Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

March 30, 2023

[redacted]
BROOKDALE SENIOR LIVING COMMUNITIES INC
5300 OLD WILLIAM PENN HIGHWAY
EXPORT, PA, 15632

RE: BROOKDALE MURRYSVILLE
5300 OLD WILLIAM PENN HIGHWAY
EXPORT, PA, 15632
LICENSE/COC#: 42868

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/19/2022, 02/28/2023, 03/01/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE MURRYSVILLE* **Licen e #**: *42868* **Licen e Expiration**: *02/19/2024*

Address: *5300 OLD WILLIAM PENN HIGHWAY, EXPORT, PA 15632*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone** [redacted] **Email** [redacted]

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*

Address: *5300 OLD WILLIAM PENN HIGHWAY, EXPORT, PA, 15632*

Phone: [redacted] **Email**: [redacted] *m*

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/09/1997* **I ued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *57* **Waking Staff**: *43*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/01/2023*

Inspection Dates and Department Representative

12/19/2022 On Site [redacted]
02/28/2023 On Site
03/01/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* **Residents Served**: *30*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *42* **Residents Served**: *30*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *27*
Have Physical Disability: *0*

Inspections / Reviews

12/19/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2023*

Inspections / Reviews *(continued)*

03/29/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2023*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/05/2023*

03/30/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2023*

Reviewer [redacted] **Follow-Up Type:** *Not Required*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract completed [redacted]22 for resident #1 was not signed by the resident. There was no documentation that the resident was unable or refused to sign the contract.

The resident-home contract completed [redacted]22 for resident #2 was not signed by the resident. There was no documentation that the resident was unable or refused to sign the contract.

The resident-home contract completed [redacted]/21 for resident #3 was not signed by the resident. There was no documentation that the resident was unable or refused to sign the contract.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

anuary 16, 2023 Signatures or initials needed for Resident #2 and Resident #3 were obtained and marked with current date by the Executive Director. Residents unable to sign were marked by a witness and initialed. [redacted].

March 1, 2023 Executive Director audited Residency Agreements for resident signatures and any missing signatures were secured according to community policy.

March 22, 2023 Executive Director retrained management staff who assist with the Residency Agreements on the process for completion.

o assist with ongoing compliance, the Executive Director or designee will audit new residents Residency Agreements to verify compliance weekly for 2 months.

Attachments contracts for resident #2 and resident #3, training attendance sheet, new move in checklist

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] 03/30/2023)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1, admitted [redacted]/22, did not sign the Resident Rights acknowledgement.

Resident #2, admitted [redacted]/22, did not sign the Resident Rights acknowledgement.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

March 1, 2023 Executive Director obtained acknowledgement regarding Resident Rights for Resident #2. [redacted]

March 1, 2023 Executive Director audited the Residency Agreements for signatures according to community policy. Any signatures or initials needed were obtained and marked with the current date. Any residents unable to sign

41e - Signed Statement (continued)

due to their dementia were marked by a witness and initialed.
March 22, 2023- District Director of Clinical Services retrained the management staff who assist with the completion of Residency Agreements regarding the community policy on move-in documentation.
To assist with ongoing compliance, the Executive Director or designee will audit new residents' Residency Agreements weekly for two (2) months, to verify the Resident Rights acknowledgement was signed..
Attachments: Resident Rights Acknowledgement for Resident #2, Training attendance, move-in checklist

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

54a Direct Care Staff

3. 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

The home does not have documentation that direct care staff person A, hired [redacted]/22, has a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. According to staffing schedules provided to the Department, staff person A provided unsupervised direct care services to residents on the following dates: [redacted]2022, [redacted]22, [redacted]/22 through [redacted]/22, [redacted]/22, [redacted]/23, and [redacted]/23.

