



pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUL 03 2018

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's Bureau of Human Services Licensing annual inspection on May 10, 2018 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 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600

2600.3(c) - The personal care home shall post the current license, a copy of the current licensing inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

2a. DESCRIPTION OF VIOLATION

The home posts their current and previous License Inspection Summary (LIS) reports on a wall located behind a diagonal shaped reception desk. The reports are not clearly displayed in a conspicuous area in the home that is easily visible by the public.

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

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)

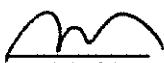
Julie L Heeter, ED

Date *6/11/18*

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

The above plan of correction is approved as of 6/12/18
 (Date)

Plan of correction implementation status as of 6/12/18
 (Date)

The above plan of correction was approved by 
 (Initials)

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

Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600

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.

2a. DESCRIPTION OF VIOLATION

The License Inspection Summary (LIS) report dated 5/24/2017 contained the resident and staff privacy coding sheets attached.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Julie Heeter, ED</i>	Date <i>6/12/18</i>
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 (Date)

The above plan of correction was approved by *m*
 (Initials)

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 (Date)

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- Partially Implemented - Inadequate Progress
- Not Implemented

Brookdale Bloomsburg

Plan of Correction

The following is the Plan of Correction for Brookdale Bloomsburg regarding the Statement of Deficiency dated May 24, 2018 for the renewal survey on May 10, 2018. 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 2600.3(c)

Immediately, current and previous License Inspection Summary reports have been relocated to a bulletin board in the main hallway. All managers were trained on 5/11/18 by the Executive Director to be aware of what the required postings are and to notify the ED know if a licensing inspection summary is missing and not posted.

The Business Office Coordinator will audit the postings weekly x 2 months. The Executive Director or designee will review the audit results to verify if any further action is warranted.

Evidence: training attendance sheet

Completion Date: May 11, 2018



Regulation 2600.17

Immediately, the last pages containing the resident and staff names were removed.

All managers were trained on 5/11/18 regarding the community policy on the required postings and to notify the ED if a licensing inspection summary is missing and not posted in compliance.

The Business Office Coordinator will audit the postings weekly x 2 months. The Executive Director or designee will review the audit results to verify if any further action is warranted.

Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.26(a) - The home shall establish and implement a quality management plan.

2a. DESCRIPTION OF VIOLATION
 The home's most recent quality management meetings held on 9/17/17 and 3/20/18 did not include a review of the License Inspection Summary violations from 5/18/17.

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.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Julie L Heeter</i>	Date <i>6/11/18</i>
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Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.103(e) - Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

2a. DESCRIPTION OF VIOLATION

The home had the following frozen foods stored in the freezer in unlabeled, undated, clear plastic bags:
 6 bags of frozen chicken cutlets, 1 bag of frozen Italian sausage links, and 2 bags of breaded crab patties.

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

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Julie Heeter* Date *6/11/18*

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 (Date)

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

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

Evidence: training attendance sheet

Completion Date: May 11, 2018

6/12/18

Regulation 2600.26(a)

Going forward, the scheduled Quality Management meetings will include a review of the License Inspection Summary violations including the Plan of Correction on the agenda. Review of this topic will be included in the minutes.

The Executive Director was re-trained by District Director of Clinical Services on 5/25/18 on community's policy regarding Quality Management meetings and the required agenda items.

Going forward, DDCS will review minutes of Quality Management Meeting Minutes for the next 2 meetings to verify if any further action is warranted.

Evidence: training attendance sheet

Completion Date: May 15, 2018

** The administrator shall be responsible for ongoing compliance -*

6/12/18

2600.103(e)

Immediately, the just delivered frozen food items were discarded. New stock was then ordered to replace those discarded items that were unlabeled. All refrigerators and freezers were audited by the Dining Services Coordinator to verify that all other items had appropriate labels.

On 5/11/18, the Executive Director re-trained the Dining Service Coordinator on the community policy regarding labeling of food items. On 5/11/18, dietary staff was re-trained by the Dining Service Coordinator on the community policy regarding labeling of food items.

