

Department of Human Services
Bureau of Human Service Licensing

September 24, 2020

KEN WILLIAMS, EXECUTIVE DIRECTOR
BROOKDALE SENIOR LIVING COMMUNITIES INC
6737 W. WASHINGTON ST, STE 2300
MILWAUKEE, WI 53214

RE: BROOKDALE NORTHAMPTON
65 RICHBORO-NEWTOWN ROAD
RICHBORO, PA, 18954
LICENSE/COC#: 12714

Dear Mr. Williams,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 08/24/2020, 08/25/2020, 08/26/2020, 08/27/2020, 08/28/2020, 08/31/2020, 09/01/2020, 09/01/2020, 09/02/2020, 09/10/2020 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *BROOKDALE NORTHAMPTON* License #: *12714* License Expiration Date: *07/16/2021*
 Address: *65 RICHBORO-NEWTOWN ROAD, RICHBORO, PA 18954*
 County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: *Ken Williams* Phone: *2153576565* Email: *kwilliams198@brookdale.com*

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*
 Address: *6737 W. WASHINGTON ST, STE 2300, MILWAUKEE, WI, 53214*
 Phone: *2153576565* Email: *CSTRASBURG@BROOKDALE.COM, clmendez@pa.gov*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *04/23/1993* Issued By: *Dept.L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *84* Waking Staff: *63*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint* Exit Conference Date: *09/10/2020*

Inspection Dates and Department Representative

08/24/2020 - Off-Site: David Carrion
08/25/2020 - Off-Site: David Carrion
08/26/2020 - Off-Site: David Carrion
08/27/2020 - Off-Site: David Carrion
08/28/2020 - Off-Site: David Carrion
08/31/2020 - Off-Site: David Carrion
09/01/2020 - Off-Site: David Carrion
09/01/2020 - Off-Site: David Carrion
09/02/2020 - Off-Site: David Carrion
09/10/2020 - Off-Site: David Carrion

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* Residents Served: *62*

Secured Dementia Care Unit

In Home: *Yes* Area: *Clare Bridges* Capacity: *23* Residents Served: *15*

Resident Demographic Data as of Inspection Dates (*continued*)

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 62

Diagnosed with Mental Illness: 1

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 22

Have Physical Disability: 1

Inspections / Reviews

08/24/2020 - Partial

Lead Inspector: *David Carrion*Follow-Up Type: *POC Submission*Follow-Up Date: *09/24/2020*

9/24/2020 - POC Submission

Lead Reviewer: *Claire Mendez*Follow-Up Type: *Document Submission*Follow-Up Date: *11/02/2020*

54a - Direct Care Staff

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction**Accept**

Immediately- Staff Person A was taken off the schedule until proper qualifying documentation was received. As documentation received did not meet the qualification, staff person A has been terminated.

September 23, 2020- The Business Office Manager is completing an audit of all team members Human Resource files to verify proper qualifying documentation is contained in the record. This audit will be completed by 10/2/20. Any team member found to be out of compliance will be taken off the schedule until proper documentation received.

September 24, 2020- The Executive Director retrained the Business office Manager on the community policy regarding qualifying documentation for new hires.

Ongoing- The Business Office Manager is now reviewing qualifying documentation of newly hired team members with the Executive Director for approval prior to start date.

The Executive Director will review the results of these audits as well as records on newly hired employees for 2 months to determine if any further action is warranted.

Evidence- Training log

Completion date: October 2, 2020

Completion Date: 10/02/2020

60a - Staff/Support Plan

1. Requirements

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 09/03, Resident #1 did not receive the instrumental activities of daily living, as required by his/her assessment and support plan. According to resident interviews, these services could not be provided due to lack of available direct care staffing in the home.

On 9/03 at 8 pm, Resident #1 requested assistance and rang the call bell. The home did not answer the call bell until the next day. Resident #1 needed a personal item from the top bookshelf of his room.

60a - Staff/Support Plan (continued)**Plan of Correction****Accept**

Immediately- Upon review of the call bell response time on the date of incident, the community did determine a pager was faulty. This equipment has been replaced.

On September 24, 2020 – The Health and Wellness Director reviewed with the appropriate care staff the community policy on responding to call bells as well as verifying that all equipment necessary to perform their jobs was in working order prior to starting their shift.

Ongoing- The clinical department has set up an audit to verify testing the functionality of pagers daily and monitoring the call response times to determine opportunities for correction of either personnel, equipment failure or staffing patterns. This will be in place for 2 months and then weekly thereafter.

The Health and Wellness Director will review the results of the audits to verify if any further action is warranted.

Evidence- Training log

Completion date: October 1, 2020

Completion Date: 10/01/2020

60b - Additional Staffing**1. Requirements**

2600.

- 60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

On September 2, Staff member B stated during the 7 am to 3 pm shift, she worked by herself providing all the care to the residents. She also served breakfast and lunch and cleared up the trays and placed them in the cart after meals. She provided ADL's and IADL's and completed the daily assignments. The 1st floor had 27 residents with one med tech and one caregiver. Per staff member B's statement "Residents were taken care, but they deserve a better care" and if the caregiver asks for help, another caregiver or med tech would come and help with one resident and leave.

60b - Additional Staffing (*continued*)**Plan of Correction****Accept**

Immediately- The staffing patterns in the dining and clinical department were reviewed by the Executive Director, Health and Wellness Director and the District Director of Clinical Services. The established staffing pattern is determined by accurate resident assessments, corresponding support plans as well as the occupancy in the community.

September 17, 2020- The Health and Wellness Director and District Director Clinical Services completed a re-assessment audit of care needs specific to the residents on the first and second floor of the community to determine if the staff are providing care as determined by resident need.