Plan of Correction ***Accept [redacted] 03/29/2023)***

February 28, 2023- Staff person "A" was notified of the need to provide a copy of her high school diploma or GED for this document by the Executive Director. Staff person "A" was removed from the schedule until the document is received.
March 1, 2023- Executive Director completed an audit of employee files to verify community has a copy of the employee's high school graduation for diploma, GED, or transcripts. Audited files were found to be in compliance.
March 21, 2023- Executive Director retrained the management staff who assist with the employee documentation process regarding the community policy on documentation requirement for hiring direct care staff.
March 24, 2023 – Staff "A" no longer employed here.
To assist with ongoing compliance, Executive Director or designee will audit new employee personnel documents weekly for 2 months then monthly thereafter for 3 months using a new hire checklist.
Attachments- training attendance, audit of employee files, new hire checklist

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.

65b - Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person C, hired [redacted]/21, did not receive training within 40 scheduled working hours that included:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.
(4) Reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 03/29/2023)***

March 3, 2023-The Executive Director retrained the managers who supervise staff and assist with staff training, on the community policy regarding completion of the department-approved training prior to providing care to residents.
March 20, 2023- Executive Director performed an audit of employee files/ training documentation to verify required trainings have been completed timely during New Hire Orientation process according to community policy. Any other files found to not be in compliance, staff were trained and documented with the date of the training.
March 21, 2023- Executive Director retrained the managers who have staff reporting to them regarding the community policy on training requirements for newly hired direct care staff.
To assist with ongoing compliance, the Executive Director or designee will review new hire files for completion of required trainings monthly, prior to caring for residents, for 2 months.
Attachments: training attendance

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

86b - Bathroom

5. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 12/19/22, at 11:15 a.m., the exhaust fan in the bathroom in resident room [redacted] was not operational. There is no window in the bathroom.

On 12/19/22 at 11:30 a.m., the exhaust fan in the bathroom in resident room [redacted] was not operational. There is no window in the bathroom.

On 12/19/22 at 11:45 a.m., the exhaust fan in the bathroom in resident room [redacted] was not operational. There is no window in the bathroom.

On 12/19/22 at 11:55 a.m., the exhaust fan in the bathroom of resident room [redacted] was not operational. There is no window in the bathroom.

86b - Bathroom *(continued)*

Plan of Correction ***Accept (JK - 03/29/2023)***

December 19, 2022- Maintenance Manager Director notified the surveyor that the necessary parts for this repair were on order and he was waiting on a specific part that would enable the repair to be completed.
December 27, 2022- The parts to repair the exhaust fans arrived at the community and the 3 exhaust fans were then repaired in resident rooms [redacted] and [redacted] by the Maintenance Manager. Clinical staff were retrained to report any ssues with equipment not working.
January 4, 2022- Executive Director and Maintenance Manager rounded in the community to verify bathroom fans were operational. Other bathroom exhaust fans were noted in compliance.
March 2, 2023- Maintenance Manager retrained the management team during the monthly meeting on the LOG OUT/TAG OUT and work order procedures according to community policy.
Maintenance Director, Housekeeper or designee will continue to maintain the preventative maintenance schedule as directed in the Electronics Maintenance System (TELS).
To assist with ongoing compliance, the Executive Director or designee will review the TELS maintenance schedule to erify completion.
Attachments: Training attendance, documentation of exhaust fan audit

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented ([redacted] - 03/30/2023)

91 - Telephone Numbers

6. Requirements

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

On 12/19/23 at approximately 11:00 a.m., there were no telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline posted on or by the telephone in the home's Activities Room.

Plan of Correction ***Accept ([redacted] - 03/29/2023)***

December 19, 2022- Emergency phone number sticker was replaced in the activity room phone at time of survey by the Maintenance Manager.
December 21, 2022-Executive Director completed an audit for emergency phone number listings on phones with outgoing lines. Any areas of non-compliance were rectified immediately.
March 2, 2023- Executive Director retrained the managers regarding the community policy.
Housekeeper or designee will check common area telephones while cleaning weekly. Housekeeper has been trained on the label placement and has several sheets of replacement stickers on her housekeeping cart. An audit schedule has been established weekly to check phones with outside lines for posting of emergency phone numbers. This will be completed weekly for 2 months and monthly thereafter.
To assist with ongoing compliance, the Executive Director or designee will review audits monthly for 2 months.
Attachments: Training attendance sheet, audit results

Licensee's Proposed Overall Completion Date: *03/31/2023*

91 - Telephone Numbers *(continued)*

Implemented (JK - 03/30/2023)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 12/19/22 at 10:50 a.m., there was a bed enabler on resident #1's bed in room [redacted] with a rectangular opening approximately 16" long X 6" high. There was no covering on the enabler posing an entrapment risk.

