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

March 4, 2025

[redacted], EXECUTIVE DIRECTOR
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 review on 09/27/2024 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: *APPLE BLOSSOM SENIOR LIVING* **License #**: *45073* **License Expiration**: *10/11/2025*

Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*

Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/27/2019* **Issued By**: *Township of Moon*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/27/2024*

Inspection Dates and Department Representative

09/27/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *40* **Residents Served**: *32*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

09/27/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/20/2024*

10/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/24/2024*

Inspections / Reviews *(continued)*

10/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/28/2024*

03/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/28/2024*

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

103g - Storing Food

1. Requirements

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

Description of Violation

At 10:38 AM, there was an open and unsealed 30 lb. bag of frozen blueberries, which was almost full, present in the upright commercial freezer in the kitchen.

Plan of Correction ***Accept ([redacted] - 10/25/2024)***

No residents were adversely affected. Upon notification, the bag of blueberries was immediately sealed. Audit completed of items in the memory care commercial freezer and all other food storage areas for proper storage – no concerns noted. Education completed by the Memory Care Director with memory care team members on proper storage of frozen food immediately on 9/27/24 and again on 10/7/24 and 10/14/24. Weekly audits began immediately on 9/27/24 of the commercial freezer and all food storage areas for proper food storage to be completed by Memory Care Director or designee, weekly x 4, then monthly. All audits will be reviewed at quality meeting on 10/22/24 for further action and/or audits needed.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented ([redacted] - 03/04/2025)

132c - Fire Drill Records

2. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the following fire drills do not include the exact start time of the fire drills, and were rounded to the nearest hour:

- *9/23/24 at 5:00 PM*
- *8/23/24 at 10:00 AM*
- *7/15/24 at 5:00 AM*
- *6/21/24 at 5:00 PM*
- *5/25/24 at 8:00 PM*
- *4/16/24 at 2:00 PM*
- *3/7/24 at 1:00 AM*

Plan of Correction ***Accept ([redacted] - 10/25/2024)***

No residents were adversely affected. The Maintenance Director was educated on 10/8/24 by the Executive Director to input the exact time on future fire drills. Fire drills will continue to be conducted by the Maintenance Director or designee on a monthly basis. The Executive Director or designee will begin auditing the fire drills on 10/14/24 monthly to ensure that the exact time is present. The audits will be completed monthly x 6. Audits will be reviewed at the Quality Meeting on 10/22/24 for further action and/or audits needed.

132c - Fire Drill Records (continued)

Proposed Overall Completion Date: 11/20/2024

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented (- 03/04/2025)

132g - Fire Drills Days/Times

3. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons in the home from approximately 11:00 PM through 7:00 AM; however, the home has not conducted a fire drill with only 2 staff persons within the past year.

Plan of Correction ***Directed (- 10/25/2024)***

No residents were adversely affected. The Maintenance Director was educated by the Executive Director on 10/8/24 regarding completion of fire drills with the designated memory care team members. A fire drill will be conducted on 10/23/24 on the 11pm-7am shift with 2 staff members. Fire drills will continue to be conducted by the Maintenance Director or designee on a monthly basis. The Executive Director or designee will audit the fire drills monthly x 6 to ensure that only designated memory care team members participate. (DIRECTED: The Executive Director monthly audits shall begin within 48 hours of receipt of the plan of correction and shall include a review of the fire drill conducted on 10/23/24 during the overnight shift to ensure compliance with 2600.132c, 2600.132d, 2600.132g and 2600.132h. 10/25/24). Audits will be reviewed by the Quality Committee at the quality meeting on 10/22/24 for further action and/or audits needed.

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *10/27/2024*

Implemented (- 03/04/2025)

132h - Designated Meeting Place

4. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

According to staff person the home's administrator, residents are evacuated behind auto-closing fire doors in the home during each monthly fire drill; however, according to the most recent documentation from a fire safety expert,

132h - Designated Meeting Place (continued)

dated 3/13/24, the home does not have any internal fire-safe areas.

