



pennsylvania
DEPARTMENT OF HUMAN SERVICES

SEP 13 2017

Ms. Stacey Meyer,
Assistant Secretary
Emeritus Corporation
6737 West Washington Street, Suite 2300
Milwaukee, Wisconsin 53214

RE: Brookdale Bloomsburg
420 Shaffer Road
Bloomsburg, Pennsylvania 17815
License #: 211200

Dear Ms. Meyer:

As a result of the Department of Human Services' annual licensing inspection on May 18, 2017 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Rowe'.

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600

2600.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION

The home serves 47 residents. Seven residents are considered immobile with 4 residents needing a 2 person assist to transfer and 3 residents needing a 1 person assist to transfer. 2 staff are scheduled for the overnight shift. The home is given 6 minutes to evacuate with 3 fire safe areas in the home. Considering the needs of the residents with mobility needs, the home has insufficient staff during the overnight hours.

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.

Please see attachment.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, Executive Director*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Julie L Heeter, ED</i>	Date <i>7/1/17</i>
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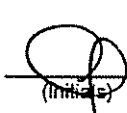
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

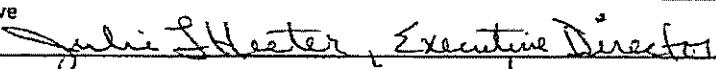
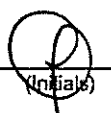
The above plan of correction is approved as of 7-6-17
 (Date)

Plan of correction implementation status as of 7-6-17
 (Date)

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

The above plan of correction was approved by *[Signature]*
 (Initials)

Violation Report: 21120 - 05/18/2017 - Dumas, Gerald	
PCH Name: BROOKDALE BLOOMSBURG	
<p>1. REGULATION 55 Pa.Code §2600 2600.96(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.</p>	
<p>2a. DESCRIPTION OF VIOLATION The first aid kit in the wellness office/record room does not include a working thermometer. The one in the first aid kit is not operable.</p>	
<p>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.</p> <p style="font-size: 1.2em; margin-top: 20px;">Please see attachment</p>	
Repeat Violation: No	Date(s) of Previous Violation(s):
Signature of Legal Entity Representative (Required on EVERY Page) <i>Julie L Heeter, Executive Director</i>	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Julie L Heeter, ED</i>	Date <i>7/1/17</i>
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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald	
PCH Name: BROOKDALE BLOOMSBURG	
<p>1. REGULATION 55 Pa.Code §2600 2600.107(d) - The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.</p>	
<p>2a. DESCRIPTION OF VIOLATION The home's written emergency procedures have not been reviewed since 1/5/16.</p>	
<p>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.</p> <p style="font-size: 1.2em; font-family: cursive;">Please see attachment p 3 of 12</p>	
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)	
Julie Heeter, ED	
Date	
7/1/17	
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 (Initials)	

Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION
 Outside of the emergency exit, closest to where the medication room, is an enclosed border of approximately 15 foot Arborvitae shrubs. To exit, one must go between the overgrown arborvitae to the designated meeting location to the rear of the home. The egress path is blocked by overgrown Arborvitae shrubs. It is not visually clear how or where to exit from this location thereby preventing immediate egress, away from the building, in the event of an emergency.

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.

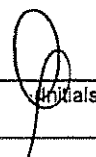
Please see attachment. p 5 of 12

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/24/2016
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, Executive Director*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, ED* Date *7/1/17*

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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
2600.124 - The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

2a. DESCRIPTION OF VIOLATION
The home sends a resident roster to the fire department as part of the notification that indicates the resident room numbers and mobility needs. The last time this was sent to the fire department was on 12/20/16. The evacuation needs of the residents have changed since this time and the home has not notified the fire department of these changes.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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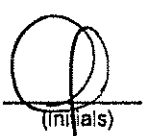
Please see attachment p5 a g 12

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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.125(a) - Combustible and flammable materials may not be located near heat sources or hot water heaters.

2a. DESCRIPTION OF VIOLATION
 At approximately 2:30 p.m. blankets and sheets were observed stored within less than a foot from the home's hot water heater in the home's utility room. The cotton blankets and sheets pose a fire hazard stored in close proximity to the water heater.

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.

Please see attachment p 5 a g 12

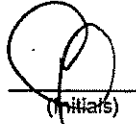
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Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, ED* Date *7/1/17*

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 (Initials)

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 (Date)

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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION
The medical evaluation for resident # 1, dated 1/13/17, does not include section (7) medication addendum. It states, "See med list attached" but there is no attachment.

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.