Going forward, all freezers and refrigerators will be audited weekly x 3 months by Dining Services Coordinator or designee. The Executive Director will review the audit results to verify if any further action is warranted.

Evidence: training attendance sheet

Completion Date: May 15, 2018

** The administrator shall be responsible for ongoing compliance -*

6/12/18
2

Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION
 The home conducted fire drills during sleeping hours on 11/16/2017 and 4/30/2018. It was determined through resident interviews that not all residents evacuated during the drill held on 4/30/2018, therefore, the home is not in compliance with this regulation.

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.

• The home will hold fire drills between 11 p.m. and 6 a.m.
 • The administrator shall monitor and be responsible for ongoing compliance - w/ 6/12/18
 See attached

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, ED* Date *6/11/18*

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Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 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.

2a. DESCRIPTION OF VIOLATION
 The home held a fire drill on 4/30/2018 at 10:30pm. According to interviews with several residents, residents were told by the person conducting the drill that they did not need to leave their bedrooms. One resident was told they could stay in bed.

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.

The administrator shall monitor and be responsible for ongoing compliance *6/12/18*

See attached →

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Julie L Heeter, ED* Date *6/11/18*

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2600.132(e)

On 5/11/18 all Management Staff were re-trained by the Executive Director on the community policy regarding fire drill procedures and the importance that all residents must be evacuated to the safe area unless physician orders designate otherwise. On 6/6/18 at Resident Council Meeting this will be reviewed with the residents by the Executive Director. On 6/13/18 at the monthly All Staff Meeting, review of the community policy on fire drill procedures will be discussed. The Maintenance Technician will submit schedules of drills and documentation of drills to the Executive Director for 3 months. The Executive Director will review the audit results to verify if any further action is warranted.

Evidence: training attendance sheet, meetings for June trainings will be submitted on completion

Completion Date: June 15, 2018

 6/12/18

Regulation 2600.132(h)

On 5/11/18 the Executive Director retrained all management staff on the community policy regarding fire drill procedures and the importance for all residents to be evacuated to the safe area. On 6/6/18 at Resident Council Meeting the community policy on fire drills will be reviewed with the residents by the Executive Director. On 6/13/18 at the monthly All Staff Meeting, review of the community fire drill procedures will be reviewed by the Executive Director. The Maintenance Technician will submit the schedule of drills and documentation of drills to the Executive Director for 3 months. The Executive Director will review the audit results to verify if any further action is warranted.

Evidence: training attendance sheet, meetings for June trainings will be submitted on completion

Completion Date: June 15, 2018

Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.171(b)(5) - If staff persons or volunteers of the home provide transportation for the residents, the vehicle must have a first aid kit with the contents in § 2600.96 (relating to first aid kit).

2a. DESCRIPTION OF VIOLATION
 The first aid kit located in the home's vehicle used to transport residents did not contain eye coverings.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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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>6-1-18</i>
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Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
 Resident #1 has a 100 unit Novolog pen that was labeled as opened on 4/10/2018. The medication is to be discarded 28 days after the date it is opened. Resident #1's Novolog pen should have been discarded on 5/8/2018. The home administered medication from the expired pen on 5/9/18 and 5/10/18 and it was still in the cart available for use.

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.

The administrator shall monitor and be responsible for ongoing compliance in 6/12/18

see attached →

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 Date
 (Required on EVERY Page) *Julie L Heeter, ED* *6/11/18*

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 (Initials)

Plan of correction implementation status as of 6/12/18
 (Date)

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- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 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 glucometer for resident #2 is not calibrated with the correct date and time as recorded on the Medication Administration Record (MAR). The glucometer readings recorded for May 2018 are in the resident's glucometer as dates and times in February 2018. Resident #3 receives blood glucose checks and insulin based on a sliding scale before meals and at bedtime. The following errors were noted on the resident's MAR:
 On 5/2/2018 at 9:00pm the glucometer reading was 342 and was recorded as 343 on the MAR; 5/4/18 at 9:00pm the glucometer reading was 120 and was recorded as 130; 5/5/18 at 11:30am the glucometer reading was 206 and was recorded as 207; on 5/7/18 at 7:14am there is a glucometer reading of 193 that is not recorded on the MAR; there is also a reading on 5/7/18 at 9:00pm of 187 recorded on the MAR that is not in the glucometer.
 Resident #3's glucometer is also not calibrated to the correct dates and times.

