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

April 20, 2026

[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 12/23/2025, 01/02/2026 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**: *10/11/2026*

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

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*

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

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/27/2019* **Issued By**: *Township of Moon*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/02/2026*

Inspection Dates and Department Representative

12/23/2025 - On-Site:

01/02/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *33*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *40* **Residents Served**: *33*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

12/23/2025 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/06/2026*

02/11/2026 - POC Submission

Submitted By: **Date Submitted**: *02/24/2026*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/18/2026*

Inspections / Reviews *(continued)*

02/13/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *02/24/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *02/25/2026*

04/20/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *02/24/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/23/25 at 11:15 a.m., there was an accessible, unattended, conspicuously posted licensing inspection summary (LIS) dated 12/1/22 inside the main entrance to the home that included the privacy coding to include the names of resident #1, resident #2, resident #3, resident #4 and resident #5. Plan of correction documentation was also included with the LIS including a physician order for resident #1, and pharmacy packing slips which included the names of medications for residents #1, #3, #4, #5, and #6.

Plan of Correction ***Accept (- 02/11/2026)***

No residents were adversely affected, documentation was immediately removed when notified on 12/23/25. Verified one last years survey results in binder by PCHA. staff education completed on 12/23/25 and 1/14/26. Weekly audits STARTING ON 1/5/26 times 4 weeks, then monthly times 2months. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.17. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 12/28/25, from 11:30 p.m. – 7:00 a.m., 33 residents were present in the home. During this time, there were no staff persons in the home who are trained in first aid and certified in CPR.

Plan of Correction ***Accept (- 02/13/2026)***

No residents were adversely affected. a complete audit of all CPR certifications was to complete a weekly review or the actual staff persons who worked in the home to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR was in the home at all times. conducted on 1/2/26. Staff education was completed on 1/2/26 and 1/14/26. a CPR class is scheduled for 2/9/26 and 2/23/26 then twice monthly there after. Memory Care Director to complete a weekly review or the actual staff persons who worked in the home to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR was in the home at all times. this will be posted on the schedule starting 2/16/26 completion of weekly schedules starting on 2/16/26 will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.63.a. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

82c - Locking Poisonous Materials

3. 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 12/23/25 at 11:44 a.m., a 24 oz can of Lysol Foam cleaner with manufacturer's label indicating "... Call a Poison Control Center or doctor for treatment advice" was unlocked, unattended, and accessible to residents in the desk/cabinet area in the Care Base near the dining room.

On 12/23/25 at 11:46 a.m., a partially full canister of 135 82PDI Sani Hands instant hand sanitizing wipes with manufacturer's label indicating "If swallowed, get medical help or contact a PCC right away" was unlocked, unattended, and accessible to residents in the Care Base near the dining room.

On 12/23/25 at 11:48 a.m., six containers of 160 wipes Super Sani-Cloth germicidal disposable wipes with manufacturer's label indicating "First Aid: Call a poison control center or doctor for treatment advice. Have the product container with you when calling ... " was unlocked, unattended, and accessible to residents in a desk drawer in the Care Base near the dining room.

Not all the residents of the home, including residents #7 have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 02/11/2026)***

no resident was adversely affected, all potentially poisonous material were immediately removed on 12/23/25. staff education provided immediately on 12/23/25 and 1/14/26. audit began on 1/5/26 weekly x 4 weeks then monthly x 3 months All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a
review of all items specified in 2600.82.c. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

85e - Trash Outside Home

4. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 12/23/25 at 11:56 a.m., there were at least 25 latex gloves, an empty drink bottle and 2 flattened cardboard boxes scattered on the pavement outside of the dumpster enclosure and in the adjacent grassy area. There were also miscellaneous items strewn about the grassy area in front of the building.

Plan of Correction ***Accept (- 02/11/2026)***

no residents were adversely affected. trash was immediately cleaned up on 12/23/25. staff members educated on 2600.85.e 12/23/25and 1/14/26. audit daily starting on 12/23/25 for 4 weeks . All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.85.e. Documentation of the quality management review shall be kept.

85e Trash Outside Home *(continued)*

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (█ - 04/20/2026)

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 12/23/25 at approximately 11:20 a.m., the knob was missing to turn on the exhaust fan in room #101 precluding the fan from being operable.

Plan of Correction ***Accept (█ - 02/11/2026)***

no residents were adversely affected. exhaust fan in room 101 was fixed immediately and knob replaced. staff members educated on 2600.86.b. on 12/23/25and 1/14/26 audits to be completed daily starting on 12/23/25 on 2 random rooms for 2 weeks then monthly. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.85.e. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (█ - 04/20/2026)

100a - Exterior - Free of Hazards

6. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 12/23/25 at 11:25 a.m., there were leaves piled up against the outside of the exit door near room #109 posing a risk of slipperiness and falls if the exit was to be used in an emergency.

