hills

Plan of Correction

The following is the Plan of Correction for Brookdale Penn Hills regarding the Statement of Deficiency dated April 4, 2019 for the complaint follow-up survey on February 25, 2019. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Violation Report: 43159 - 02/25/2019 - Flinner-Alman, Lisa

PCH Name: BROOKDALE PENN HILLS

1. REGULATION 55 Pa.Code §2600

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 section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 2/7/19, protective services presented at the home to investigate a complaint of abuse involving resident #1. The home did not report the allegation of abuse or submit an incident report to the Department until 2/25/19.

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 2600.16 (c)

Immediately- The Executive Director prepared the incident report and submitted it to the surveyor. The community was not aware of the complaint, going forward the community will continue to follow the community policy regarding timely reporting to the Department.

February 26, 2019- Appropriate staff were re-trained on the community policy regarding timely reporting of reportable events by the Executive Director

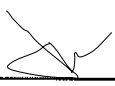
April 5, 2019 -The Executive Director and Health and Wellness Director were re-trained on the community policy regarding timely reporting of reportable events to the department by the District Director of Clinical Services.

Ongoing- The Executive Director or designee will review all reportable events to verify reporting is in accordance with the community policy.

The Executive Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet,

Completion Date: April 5, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page)			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)			Date
Judy Carrabba ED			4/9/19
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!			
The above plan of correction is approved as of		4/18/19 (Date)	Plan of correction implementation status as of
The above plan of correction was approved by		 (Initials)	4/18/19 (Date)
		<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	

Violation Report: 43159 - 02/25/2019 - Flinner-Alman, Lisa

PCH Name: BROOKDALE PENN HILLS

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:

- (1) Annually.
- (2) If the condition of the resident significantly changes prior to the annual assessment.
- (3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

The assessment, dated 8/15/18, for resident #1 does not include the diagnoses of Alzheimer's disease, gummata and ulcers of yaws, glaucoma, heart disease and depression, as indicated on the resident's medication list attached to the medical evaluation, dated 8/16/18.

The assessment, dated 12/14/18, for resident #2 indicates the resident does not require assistance with bathing or showering. However, the support plan, dated 12/14/18, indicates hospice provides the resident assistance with showers.

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 next page)

Page 3A of 4

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Judy Carrobbia

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


Judy Carrobbia, ED

Date *4/9/19*

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

The above plan of correction is approved as of 4/18/19
(Date)

Plan of correction implementation status as of 4/18/19
(Date)

The above plan of correction was approved by 
(Initials)

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

Immediately- The support plan/ RASP for resident #1 was updated to include pertinent diagnoses with plans for monitoring and managing each per community policy.

Immediately- The support plan/RASP for resident #2, who was on hospice, noted that hospice would perform the showers twice weekly not the care staff. An additional note was made that in the event that hospice is unable to perform the showers then the care staff would perform that task.


April 5, 2019- All appropriate clinical staff were in-serviced by the Executive Director regarding the community policy on accurate resident assessments.

The Health and Wellness Director or designee will audit 3 support plans monthly for 3 months to review to verify any changes in condition are reflected.

The Executive Director will review audit results 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, revised support plans

Completion date: April 5, 2019

 4/18/19

Violation Report: 43159 - 02/25/2019 - Flinner-Alman, Lisa
 PCH Name: BROOKDALE PENN HILLS

1. REGULATION 55 Pa.Code §2600

2600.227(c) - The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION

Resident #2 was assessed a moderate problem for irritability by the home; however, the support plan, dated 12/14/18, does not address the services the home will provide to assist the resident during periods of irritability, signs to look for, or how to reduce the risk of irritability.

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 2600.227 (c)

Immediately- Resident #2 was reassessed for irritability and it was found to be an error in documentation. Resident #2 does not have a problem with irritability. The support plan/RASP was updated to include there was no issue with irritability so no additional plan was required.

April 5, 2019- The Executive Director retrained the appropriate clinical staff on the community policy regarding documentation accuracy.

The Health and Wellness Director or designee will randomly audit 3 support plans monthly for 3 months for accuracy of the support plans/RASP.

The Executive Director will review audit results 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, revised support plan/PA addendum

Completion Date: April 5, 2019

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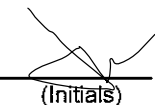
Signature of Legal Entity Representative
 (Required on EVERY Page) *Judy Corabbia*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Judy Corabbia, CEO* Date *4/9/19*

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 (Date)

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