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.

The administrator shall monitor and be responsible for ongoing compliance. 6/12/18
 See attached →

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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 Date 6/11/18

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Violation Report: 21120 - 05/10/2018 - Deluca, Amy
 PCH Name: BROOKDALE BLOOMSBURG

1. REGULATION 55 Pa.Code §2600
 2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #3 has a physician's order for blood glucose readings to be done four times daily, before meals and at bedtime, and receives insulin based on a sliding scale at those times. The resident did not have blood glucose readings taken on the following dates: 5/2/2018 at 4:30 pm and on 5/8/2018 at 11:30am.

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.

- The administrator shall monitor and be responsible for ongoing compliance.

6/12/18

see attached →

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 (Required on EVERY Page) *Julie L Heeter, Executive Director*

Printed Name and Title of Legal Entity Representative
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 (Initials)

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- Not Implemented

Regulation 2600.171(b)(5)

Immediately, the goggles were replaced in the first aid kit. The Health and Wellness Director was re-trained by the Executive Director on May 11, 2018 regarding the community policy on stocking first aid kits.

A list of required items for kit will be included in each kit. The first aid kits to be audited monthly x 3 months by the Health and Wellness Coordinator or designee. The Health and Wellness Director will review audits for 3 months to verify if any further action is warranted.

Evidence: training attendance sheet, list of required items in first aid kit

Completion Date: May 15, 2018

m 6/12/18

Regulation 2600.183(d)

The insulin pen was immediately discarded. Pharmacy was contacted and a new pen was ordered on 5/7/18 then scheduled to be delivered the evening of 5/10/18. New Insulin pen arrived on 5/10/18.

The Health and Wellness Director in-serviced nurses and Medication Techs on May 16, 2018 regarding the 28 day expiration for insulin pens as well as the importance of re-ordering medications timely. The Health and Wellness Coordinator or designee will audit the medication carts weekly for 3 months. The Health and Wellness Director will review audit results to verify if any further action is warranted for 3 months.

Evidence: training attendance sheet

Completion Date: May 15, 2018

m 6/12/18

Regulation 2600.185(a)

Immediately, all glucometers were audited and reprogrammed with date and time. Instructions on how to reset each meter were placed inside each glucometer bag for future reference when needed.

The Health and Wellness Director retrained the nursing staff and Medication Technicians on 5/16/18 on the community policy regarding checking date and time on all glucometers prior to performing an accucheck. The Health and Wellness Coordinator or designee will audit the glucometers weekly for 3 months. The Health and Wellness Director will review audit results to verify if any further action is warranted for 3 months.

Evidence: training attendance sheet

M 6/12/18

Completion Date: May 16, 2018

Regulation 2600.187(d)

Resident #3 is no longer residing in the home. On both dates listed, Resident #3 signed himself out of the home in the 'Sign Out' log and the EMAR reflected resident was out of the home on an outing with family. Resident #3 and his daughter opted not to take Accucheck machine on the outing when offered by care staff. All residents are informed on admission to see the nursing staff prior to leaving the home to obtain any medications that would be needed while out of the community. The community policy regarding outings and medication procurement prior to leaving the community will be reviewed by the Executive Director at the Resident Council Meeting June 6, 2018. The Health and Wellness Coordinator will audit the EMAR for 2 months for residents taking their medications with them outings. The Health and Wellness Director will review the audit results to verify if any further action is warranted.

Evidence: training attendance sheet, Resident Counsel Minutes following the June Meeting will be submitted

M 6/12/18

Completion Date: May 16, 2018