pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: January 9, 2020

Ms. Stacey Meyer
Assistant Secretary
Brookdale Senior Living Communities, Inc.
5300 Old William Penn Highway
Export, Pennsylvania 15632

RE: Brookdale Murrysville
License #: 428680

Dear Ms. Meyer:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 12, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Larry Mazza
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
12/13/2019

Violation Report

Western Region Field Office
Bureau of Human Services Licensing

Facility Information

Name: *BROOKDALE MURRYSVILLE*
Address: *5300 OLD WILLIAM PENN HIGHWAY,, EXPORT, PA 15632*
License Number: *42868*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: *Sherrie Gillespie* Phone: *7243273655* Email: *CSTRASBURG@BROOKDALE.COM*

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*
Address: *5300 OLD WILLIAM PENN HIGHWAY, EXPORT, PA, 15632*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/09/1997* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *64* Waking Staff: *48*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

11/12/2019 - On-Site: Michael Marini, Deb McConnell

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* Residents Served: *32*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire Building* Capacity: *42* Residents Served: *32*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *32*
Are 60 Years of Age or Older: *32*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

18 - Compliance With Laws

Regulations

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 6-23-16, requires carbon monoxide alarms to be installed in close proximity to, but not less than 15 feet from, any fossil-fuel burning device or appliance. The carbon monoxide detectors at the following areas were within 15 feet from the fossil-fuel burning device:

* The carbon monoxide detectors in the 5 gas furnace closets are mounted approximately 2 feet from the furnaces

* The carbon monoxide detectors in the maintenance room are mounted approximately 4 feet from the gas water heaters

* The carbon monoxide detector at the gas fireplace is mounted on the fire place

* The carbon monoxide detector in the kitchen is mounted approximately 4 feet from the gas stove

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.)

Please see attached page,

See Page 2A of 7

Legal Entity Representative

Sherri Gillespie, RN, ED — Signature

Sherri Gillespie, RN — Printed Name and Title

Executive Director

12-13-19 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 12/16/19 (Date)

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

Plan of correction implementation status as of 1/6/2020 (Date)

☑ [redacted] Implemented

[redacted]

☐ Not Implemented

Regulation 2600.18

Immediately- The Maintenance Director relocated all carbon monoxide detectors to a distance of 15 feet or more away from the fossil fuel burning devices.

November 12, 2019- The Executive Director re-trained the Maintenance Director on proper placement of the carbon monoxide detectors.

Ongoing-The Maintenance Director or designee will perform weekly audits on the placement and functioning of the carbon monoxide detectors for a period of two months. The Executive Director will review the results of the audits to determine if any further action is warranted.

Evidence-Staff training attendance log

Completion Date: 11-13-19

Sherri Gillespie, RN, ED
Sherri Gillespie, RN
Executive Director
12-13-19

60a - Staff/Support Plan

Regulations

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

On 11-8-19, 11-9-19 and 11-10-19, there were 32 residents in the home. All 32 residents are residents with mobility needs, and 2 residents require the assistance of 2 staff persons to transfer in/out of bed/chair. According to the most recent fire safety inspection conducted by a fire safety expert on 3-28-19, the home has 6 internal fire-safe areas and a maximum safe evacuation time of 10 minutes. However, only 2 staff persons were on duty from 11:00 PM to 7:00 AM on 11-8-19, 11-9-19 and 11-10-19, which is not adequate to safely evacuate all residents in an emergency.

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.)

Please see attached.

See Page 3A of 7

Legal Entity Representative

Sheri Gillespie, RN, ED — Signature

Sheri Gillespie, RN, Executive Director — Printed Name and Title

12-27-19 — Date

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The above plan of correction is approved as of 1/6/2020 (Date)

The above plan of correction was approved by [redacted] (Initials)

Plan of correction implementation status as of 1/6/2020 (Date)

☑ [redacted] Implemented

☐ Not Implemented

Regulation 2600.60 (a)

Immediately- Two additional staff persons were present in the building for the 11-7 shift during the week, and one additional staff person was present in the building for the 11-7 shift over the weekend to ensure that a two-person transfer was no longer necessary with these residents. This was completed November 18, 2019.

The two residents who required the assistance of two staff persons for transfers were having behaviors intermittently prior to the survey were reassessed by the Health and Wellness Director. The support plans/RASP and the medications for these persons requiring additional assistance were reviewed by the Health and Wellness Director along with the medical professional. One resident had medications adjusted.

There have been no further behaviors noted at night requiring a two person transfer. These residents are no longer experiencing these behaviors and are now able to be transferred with the assistance of one staff person.

November 13, 2019-The Executive Director re-educated the Health and Wellness Director and Resident Care Coordinator on staffing by acuity.

November 13, 2019-On November 13, 2019, the Executive Director started to retrain appropriate staff on "Approach for Residents with Dementia" when caring for or transferring residents. The appropriate staff training was completed on December 12, 2019.

The Health and Wellness Director and/or Resident Care Coordinator will audit the schedule on a daily basis to ensure proper staffing needs are adequate. In addition, the Executive Director or designee will audit the staff schedule every two weeks for two months and as needed to ensure that staffing needs are adequate for evacuation in the event of an emergency and determine if any further action is warranted.

Three staff members are now being scheduled for the 11-7 shift to ensure that staffing needs are adequate.