Plan of Correction ***Directed (- 10/25/2024)***

The Executive Director has notified the Fire Safety Expert they will be at the facility on 11/5/24 at 10am to complete a new fire evacuation time and fire safety area form to accurately capture the internal fire-safe areas. a new SOP was initiated to increase the number of team members to aid in the evacuation on the 11-7 shift. Monthly fire drills will continue to be completed by the maintenance director or designee with memory care residents being evacuated appropriately according to the fire safety expert documentation. Audits will be completed by the Executive Director or designee starting 10/14/24 then monthly x 6 to ensure residents are evacuated to an appropriate area, per the fire safety expert documentation. Audits will be reviewed at the quality meeting on 10/22/24 by the Quality Committee for further action and/or audits needed.

A new fire safety inspection and supervised fire drill were conducted by a fire safety expert on 10/24/24 indicating the location of internal fire-safe areas within the home. The administrator shall maintain documentation of this fire safety inspection. 10/25/24

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *10/27/2024*

Implemented (- 03/04/2025)

183d - Prescription Current

5. Requirements

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

On 8/13/24, resident #1 was prescribed Clotrimazole Cream 1%-Apply to right foot twice daily for 2 weeks; however, on 9/27/24, this medication was still present in the home.

Plan of Correction ***Accept (- 10/25/2024)***

The identified resident was not adversely affected. The Clotrimazole cream was immediately removed from cart. The 2 medication carts and medication storage area was audited on 9/27/24 by the unit coordinator, no concerns noted. The Memory Care medication aides and licensed nurses will be educated by the memory care director or designee on 10/7/24 for identification and proper disposal of discontinued medications. The memory care 2 medication carts and medication storage area will be audited weekly x 4, starting 10/7/24 then monthly by the Memory Care Director or designee for discontinued medications and proper disposal. Audits will be reviewed on 10/22/24 at the quality meeting by the Quality Committee for further action and/or audits needed.

Proposed Overall Completion Date: 11/20/2024

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented (- 03/04/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 9/13/24, resident #1 was prescribed Colace 100 mg capsule-Take 1 capsule by mouth twice a day; however, this medication was not administered to resident #1 from 9/13/24 through 9/27/24.

Plan of Correction ***Directed (- 10/25/2024)***

The identified resident was not adversely affected. All other hospice resident medications audited on 9/27/24 and were accurate. The hospice agency that prescribed the over-the-counter medication was notified and physician discontinued the medication on 9/27/24. Further investigation showed the hospice nurse sent the order to the pharmacy and failed to notify the community. The hospice nurse was educated by the Executive Director on 9/27/24 to notify the community about new recommendations/orders. Hospice recommendations/orders for all hospices residents will be audited 5 times a week for 2 weeks, then monthly by the memory care director or designee. (DIRECTED: The audits shall begin on 10/28/24. 10/25/24). All other resident's order's will be audited with the weekly Medication Cart audits. Audits will be reviewed on 10/22/24 at the Quality Management meeting by the Quality Committee for further action and/or audits needed.

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *10/28/2024*

Implemented (- 03/04/2025)

233c - Key-Locking Devices

7. 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

The directions to operate the keypad-locking devices at the following exits were not conspicuously posted near the doors:

- *The emergency exit door near bedroom #139*
- *The emergency exit door leading to the rear parking lot/dumpster area*
- *The emergency exit door at the main entrance*

The entire home is licensed as a secured dementia care unit (SDCU).

Plan of Correction ***Accept (- 10/25/2024)***

No residents were adversely affected. Upon notification, all exits updated with directions to operate keypads. Memory Care team members were educated on9/27/24 by the Memory Care Director on the requirement to keep directions on how to operate the keypads at each exit door. Audits of each memory care exit door will be completed weekly x 4 starting 9/27/24, then monthly to ensure directions are in a conspicuous place near the device, audits to be completed by the Memory Care Director or designee. Audits will be reviewed on 10/22/24 by the Quality

233c - Key-Locking Devices (continued)

Committee at the Quality Management Meeting for further action and/or audits needed.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented (- 03/04/2025)