Plan of Correction ***Accept ([redacted] - 03/29/2023)***

mmediately, December 19, 2022- The bedside mobility device was re-covered with the mesh cover that was in the room during Inspector's walk-through by the Executive Director. Family of resident #1 had brought in and installed the enabler themselves. Family was reeducated regarding the community policy for bedside mobility devices. [redacted].

December 28, 2022 – An audit was conducted of current residents' rooms/beds by the Health and Wellness Director to verify no other bedside mobility devices or similar devices were present. No other enabler devices were identified n the community. Health and Wellness Director will review community policy on bedside mobility devices with families during the move-in process.

March 2, 2023 –clinical staff were retrained on this regulation and use of bedside mobility devices according to community policy.

Ongoing – When the need for a bedside mobility device is identified, the Health and Wellness Director or designee will assess the resident for use of the device prior to installation per community policy. The Health and Wellness Director or designee will audit resident rooms for approved bedside mobility devices monthly for three (3) months. To assist with ongoing compliance, the Health and Wellness Director will review results of audits monthly for two (2) months.

Attachments: training attendance

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented ([redacted] - 03/30/2023)

101j7 - Lighting/Operable Lamp

8. Requirements

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

On 12/19/22 at approximately 11:35 a.m., there was no operable lamp or source of light within reach of the bed in resident room [redacted].

Plan of Correction ***Accept [redacted] 03/29/2023)***

December 19, 2022, the bedside lamp was replaced beside the bed of Resident Room [redacted] by the Maintenance Manager.

December 19, 2022-Family re-educated by the Executive Director on the regulation regarding light placement in

101j7 - Lighting/Operable Lamp (continued)

resident rooms. The table with lamp that had been relocated by the family was replaced near the bed by the Executive Director.
December 19, 2022- Maintenance Manager performed an audit of resident rooms to verify tables with lamps were placed near resident beds allowing access by the residents. One other light had been relocated by the family and the Maintenance Manager replaced it at the residents bedside.
January 4, 2023- A letter was emailed to families stressing the importance of lights being placed bedside for safety reasons.
January 25, 2023- In-service was conducted for clinical staff by the Executive Director regarding the community policy on operable lighting in each resident room being within reach of the bed.
January 25, 2023- resident rooms will be monitored for available lighting by housekeeping or designee on the scheduled cleaning days weekly for 2 months then monthly thereafter.
The Executive Director will review the results of these audits for 2 months.
Attachments: training attendance sheet, picture of bedside lighting resident room C2

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 12/19/22 at 11:30 a.m., there was no thermometer in the freezer compartment of the refrigerator/freezer in the "butler's pantry " between the A/B and C/D dining rooms.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

December 19, 2022- The thermometer was replaced in the freezer compartment during Inspector's walk-through by the Dining Services Manager.
December 20, 2022- Dining Services Manager audited refrigerators/freezers in the community for availability of working thermometers. Other refrigerators/freezers were noted in compliance.
December 20, 2022- The Executive Director retrained the Dining Services Manager and cook regarding the community policy on refrigerator/freezer temperature monitoring.
An audit schedule has been established in conjunction with temperature log readings for the Dining Manager or designee to check for thermometers daily for 2 months then weekly for one (1) month.
To assist with ongoing compliance, the Executive Director or designee will review audit results for the next 2 months.
Attachments: training attendance sheet

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] 03/30/2023)

103g - Storing Food

10. Requirements

103g - Storing Food *(continued)*

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 12/19/22 at 11:30 a.m., there was a nearly full uncovered vanilla Magic Cup dessert dish with a spoon in it in the freezer section of the refrigerator/freezer in the "butler's pantry" between the A/B and C/D dining rooms.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