Evidence: Training attendance sheets

Completion Date: 11-18-19

Within 30 days of receipt of the plan of correction: A designated staff person shall conduct an unannounced fire drill during sleeping hours with 3 staff persons to ensure all residents are able to safely evacuate to the fire-safe areas designated in writing within the past year by a fire safety expert, within the time specified in writing within the past year by a fire safety expert. If the fire drill exceeds the maximum safe evacuation time, additional staff shall immediately be scheduled. Documentation of the fire drill shall be kept. 1/6/2020

Sherri Gillespie, RN, ED
Sherri Gillespie, RN
Executive Director
12-27-19

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The emergency telephone numbers posted near the telephone in Hallway C are worn and not legible.

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.)

Please see attached page.

See Page 4A of 7

Legal Entity Representative

Sherri Gillespie, RN, ED — Signature

Sherri Gillespie, RN — Printed Name and Title: Executive Director

12-13-19 — Date

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☑ [redacted] Implemented

[redacted]

☐ Not Implemented

Regulation 2600.91

The emergency telephone numbers posted near the telephone in hallway C were worn and not legible.

Immediately- The Resident Care Coordinator replaced the emergency phone numbers that were illegible on the phone in hallway C.

Immediately- An audit was done of the emergency telephone numbers posted on all hallway phones and illegible labels were replaced by the Resident Care Coordinator.

November 13, 2019- The Executive Director re-educated all managers on the community policy regarding the need for legible emergency telephone numbers on all public telephones.

Executive Director or designee will perform weekly audits on telephones for a month to ensure all numbers are legible.

Evidence: Attendance in-service sheet
Completion Date: 11- 13-19

Sherri Gillespie, RN, ED
Executive Director
Sherri Gillespie, RN
12-13-19

101j7 - Lighting/Operable Lamp

Regulations

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

No operable source of lighting that can be turned on/off at bedside is present next to the bed in bedroom #D5.

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.)

Please see attached page.

See Page 5A of 7

Legal Entity Representative

Sherri Gillespie, RN, ED
Signature

Sherri Gillespie, RN 12-13-19
Printed Name and Title Executive Director
Date

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☑ [redacted] Implemented

[redacted]

☐ Not Implemented

Regulation 2600.101.j

No operable source of lighting that can be turned on/off is present next to the bed in D#5.

Immediately- The inoperable light source was corrected by placing a new battery in the light by the Maintenance Director.

November 13, 2019- The Executive Director re-educated all managers on the need for residents to have a properly operating light at their bedside.

November 13, 2019- An audit was performed by the Maintenance Director of all the battery operated light sources. Light sources were replaced or new batteries were inserted, when indicated, to verify they were operating correctly and within reach of the residents.

Ongoing- The Maintenance Director or designee will conduct audits weekly for two months. The Executive Director will review the results of the audits to verify if any further action is warranted.

Evidence- attendance sheet, audit sheet

Completion Date: 11-13-19

Sherri Gillespie, RN, ED
Sherri Gillespie, RN
Executive Director
12-13-19

131f - Fire Extinguisher Inspection

Regulations

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The tags on the fire extinguishers in the following locations do not indicate the month the extinguishers were last inspected by a fire safety expert:

* The fire extinguisher next to bedroom #D1

* The fire extinguisher next to the tool room

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.)

Please see attached page.

See Page 6A of 7

Legal Entity Representative

Sherri Gillespie, RN, ED
Signature

Sherri Gillespie, RN
Printed Name and Title Executive Director

12-13-19
Date

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Plan of correction implementation status as of 1/6/2020 (Date)

☑ [redacted] Implemented

[redacted]

☐ Not Implemented

Regulation 2600.131.f

The tags on the fire extinguishers in the following locations do not include the month the extinguishers were last inspected by a fire expert near #D1 and next to the tool room.

Immediately- At the time of the survey, the Maintenance Director was able to produce documentation that demonstrated the necessary servicing of all the fire extinguishers in the community had been completed properly. Inspection dates that were not properly marked on the 2 tags have now been marked accordingly to match the fire expert's site visit.

November 13, 2019- The Maintenance Director audited all fire extinguishers in the community for the proper tag labeling.

Ongoing- The Maintenance Director or designee will audit after the yearly inspection all fire extinguishers to verify that all labels are tagged correctly. The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence-Staff training attendance log

Completion Date: 11-13-19

Sherri Gillespie, RN, ED
Sherri Gillespie, RN
Executive Director
12-13-19

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #1 was prescribed Loperamide 2mg-1 tablet every 6 hours as needed for diarrhea and Ondansetron 4mg-1 tablet every 6 hours as needed for nausea and vomiting. These medications were discontinued on 10-17-19; however, were still present in the medication cart.

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.)

Please see attached pgs.

Legal Entity Representative

Sherri Gillespie, RN, ED
Signature

Sherri Gillespie, RN
Printed Name and Title Executive Director

12-B-19
Date

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Plan of correction implementation status as of 1/6/2020 (Date)

☑ [redacted] Implemented

[redacted]

☐ Not Implemented

Regulation 2600.183 (d)

Resident #1 was prescribed Loperamide 2 mg- 1 tablet every 6 hours as needed for diarrhea and Ondansetron 4mg-1 tablet every 6 hours as needed for nausea. These medications were still in the cart after being discontinued 10-17-19.

Immediately-The medications were removed from the medication cart for proper disposal.

November 13, 2019-The Health and Wellness Director and Resident Care Coordinator completed an audit on the medication carts for any medications that were discontinued.

November 13, 2019- Medication Technicians will be re-educated on the proper removal of discontinued medications and their disposal according to community policy.

Ongoing- The Health and Wellness Director or designee will complete audits weekly on the medication carts for a period of two months.

Evidence-Staff training attendance log

Completion Date: 11-13-19

Sherri Gillespie, RN, ED
Sherri Gillespie, RN
Executive Director
12-13-19