Plan of Correction ***Accept (█ - 02/11/2026)***

no residents we adversely affected related 2600.100.a, this area was cleaned immediately. Maintainence Director educated on 2600.100.a. on 12/23/25. Daily audits x 2 weeks then monthlystarting on 12/23. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.100.a. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (█ - 04/20/2026)

127a - Portable Space Heaters

7. Requirements

2600.
127.a. Portable space heaters are prohibited.

127a - Portable Space Heaters *(continued)*

Description of Violation

On 1/2/26 at 1:25 p.m., a portable space heater was in use in the Memory Care Director's office.

Plan of Correction ***Accept (- 02/11/2026)***

no residents were adversely affected. Space heater was immediately shut off and immediately removed from office. MC director, Wellness Director and Executive Director Educated on 1/2/26. Audits will be conducted daily for 2 weeks and then weekly for 2 weeks. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.127.a. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

132d - Evacuation

8. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home exceeded the safe evacuation time of 5 minutes 30 seconds as determined by a fire safety expert on 10/22/25 and 10/24/24 during the following drills:
- *11/17/25 at 6:45 p.m. 7 minutes and 36 seconds.*
- *10/31/25 at 6:45 p.m. 7 minutes and 9 seconds.*
- *8/14/25 at 5:00 p.m. 5 minutes and 52 seconds.*
- *7/29/25 at 3:34 a.m. 7 minutes and 39 seconds.*
- *6/23/25 at 1:45 p.m. 6 minutes and 2 seconds.*

Plan of Correction ***Accept (- 02/11/2026)***

no residents we adversely affected. maintenance Director documented the wrong fire drills on the MC fire log. Maintenance Director educated 12/23/25 on 2600.132.d, fire logs placed in seperate binders. all staff educated on 1/14/26 regarding 2600.132.d fire drills to be completed weekly starting 1/2/26 times 4 weeks to ensure a time of 5:30 if compliant based on fire safety experts observation. All fire drill logs will be reviewed by the quality committee on 2/23/26 for further action and/or fire drills needed. The quality management review shall include a review of all items specified in 2600.132.d. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

132g - Fire Drills Days/Times

9. 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.

132g - Fire Drills Days/Times *(continued)*

Description of Violation

There are typically only four staff scheduled during the 11:00 p.m.-7:00 a.m. shift. However, the fire drill log for the following drills indicate that more than four staff participated in the drill:
- *1/15/25 6:32 a.m., 4 minutes, 39 seconds; six staff participated.*
- *1/28/25 6:41:22 a.m., 4minutes, 38 seconds; six staff participated.*
- *7/29/25 3:34 a.m., 7 minutes, 39 seconds; five staff participated.*
- *10/31/25 4:30 a.m., 7 minutes, 09 seconds; six staff participated.*

Repeat violation 9/27/24

Plan of Correction ***Accept (- 02/11/2026)***

no residents we adversely affected. Maintenance Director educated 12/23/25 regarding 2600.132.g., all staff educated on 1/14/26 on 2600.132.g. fire drills to be completed weekly times 4 weeks starting on 1/2/26 to ensure a time of 5:30 based on fire safety experts observation. All fire drills logs will be reviewed by the quality committee on 2/23/26 for further action and/or fire drills needed. The quality management review shall include a review of all items specified in 2600.132.d. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident’s name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 9/30/25, resident #8 was ordered Bisacodyl 5mg – take by mouth daily for 3 days then change to every other day. However, on 1/2/26 at approximately 2:25 p.m., the pharmacy label on the blister pack of this medication indicated Bisacodyl tab 5mg EC - take 1 tablet by mouth once daily for constipation.

Resident #9 is ordered Apply zinc mixed with nystatin powder apply to coccyx after every brief change. However, on 1/2/26 at 2:31 p.m., the pharmacy label for the resident’s Nystatin powder indicates – Apply a small amount topically to affected area twice daily to affected area.

On 12/17/25, resident #10’s Miralax oral powder order was changed to “Please change Miralax oral powder 17gm by mouth after constitution to every other day.” However, on 1/2/26 at 2:46 p.m., the pharmacy label for polyethylene glycol (same medication) indicates Dissolve 1 packet (17g) in 8 ounces of liquid and drink by mouth once daily for constipation.