September 21, 2020- The community has added an additional caregiver, assigned to the first floor, to the staffing pattern as they continue to review assessments and staffing patterns.

September 21, 2020- The community has added an additional caregiver, assigned to the first floor, to the staffing pattern as they continue to review assessments and staffing patterns.

September 22, 2020 and ongoing - Assessments will be updated by the Health and Wellness Director and District Director of Clinical Services if it is determined appropriate and staffing will be adjusted if warranted.

September 24, 2020- Health and Wellness Director in serviced the care staff regarding working together as a team to provide care as well as communicate to the clinical leadership team if there is an increase or decrease in a resident's care needs. A plan will then be put in place to meet those identified needs.

The Health and Wellness Director and Executive Director will continue to review the staffing patterns along with resident needs, acuity and occupancy to address quality care and to verify if any further action is warranted.

Evidence- Training log

Completion date: October 31, 2020

Completion Date: 10/31/2020

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day (continued)

Description of Violation

Staff person C, whose first day of work was 7/15/20, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction**Accept**

Immediately- Orientation training was completed but not within the required time frame. The community adjusted the scheduling of the start date training process for new hires to assure coordination with and availability of the designated trainer to assure compliance. Video training will also be reviewed as a potential option.

September 10, 2020- A back-up trainer has also been identified in the event the designated fire safety trainer is unavailable. The community will schedule a train the trainer, pending availability to provide additional trainers within the community to assist with ongoing compliance with orientation training.

September 24, 2020- The Executive Director retrained the appropriate managers regarding the community policy on orientation to fire safety and emergency preparedness.

The Business Office Manager will audit all new hire files for 2 months to verify training has been completed according to community policy. A new hire training checklist is in place to track training completion for new hires in each file.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- Training log

Completion date: October 31, 2020

Completion Date: 10/31/2020

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on 01/25/17, began providing unsupervised ADL's services on 01/28/17. However, the staff person did not complete the Department approved direct care training course and pass the competency test.

65d - Initial Direct Care Training (*continued*)**Plan of Correction****Accept**

Immediately-Staff person A was taken off the schedule until the Department approved direct care training course was completed and the competency test passed. As it was discovered, staff person A also lacked proper qualifying documentation, employment has been terminated.

September 21, 2020- The Business Office Manager is completing an audit of all team members to assure proper qualifying documentation is on file regarding direct care training. This audit will be completed by 10/2/20. Any team member found to be out of compliance will be taken off the schedule until proper documentation received.

September 24, 2020- The Executive Director retrained the appropriate managers regarding the community policy on provision of unsupervised ADL's by newly hired direct care staff.

September 23, 2020- The Business Office Manager is auditing qualifying documentation of newly hired direct care team members with the Executive Director for approval prior to start date for 2 months.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- Training log

Completion date: October 2, 2020

Completion Date: 10/02/2020

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Repeat Violation

Direct care staff person A did not receive training in medication self-administration training, care for residents with dementia and cognitive impairments, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2019.

Direct care staff person C did not receive training in medication self-administration training, 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, safe management techniques during training year 2019.

Repeat Violation: 3/9/20

65f - Training Topics *(continued)***Plan of Correction****Accept**

Immediately- The Business Office Manager is currently auditing the 2020 training completion record for all team members, to be completed by 10/2/20. Team member training completion that is not consistent with the 2020 annual training plan will be scheduled by the Department Director to complete the required training to bring them current with the annual training plan schedule.

September 24, 2020- The Executive Director retrained the appropriate managers regarding the community policy on provision of unsupervised ADL's by newly hired direct care staff.

The Business Office Manager along with the Department Directors will then complete a quarterly audit moving forward to review compliance with the annual training plan.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- Training log, annual training plan

Completion date: October 2, 2020

Completion Date: 10/02/2020

65g - Annual Training Content

1. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Repeat Violation

Staff person A did not receive training in resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2019.

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert , emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2019.

Repeat Violation: 3/9/20

65g - Annual Training Content (continued)

Plan of Correction**Accept**

Immediately- The Business Office Manager is currently auditing the 2020 training completion record for all team members, to be completed by 10/2/20. Team member training completion that is not consistent with the 2020 annual training plan will be scheduled by the Department Director to complete the required training to bring them current with the annual training plan schedule.

September 23, 2020- The Executive Director retrained the appropriate managers regarding the community policy on annual trainings required.

The Business Office Manager along with the Department Directors will then complete a quarterly audit moving forward to review compliance with the annual training plan.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- Training log, annual training plan

Completion date: October 2, 2020

Completion Date: 10/02/2020

236 - Staff Training

1. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Repeat Violation

Direct care staff person A , who works in the Secure Dementia Care Unit (SDCU) had only 2 hours of training in dementia care during the 2019 training year.

Direct care staff person D , who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2019 training year.

Repeat Violation: 3/9/20

Plan of Correction**Accept**

Immediately- Staff person D was not scheduled to work in the Secure Dementia Unit until this training is completed. This training will be completed by October 30, 2020.

Staff Person A no longer works for the community.

September 21, 2020- The Business Office Manager is auditing the 2020 training completion record for all direct care staff working in the Secure Dementia Unit to be completed by 10/2/20. Team member training completion that is not consistent with the 2020 annual training plan will be scheduled by the Department Director and Clare Bridge Coordinator to complete the required training to bring them current with the annual training plan schedule.

The Business Office Manager along with the Clare Bridge Coordinator will then complete a quarterly audit moving forward to review compliance with the annual training plan for training in dementia care.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- Training log, annual training plan

Completion date: October 30, 2020

Completion Date: 10/30/2020