Please see attachment pg 12

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Julie L Heeter, Executive Director*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Julie L Heeter, ED Date 7/1/17

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(Date)

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(Initials)

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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION
 The home did not implement procedures for the safe use of medications.
 On 5/18/17, resident # 2 Desitin Hypoallergenic 13% cream, a PRN (as needed medication), was not available in the home.
 On 5/18/17, the home's "short hall" medication cart had a loose light blue pill labeled L490 located in the second drawer from the top down on the right side.

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.

Please see attachment. p 8 a 8/17

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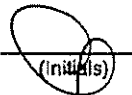
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- Not Implemented

The above plan of correction was approved by 
 (Initials)

Violation Report: 21120 - 05/18/2017 - Dumas, Gerald PCH Name: BROOKDALE BLOOMSBURG	
1. REGULATION 55 Pa.Code §2600 2600.190(c) - A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.	
2a. DESCRIPTION OF VIOLATION The annual practicum for med tech "A" is incomplete as the student examination date summary sheet did not indicate staff person "A" has successfully completed the annual practicum . Additionally the trainer did not sign and indicate the student pass date. The annual practicum for med tech "B" is incomplete as the student examination date summary sheet did not indicate staff person "B" has successfully completed the annual practicum . Additionally, the trainer did not sign and indicate the student pass date. The annual practicum for med tech "C" is incomplete as the student examination date summary sheet did not indicate staff person "C" has successfully completed the annual practicum . Additionally, the trainer did not include the student pass date.	
3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) <i>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.</i> <div style="text-align: center; font-size: 1.2em; font-family: cursive;"> Please see p 9 of 12. </div>	
Repeat Violation: No	Date(s) of Previous Violation(s):
Signature of Legal Entity Representative (Required on EVERY Page) <div style="text-align: right; font-family: cursive; font-size: 1.2em;"> Julie L Heeter, Executive Director </div>	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <div style="text-align: right; font-family: cursive; font-size: 1.2em;"> Julie L Heeter, ED </div>	
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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.227(d) - Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

2a. DESCRIPTION OF VIOLATION
 Resident # 3, date of admission [redacted] 17, has had 12 falls from 1/14/17 through 5/16/17. The resident's personal service plan lists the dates of the falls, however the support plan portion of the document does not indicate any interventions or plan on how to meet these needs. The resident is also prescribed PT/OT, however it doesn't indicate who is providing these services or the frequency of services.

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.

Please see attachment. Page 12

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Julie L. Hoeter, Executive Director

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page)

Julie L. Hoeter, ED Date 7/1/17

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Violation Report: 21120 - 05/18/2017 - Dumas, Gerald
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.252 - Each resident's record must include the following information: (1) through (26)

2a. DESCRIPTION OF VIOLATION
 Resident # 2's records does not include a photograph that is less than 2 years old. The most recent photo is dated 10/3/14.

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.

Please see attachment. p11 a b 12

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
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- Not Implemented

Brookdale Bloomsburg

Plan of Correction

Page 12

The following is the Plan of Correction for Brookdale Bloomsburg regarding the Statement of Deficiency dated June 21, 2017 for the full renewal survey on May 18, 2017. 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 2600.60(a)

Immediately, the community started recruiting for the night shift care staff position. Overtime shifts were scheduled to add additional staff to the night shift until permanent staff could be hired, additional shift availability allowed for overtime to encourage staff to pick up overnight hours to increase our staffing to 3. Recruitment interviews are being conducted and persons hired to have permanent additional staff coverage. One part time night shift care associate has been hired and the other position is in the interview process. The residents listed as two person assist for transfers have been reassessed to ensure they do require 2 staff persons to assist during a transfer. An audit of resident acuity in the community was completed June 27, 2017 by the Executive Director (ED), Health and Wellness Director (HWD) and District Director of Clinical Services. The HWD or designee will monitor resident care needs weekly to assure community is able to meet care needs. The HWD will monitor staffing needs on a daily basis to ensure staffing is adequate to meet the needs of our residents.

The ED will review audit findings and staffing for 3 months to determine compliance and to verify if any further action is warranted.

ALY
7-6-17

Evidence: Re-training attendance sheets

To be completed: July 31, 2017

Regulation 2600.96(a)

P3 Aug 12

Immediately, the thermometer with the dead battery was discarded and replaced with a new thermometer.

Immediately, all other first aid kits were audited for functional thermometers. The appropriate staff were retrained on the community policy regarding availability of emergency equipment on May 19, 2017 by the ED,

The HWD put in place a process/ schedule for auditing first aid kits monthly.

The ED will review audit findings for 3 months to determine compliance and to verify if any further action is warranted.