Plan of Correction ***Accept (- 02/11/2026)***

no resident was adversely affected, on 1/2/26 medication change stickers placed immediately on medication cards

184a - Resident's Meds Labeled (continued)

for resident #8 and resident #10. on 1/2/26 resident #9 order changed to 4 times daily. Staff educated on 1/2/26 and 1/14/26 2600.184.a. audits of order changes will be completed daily starting 1/2/26 x 2 weeks then weekly for 4 weeks. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.184.a. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

187b - Date/Time of Medication Admin.

11. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #9 is ordered Apply zinc mixed with nystatin powder apply to coccyx after every brief change. The entries on the medication administration record (MAR) for Nystatin 100,000un/gm powder and for Zinc both indicate – apply zinc mixed with nystatin powder, apply topically to coccyx after every brief change. However, on 1/2/26, the resident's MAR only had one entry for admission of these medications at 8:00 a.m. The other times that this medication is being applied are not documented.

Plan of Correction ***Accept (- 02/11/2026)***

no resident was adversely affected, on 1/2/26 resident #9 order changed to 4 times daily. Staff educated on 1/2/26 and 1/14/26 2600.187.b. audits to start on 1/2/26 of all skin treatments will be completed and reviewed weekly for 4 weeks. All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.187.b. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (- 04/20/2026)

233a - Lock Approval

12. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking system used on the exit doors from the Secure Dementia Care Unit.

Plan of Correction ***Directed (- 02/13/2026)***

No residents were adversely affected, unable to locate the written approval letter from labor and industry or the moon township municipality several attempts have been made including reaching out to DHS to see if there was a copy on file. every attempt has been unseccuessful. the Executive Director placed calls on 2/11/26 to Moon Township Manager to assist with retreival awaiting call back, call also placed to , Moon Township Code official to see if a new inspection can be set up, awaiting return call.Executive Director to call

233a Lock Approval (continued)

township officials daily until issue is acknowledged and resolved. Executive Director scheduled inspections for 2/13/24 to have doors inspected by the original contractor All Secured, per [redacted], in a previous conversation stated that is where the letter would have originated from. Once Letter is obtained, it will be secured electronically and a hard copy will remain in the Executive Director's office. will be reviewed by the quality committee on 2/23/26 for further action is needed. The quality management review shall include a review of all items specified in 2600.187.b. Documentation of the quality management review shall be kept.

Proposed Overall Completion Date: 02/24/2026

DIRECTED

Within 5 days of receipt of the plan of correction: The administrator shall obtain the approval for the use of a device or system that prevents the immediate egress of residents, such as electronic card locks or electromagnetic locks, the home must present the Department with written documentation that the Department of Labor and Industry, the Department of Health or the appropriate local building authority has inspected and approved the specific device or system in use by the home. This documentation must specify that the locking system will automatically and immediately release when the fire alarm system is activated. [redacted] 2/13/26

Directed Completion Date: *02/24/2026*

Implemented ([redacted] - 04/20/2026)

233b - Lock Manufacturer Statement

13. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer specific to that home, verifying that the electronic or magnetic locking system will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction ***Directed ([redacted] - 02/13/2026)***

no residents were adversely affected, unable to obtain manufacturer specifics for the electronic or magnetic locking system for the doors when fire alarm system is activated, or the home's power fails. Executive Director reached out to manufacturer on 2/3/26 requesting a statement and awaiting that letter, once obtained ED will secure letter electronically and perserve a hard copy in ED office. will be reviewed by the quality committee on 2/23/26 for further action needed. The quality management review shall include a review of all items specified in 2600.187.b. Documentation of the quality management review shall be kept.

Proposed Overall Completion Date: 02/24/2026

DIRECTED

Within 5 days of receipt of the plan of correction: The administrator shall obtain a written statement from the

233b Lock Manufacturer Statement (continued)

manufacturer, specific to the home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one or more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock releasing device.
█ *2/13/26*

Directed Completion Date: *02/24/2026*

Implemented (█ - 04/20/2026)

233c - Key-Locking Devices

14. 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 12/23/25 at 11:21 a.m., the directions for operating the home's locking mechanism were not posted near the emergency exit door near room 109.

Repeat violation 9/27/24

Plan of Correction ***Accept (█ - 02/11/2026)***

no resident was adversely affected, directions were posted immediately on 12/23/25. Staff educated immediately and on 1/14/26 on 2600.233.c. Audits initiated on 1/5/25 daily x 2 weeks then weekly for 2 weeks All Audits will be reviewed by the quality committee on 2/23/26 for further action and/or audits needed. The quality management review shall include a review of all items specified in 2600.132.d. Documentation of the quality management review shall be kept.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented (█ - 04/20/2026)