

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

October 22, 2024

[REDACTED]
BROOKDALE SENIOR LIVING COMMUNITIES INC
[REDACTED]
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/22/2024, 07/26/2024, 08/15/2024 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* License #: *42868* License Expiration: *02/19/2025*
 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: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

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: *68* Waking Staff: *51*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *08/15/2024*

Inspection Dates and Department Representative

07/22/2024 On Site [REDACTED]
 07/26/2024 On Site [REDACTED]
 08/15/2024 Off Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *42* Residents Served: *34*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Whole Building* Capacity: *42* Residents Served: *34*

Hospice
 Current Residents: *4*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *34*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *34* Have Physical Disability: *0*

Inspections / Reviews

07/22/2024 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/15/2024*

Inspections / Reviews *(continued)*

09/27/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/21/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/04/2024

10/16/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/21/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/30/2024

10/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/21/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], at approximately lunch time, resident [REDACTED] grabbed a picture frame off of the wall and attempted to hit staff with it. Staff person A took the picture frame from resident [REDACTED]. At approximately 6:30 p.m., resident [REDACTED] punched resident [REDACTED] near the back of their head. Then resident [REDACTED] slapped resident [REDACTED] in the face. In addition, at approximately 8:30 p.m., resident [REDACTED] grabbed resident [REDACTED] hand and tried to pull resident [REDACTED] out of their wheelchair. Also, at approximately 8:45 p.m., resident [REDACTED] squeezed resident [REDACTED] hand. These incidents were observed by staff persons A & B. However, these allegations of abuse were not immediately reported in accordance with the Older Adult Protective Services Act. The home reported these incidents to Protective Services on [REDACTED].

On [REDACTED] at approximately 2:00 p.m., resident [REDACTED] grabbed resident [REDACTED] arms. This incident was observed by staff person C. However, this allegation of abuse was not immediately reported in accordance with the Older Adult Protective Services Act. The home reported this incident to Protective Services on [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/27/2024)

The following is the Plan of Correction for Brookdale Murrysville regarding the Statement of Deficiency dated September 6, 2024 for the complaint/incident inspection on July 22nd, 26th and August 15th. 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

10/8/2024 Appropriate clinical and management staff will be retrained by the Acting Executive Director (ED) on the community policy regarding suspected abuse and timely notification to the local Area on Aging. Documentation of the staff education shall be kept in accordance with 2600.65i.

10/8/2024 A community retraining will be completed by Acting Executive Director regarding Mandated Reporting of allegations of abuse/ neglect by 10/8/2024. Documentation of the staff education shall be kept in accordance with 2600.65i.

Ongoing compliance The ED or designee will review any potential incidents as they occur for 2 months starting immediately. The review will include a daily review of all internal incidents to verify allegations of abuse are immediately reported to the Area Agency on Aging in accordance with the Older Adult Protective Services Act. Monthly reviews will be then be completed for 3 consecutive months by the ED or designee to verify compliance and to determine if any further action is warranted.

Required training documentation will be reported at the next Quality Management Meeting on 9/13 by the ED along with the plan for incident reviews. The home shall conduct a quality management review within 30 days of receipt of the plan of correction. The quality management review shall include a review of this plan of correction.

Documentation of the quality management review shall be kept.

Supporting Documentation: record of staff training, Resident Rights, OAPSA log of training to be completed by 10/8/24, policy on community policy regarding reporting suspected abuse.

15a - Resident Abuse Report (continued)

Licensee's Proposed Overall Completion Date: 10/08/2024

Implemented [REDACTED] - 10/22/2024)

16c Written Incident Report

2. 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 lunch time, resident [REDACTED] grabbed a picture frame off of the wall and attempted to hit staff with it. Staff person A took the picture frame from resident [REDACTED]. At approximately 6:30 p.m., resident [REDACTED] punched resident [REDACTED] near the back of their head. Then resident [REDACTED] slapped resident [REDACTED] in the face. In addition, at approximately 8:30 p.m., resident [REDACTED] grabbed resident [REDACTED] hand and tried to pull resident [REDACTED] out of their wheelchair. Also, at approximately 8:45 p.m., resident [REDACTED] squeezed resident [REDACTED] hand. These incidents were observed by staff persons A & B. The home did not report these incidents to the Department until [REDACTED].

