Department of Human Services
Bureau of Human Service Licensing

October 20, 2021

[redacted]
BRODHEAD SENIOR LIVING LLC
115 APPLE BLOSSOM WAY
MOON TOWNSHIP, PA 15108

RE: APPLE BLOSSOM SENIOR LIVING
115 APPLE BLOSSOM WAY
MOON TOWNSHIP, PA, 15108
LICENSE/COC#: 45073

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 05/24/2021, 05/25/2021, 05/26/2021, 06/09/2021, 06/30/2021 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,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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: *4123758400* **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 [redacted] at approximately 7:15 a.m., resident #1 was found on the floor of her bedroom with [redacted] head pinned between the bedframe and the bedside table. [redacted] had a laceration on [redacted]r right cheek and swelling with an indentation on [redacted] face where it had been pinned between the bed and corner of the bedside table. [redacted] was taken via ambulance to the emergency room, hospitalized and diagnosed with a subdural hematoma and compression fracture to the L1 vertebrae. However, the home failed to report this incident to the Department.

Plan of Correction **Accept**

on [redacted] 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*

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 [redacted] indicates [redacted] has a history of neck Injury. To meet this need, the home's staff will assist [redacted] in caring for [redacted] neck brace, which is to be worn at all times, indefinitely. However, on or about 4/20/21 through 4/21/21, the resident's brace was missing and could not be located. The resident was not wearing the brace on these days.

23a - Activities of Daily Living Assistance *(continued)*

Plan of Correction **Directed**

immediately on [redacted] 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 [redacted] the nurse put a towel around [redacted] neck to stabilize the neck while looking for the neck brace. the doctor was contacted for order of another brace and back up brace to be kept in medication room. a temporary brace was purchased from Walmart to stabilize residents neck.

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 she is wearing her prescribed neck brace. 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***

Completion Date: *10/12/2021*

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], 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 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] 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 fall and was noted to have an unsteady gait. Staff interviews indicate on 4/23/21 [redacted] sustained another unwitnessed fall and fell next to [redacted] bed, between the bed and the bedside table and quickly began to decline over the weekend, becoming lethargic and unable to ambulate as [redacted] had previously, requiring the use of a wheelchair to ambulate. 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 4/9/21 and 4/23/21, 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 4/23/21 and 4/26/21 were not aware that resident #1 fell on 4/23/21 and performed no additional continence or wellness checks on [redacted] through the night of 4/25/21 into 4/26/21. [redacted] was last seen by staff at approximately 5:30 a.m. on 4/26/21. On [redacted] at approximately 7:15 a.m., resident #1 was found on the floor of [redacted] bedroom with her head pinned between the bedframe and the bedside table. [redacted] had a laceration on [redacted] right cheek and swelling with an indentation on [redacted] face where it had been pinned between the bed and corner of the bedside table. [redacted] was taken via ambulance to the emergency room and diagnosed with a subdural hematoma and compression fracture to the L1 vertebrae. Resident #1 ceased to breath on [redacted] date of death. [redacted] death certificate indicates the immediate cause of death was blunt force trauma of head and neck, due to, or as a consequence of a fall. The manner of death was accidental.

42b - Abuse *(continued)*

Plan of Correction **Directed**

42b I 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 [redacted] did not reflect the start of PT/OT on 2/25/21.

Immediately on [redacted] an addendum was added to the [redacted] support plan to reflect that [redacted] had PT/OT for previous unsteady gait when [redacted] 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 4/23/21 to 4/26/21 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***

Completion Date: *10/12/2021*

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.

Completion Date: *10/12/2021*

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.

Completion Date: *10/12/2021*

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 4/23/21, the resident was found on the floor next to [redacted] bed and the alarm failed to sound.

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.

Completion Date: *10/12/2021*

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.

Completion Date: *10/12/2021*

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 1[redacted] indicates the resident has a history of neck Injury and is ordered to wear a neck brace. On or about 4/20/21 through 4/21/21, the resident's brace was missing and the resident was not wearing the brace 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] neck to stabilize the neck while looking for the neck brace. the doctor was contacted for order of another brace and back up brace to be kept in medication room. a temporary brace was purchased from Walmart to stabilize residents neck.
On [redacted] 1 resident #2 AA and SP were updated with addendum stating resident will have 2 neck braces 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 [redacted] resident #2 AA and SP were updated with addendum stating resident will have 2 neck braces 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 her prescribed neck brace. Documentation of checks shall be kept. ***S.Q. 10/20/21***

Completion Date: *10/12/2021*

225c - Additional Assessment

1. **Requirements**

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 she 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] indicates [redacted] has unsteadiness and has had 1-2 falls with bruising injury since moving into the memory care unit. In addition, resident #1 sustained unwitnessed falls on 4/9/21 and 4/23/21. However, [redacted] assessment and support plan, dated [redacted], 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, her assessment and support plan, dated [redacted] 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*

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*