



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: November 24, 2015

Mr. Mark W. Ohlendorf, President
Emeritius Corporation
6737 West Washington Street
Suite 2300
Milwaukee, Wisconsin 53214

RE: Brookdale Grandon Farms
1100 Grandon Way
Mechanicsburg, Pennsylvania 17055
Certificate #: 316120

Dear Mr. Ohlendorf:

As a result of the Department of Human Services' licensing inspections on September 11, 2015 of the above facility, the violation with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

The violation specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Brett Swanger", with a long horizontal flourish extending to the right.

Brett Swanger
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 31612 - 09/11/2015 - Springs, Israel
PCH Name: BROOKDALE GRANDON FARMS

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 8/23/15 at approximately 2:20pm, staff heard Resident #2 yelling and saw Resident #1 sitting next to Resident #2. Resident #1's hand was observed to be down the front of Resident #2's pants. Per interview with staff, Resident #1's hand was inside Resident #2's underwear causing Resident #2 to be visibly upset.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See attached

Page 2A and 2B

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) S. Denny Granahan, Exec Dir Date 11/20/2015

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 11/24/15
(Date)

The above plan of correction was approved by BAS
(Initials)

Plan of correction implementation status as of 11/24/15
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Emeritus at Creekview

Plan of Correction

The following is the Plan of Correction for Emeritus at Creekview regarding the Statement of Deficiency dated October 19, 2015 for the incident follow-up survey September 11, 2015. 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.

Regulation 2600.42(b)

On 8/23/2105 at approximately 2:20 pm, staff heard Resident #2 yelling and saw Resident #1 sitting next to Resident #2. Resident #1's hand was observed to be down the front of resident #2's pants. Per interview with staff, Resident #1s hand was inside Resident #2s underwear causing Resident #2 to be visibly upset.

Immediately – Resident #1 and #2 were separated by staff.

Immediately – Resident #2 was taken to [redacted] room and assessed by an LPN and provided comfort and security our caregivers.


Immediately – Resident #1 was placed on 24 hour direct supervision to prevent future occurrences until Resident #1's responsible party can find alternate placement

*S. Denny Granahan 11/20/2015
S. Denny Granahan, Exec. Dir.*

11/24/2015 – All staff will receive training on monitoring residents for inappropriate behaviors and changes in behaviors to reduce and prevent negative resident to resident interactions.

Ongoing – Resident #2 will be watched closely for any lingering distress from the altercation with Resident #1 and any necessary care and services will be provided.

Ongoing – All Staff will continue to observe resident interactions and intervene as required.

 11/20/2015
S. Denny Granahan, Exec. Dir.