Plan of Correction

Directed [REDACTED] 10/16/2024)

The following is the Plan of Correction for Brookdale Murrysville regarding the Statement of Deficiency dated September 6, 2024 for the complaint/incident inspection on July 22nd, 26th and August 15th. 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.

10/8/2024 - Appropriate clinical and management staff will be retrained by the Acting Executive Director (ED) on the community policy regarding suspected abuse and timely notification to the local Area on Aging by 10/8/2024.

Documentation of the staff education shall be kept in accordance with 2600.65i.

10/8/2024- A community retraining will be completed by Acting Executive Director regarding Mandated Reporting of allegations of abuse/ neglect by 10/8/2024. Documentation of the staff education shall be kept in accordance with 2600.65i.

Ongoing compliance- The ED or designee will review any potential incidents as they occur for 2 months starting immediately. The review will include a daily review of internal incidents to verify allegations of abuse are immediately reported to the Area Agency on Aging in accordance with the Older Adult Protective Services Act. Monthly reviews will be then be completed for 3 consecutive months by the ED or designee to verify compliance and to determine if any further action is warranted.

Required training documentation will be reported at the next Quality Management Meeting on 9/13 by the ED along with the plan for incident reviews. The home shall conduct a quality management review within 30 days of receipt of the plan of correction. The quality management review shall include a review of this plan of correction.

16c - Written Incident Report (continued)

Documentation of the quality management review shall be kept.

Supporting Documentation: record of staff training, Resident Rights, OAPSA log of training to be completed by 10/8/24, policy on community policy regarding reporting suspected abuse.

10/8/2024 - Appropriate clinical and management staff will be retrained by the Acting Executive Director (ED) on the community policy regarding suspected abuse and timely notification within 24 hours of incident to the local Area on Aging. [REDACTED] 10/16/24) Documentation of the staff education shall be kept in accordance with 2600.65i.

10/8/2024- A community retraining will be completed by Acting Executive Director regarding Mandated Reporting of allegations of abuse/ neglect and reporting to the state regulatory boards within 24 hours of incident.

Documentation of the staff education shall be kept in accordance with 2600.65i.

Proposed Overall Completion Date: 10/11/2024

Directed:

By 10/23/24 and daily thereafter for 2 months, the ED or designee will review all incidents and conditions as they occur, to ensure all reportable incidents and conditions are reported to the Department within 24 hours. Monthly reviews will be then be completed for 3 consecutive months by the ED or designee to verify compliance and to determine if any further action is warranted.

[REDACTED] 10/16/24

Directed Completion Date: 10/23/2024

Implemented ([REDACTED] - 10/22/2024)

16f Copy of Reportable Incident or Condition

3. Requirements

2600.

16.f. The home shall keep a copy of the report of the reportable incident or condition.

Description of Violation

On [REDACTED] staff person D, the home's District Director of Operations, submitted an incident report to the Department alleging that staff person E, the home's administrator, and staff person F, the home's Health and Wellness Director, do not assess residents when they fall. In addition, the incident report alleges that direct care staff person G does not change residents, and that staff person E is aware of this allegation. However, this incident report was not shared with the home to investigate or to retain a copy of the reportable incident.

Plan of Correction

Accept ([REDACTED] - 10/16/2024)

The following is the Plan of Correction for Brookdale Murrysville regarding the Statement of Deficiency dated September 6, 2024 for the complaint/incident inspection on July 22nd, 26th and August 15th. This Plan of Correction s 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

16f - Copy of Reportable Incident or Condition (continued)

changes and improvement to satisfy that objective.

7/18/24-District Director of Operations reported an anonymous allegation when it was reported to her. She reported as is required by regulation 15a and 16c. Investigation was opened, completed, and concluded. District Director is aware that reportable incidents should have a copy onsite however she did not immediately provide it to the Executive Director or Director of Health and Wellness in an effort to preserve the integrity of the investigation as the accusation included them.

7/22/2024- District Director of Operations did provide a copy of the reportable incident after the investigation was complete.

Supporting documentation-copy of reportable incident

Ongoing compliance- The ED or designee will review any potential incidents as they occur for 2 months starting immediately. The ED or designee will assure that all reportable incidents are available in the community. Monthly reviews will be then be completed for 3 consecutive months by the ED or designee to verify compliance and to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 10/11/2024

Implemented [redacted] 10/22/2024)