December 19, 2022 the Dining Services Manager removed and discarded the uncovered Magic Cup from the freezer.
December 19, 2022 Other refrigerators/freezers were checked for storage of food according to community policy. Other freezers were found in compliance by the Dining Manager.
December 20, 2022 The Executive Director retrained the care and dining staff regarding the community policy on storing food in closed or sealed containers.
he Dining Services Manager or designee established an audit schedule for the refrigerators daily or 5 times weekly or 2 months then weekly for one (1) month.
o assist with ongoing compliance, the Executive Director or designee will review audit results to verify compliance or 2 months.
Attachments: In service attendance sheet, audit results

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

131c - Kitchen Fire Extinguisher

11. Requirements

2600.
131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

Description of Violation

On 12/19/22 at 11:40 a.m., there was no fire extinguisher in the Country Kitchen. The nearest extinguisher was located approximately 15 feet down the hall outside the entryway to the kitchen.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

December 20, 2022-Maintenance Manager purchased a fire extinguisher and installed it in the country kitchen on wall by stove. Other areas reviewed for fire extinguishers by the Inspector were found to be in compliance.
December 20, 2022- The Executive Director retrained the Maintenance Manager regarding the community policy on fire extinguisher location requirements.
Maintenance Manager or designee will audit monthly the fire extinguishers in accordance with the schedule established in TELS (electronic maintenance schedule).
The Executive Director or designee will review audit results to verify compliance.
Attachments: training attendance form, picture of installed fire extinguisher

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] 03/30/2023)

141b1 - Annual Medical Evaluation

12. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The most recent medical evaluation (DME) completed for resident #4 was completed [redacted]/22. However, the resident's previous DME was completed [redacted]/21.

Plan of Correction ***Accept [redacted] 03/29/2023)***

March 6, 2023- The Executive Director retrained the clinical staff regarding the community policy on Annual Medical Evaluation completion.
March 19, 2023 – Health and Wellness Director completed an audit of the medical evaluation dates (DME) and other DME's were found to be in compliance.
March 6, 2023- Health and Wellness Director developed a tracker for medical evaluation (DME) completion according to community policy.
March 6, 2023 and ongoing- The Health and Wellness Coordinator or designee will manage the DME due date of completion utilizing a tracker. DMEs will be reviewed monthly for 6 months.
To assist with ongoing compliance, the Health and Wellness Director or designee will review the results of these audits to verify compliance.
Attachments- training attendance, audit results

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

191 - Resident Right to Refuse

13. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [redacted]/22, did not sign the Resident Rights acknowledgement which includes that the resident has the right to question or refuse a medication if he/she believes there may be a medication error.

Resident #2, admitted [redacted]22, did not sign the Resident Rights acknowledgement which includes that the resident has the right to question or refuse a medication if he/she believes there may be a medication error.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

January 16, 2023- Signatures or initials needed for Resident #2 were obtained and marked with current date by the Executive Director. Residents unable to sign were marked by 2 witnesses and initialed. [redacted]
March 1, 2023- Executive Director audited Residency Agreements for resident signatures according to community policy and any missing signatures were secured.
March 22, 2023- District Director of Clinical Services retrained managers on the process for completion of Residency Agreements using the move-in checklist..
To assist with ongoing compliance, weekly audits to be performed by the Executive Director or designee to verify compliance for two (2) months for new move-ins.
Attachments: Resident Rights for resident #2, training attendance sheet

191 - Resident Right to Refuse *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)

231e - No Objection Statement

14. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1, admitted [redacted]/22, did not sign the statement indicating that the resident and their designated person have not objected to the resident's admission to the secured dementia care unit.

Plan of Correction ***Accept [redacted] - 03/29/2023)***

March 1, 2023- Executive Director audited move-in documents for resident signatures according to community policy and any missing signatures were secured. [redacted].
March 22, 2023- Executive Director was retrained on the process for completion of Residency Agreements and move-in documentation by the District Director Clinical Services.
Executive Director or designee will maintain Residency Agreements including required consents and will verify that signatures are obtained upon move-in using the move-in checklist.
To assist with ongoing compliance, audits will be performed monthly for two (2) months by Executive Director or designee to verify compliance of new move-in documentation.
Attachments- training attendance sheet, move-in checklist

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented [redacted] - 03/30/2023)