Evidence: Re-training attendance sheets,

AG
7-6-17

To be completed: May 20, 2017

Regulation 2600.107(d)

Immediately, the emergency procedures were reviewed, updated and submitted to the local emergency management agency. On May 19, 2017 approval was obtained from the fire chief as evidenced by his signature on the documents.

The ED put in place a reminder system when emergency procedures are due for ^{}annual review by the local emergency management agency.*

Evidence: approved written emergency procedures

AG
7-6-17

To be completed: May 20, 2017

Regulation 2600.121(a)

Immediately, a laminated red and white sign was posted on the door leading to the courtyard stating this is not an exit. The courtyard door is not listed on our fire plan as an exit door intended for use during egress. The appropriate staff were trained on the community policy regarding this egress on May 19, 2017 by the ED. The Maintenance Director will monitor this door on weekly rounds to ensure the sign remains posted. The ED will review audit findings for 3 months to determine compliance and to verify if any further action is warranted.

Evidence: training attendance sheets, environmental audit form

To be completed: June 26, 2017

Regulation 2600.124

Immediately, the roster was updated by the HWD. The Maintenance Director met with the local Fire Chief on May 26, 2017 to review the roster and process for submission of the resident room and mobility needs. Going forward, the Fire Chief has approved the use of a red binder that is kept at the front desk of the facility that will contain a current list of immobile residents. This list will be maintained by the HWD and will be updated as the needs of the residents change or if an immobile resident is admitted or discharged. The ED will review the roster monthly for 3 months to determine compliance and to verify if any further action is warranted.

Evidence: training attendance sheets, current resident roster, approval letter from the Fire Chief

To be completed: May 30, 2017

Regulation 2600.125(a)

Immediately, the blankets and sheets were removed from the area beside the hot water heater as soon as identified during the inspection. The appropriate staff

were re-trained by the ED on the community policy regarding combustible and flammable materials stored near heat sources on May 19, 2017. The Maintenance Director or designee will conduct environmental rounds weekly which will include noting areas around heat sources for possible combustible materials. The Executive Director will review audit results for 3 months to verify if any further action is warranted.

Evidence- Staff training attendance log, Environmental Rounds Audit tool

Completion Date: June 1, 2017

Regulation 2600.141(a) (2)

The appropriate staff were re-trained on the community policy regarding securing complete information and keeping this information together with the medical evaluation on June 26, 2017 by the ED. The HWD or designee will review all medical evaluations prior to move-in to assure all information is complete. The ED will review the results of this audit for 3 months to verify if any further action is warranted.

Evidence- Staff training attendance log

Completion Date: June 30, 2017

Regulation 2600.185(a)

The blue pill was immediately discarded and the pharmacy was notified that the Desitin had not been delivered as ordered.

The appropriate staff were re-trained on the community policy regarding Medication Administration on June 26, 2017 by the HWD. The HWD or designee will conduct weekly audits of the medication cart. The ED will review the results of this audit for 2 months to verify if any further action is warranted.

Evidence- Staff training attendance log

Completion Date: June 30, 2017

Page 2

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7-6-17

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7-6-17

Regulation 2600.190 (c)

Immediately, the HWD had the forms signed and dated by the Med Tech Trainer. The HWD was retrained by the District Clinical Direct Services on May 22, 2017 on the community policy regarding accepting complete documentation on the medication training forms. The HWD or designee will audit all Med Tech training documents for completion. The ED will review the results of this audit for 2 months to verify if any further action is warranted.

Evidence- Staff training attendance log

Completion Date: June 1, 2017

Regulation 2600.227 (d)

The support plan was immediately updated to include the falls prevention intervention that was put in place to have PT/OT evaluate resident #3 which included the agency consulted and frequency of visits. The HWD was retrained by the ED on June 23, 2017 regarding the community policy on updating the resident support plan to include referrals to outside agencies. Resident #3 was assessed to need a higher level of care and plans are in place to transfer. The HWD or designee will audit any resident support plans with referrals to outside agencies for corresponding documentation for 3 months. The ED will review the results of this audit for 2 months to verify if any further action is warranted.

Evidence- Staff training attendance log, copy of updated service plan

Completion Date: June 30, 2017

Regulation 2600.252

Immediately, resident #2's photo was retaken and placed on the medical record. All medical records were audited for current photos and they were updated as necessary on May 20, 2017. The appropriate staff were retrained on the community policy regarding necessary information required in the medical record on June 26, 2017 by the ED. Going forward, a picture day will be scheduled annually to assure all residents have current photos. The ED will review the results of this audit to verify if any further action is warranted.

Evidence- Staff training attendance log, copy of updated photo of resident #2

Completion Date: June 30, 2017

P 11 a 8 12