



July 15, 2019

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

RE: Brookdale Grayson View
29 Grayson View Court
Selinsgrove, Pennsylvania 17870
License #: 227930

Dear Ms. Meyer:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 9, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report 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 that reads "J. Rowe". The signature is written in a cursive, flowing style.

Jacqueline L. Rowe
Director

Enclosure
Violation Report

Violation Report

Facility Information

Name: *BROOKDALE GRAYSON VIEW* License Number: *227930*
 Address: *29 GRAYSON VIEW COURT, SELINGSGROVE, PA 17870*
 County: *SNYDER* Region: *NORTHEAST*

Administrator

Name: *Lennie Boop* Phone: *5703742923* Email: *lennie.boop@brookdale.com*

Legal Entity

Name: *EMERITUS CORPORATION*
 Address: *SUITE 2300 6737 W. WASHINGTON STREET, WI, 53214*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/19/2000* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *79* Waking Staff: *59*

Inspection

Type: *Full Reason: Renewal / Complaint* BHA Docket #: Notice: *Unannounced*

Inspection Dates and Department Representative

05/09/2019 - On-Site: Amy Deluca, Vanessa Mendez

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* Residents Served: *64*

Secured Dementia Care Unit

In Home: *Yes* Area: *na* Capacity: *16* Residents Served: *11*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *64*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *15* Have Physical Disability: *0*

Brookdale Grayson View

Plan of Correction

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated 06/05/2019 for incident follow-up inspection on 05/09/2019. The Plan of Correction report 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 improvements to satisfy that objective.

BROOKDALE GRAYSON VIEW

227930

3c - Post Current License

Regulations

2600.

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

Description of Violation

The license inspection summaries dated 8/3/2018 and 5/9/2018 were posted on the bulletin board next to the reception desk but were found tacked to the board behind the home's license and therefore were not conspicuously posted and visible to the public.

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.)

5/9/2019 - The license was immediately relocated to another position on the bulletin board so the violation reports could be easily seen.

5/30/2019 - The most current violation report mailed 6/30/2019 was posted for the 2019-2020 year.

6/11/2019 - Appropriate management staff were re-trained on the community policy regarding posting violation reports by the Executive Director. The Executive Director or designee will review bulletin board postings weekly to ensure no other papers are placed in front of the required postings for the next two months. The Executive Director will verify if any further action is warranted based on these audits.

Evidence: Staff Training, Picture of postings

Completion Date: 6/11/2019

Legal Entity Representative

[Handwritten Signature]
Signature

Hennie C. Boop, Senior Exec. Director 6/14/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 6-20-19
(Date)

Plan of correction implementation status as of 6-20-19
(Date)

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

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

BROOKDALE GRAYSON VIEW

227930

132g - Fire Drills Days/Times

Regulations

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 has consistently conducted fire drills on or near the last day of the month or the last week of the month for the past 11 months. The home's fire drill logs indicate drills were conducted as follows: 4/25/19, 3/29/19, 2/27/19, 1/28/19, 12/30/18, 11/28/18, 10/30/18, 9/21/18, 8/28/18, 7/30/18, 6/26/18.

Plan of Correction (POC)

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6/7/2019 - The fire drill for June was conducted on June 7, 2019, the first week of the month.

6/11/2019 - Appropriate management staff were retrained on the community policy regarding the schedule plan of monthly fire drills by the Executive Director.

6/11/2019 and ongoing - The Executive Director and Maintenance Director will establish a fire drill schedule where all fire drills are conducted on different days, times, shifts and not routinely held at the end of the month. The Executive Director will review fire drills quarterly at the quality assurance meetings to verify if any further action is warranted.

Evidence: Staff Training, 2019 Fire Drill Log

Completion Date: 6/11/2019

Legal Entity Representative

[Handwritten Signature]
Signature

Lennie C. Boop, Senior Exec. Director
Printed Name and Title

6/14/19
Date

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141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The Documentation of Medical Evaluation (DME) form dated 3/19/19 for resident #1 is incomplete because the section regarding immunizations was left blank.

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 Attached.

Legal Entity Representative

[Handwritten Signature]
Signature

Senior Exec. Director
Printed Name and Title

6/14/19
Date

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Regulation 2600.141.a

5/9/2019 - The DME for resident #1 was immediately sent to the Physician and the immunization section was completed. This was corrected on site at the time of the inspection.

6/10/2019 – An audit was conducted of all other resident DME's by the Health and Wellness Coordinator and Clinical Specialist.

6/11/2019 – Appropriate management staff were retrained on the community policy regarding DME completion by the Executive Director.

6/11/2019 – The Health and Wellness Coordinator or designee will review all newly received DME's for 3 months to verify all sections are completed. DME audit summary will be reviewed as part of the quarterly quality assurance meeting. The Health and Wellness Director or Executive Director will review the results of the audits to determine if any further action is warranted.

Evidence: DME for Resident #1, Staff Training, DME Audit Result

Completion Date: 6/11/2019

6-20-19

MM

BROOKDALE GRAYSON VIEW

227930

144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

Approximately 8 cigarette butts were found in the mulch next to the home's designated smoking area gazebo.

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.)

Immediately on 5/9/2019 – all cigarette butts were picked up and properly disposed of. This was corrected on site at the time of the inspection.

6/3/2019 – The Maintenance Technician added signs near the designated smoking area stating that disposal of cigarette butts is prohibited on the ground near the designated smoking are. (picture attached)

6/6/2019 - Grayson View ordered an additional sign to be placed at the community entrance to inform everyone that this regulation prohibits throwing cigarette butts on the ground and where the community designated smoking areas are located.

6/11/2019 – Appropriate staff were retrained by the Executive Director on the community policy regarding smoking as well as the dangers of smoking as related to fire safety.

6/11/2019 - The Maintenance Director will review the smoking area, once per week for the next three months to verify compliance. The Executive Director will review audit results to determine if any additional actions need to be taken.

By 7/1/2019 – New sign will be installed at the community driveway entrance when received.

Legal Entity Repres

Evidence: Staff Training, Picture of signs and receipt of new signed ordered.

Completion date: 7/1/2019

Signature  SED

Senior Exec. Director
Printed Name and Title

6/14/19
Date

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BROOKDALE GRAYSON VIEW

227930

182b - Prescription Medication

Regulations

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

- 4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Med tech annual practicums for several med techs for 2018 were incomplete or not documented.

- *Staff person A's annual practicum sheet for 2018 was not signed or dated by the trainer.*
- *Staff person B had only 1 Medication Administration Record (MAR) review and 1 medication administration observation for 2018 and no practicum completed yet for 2019.*
- *Staff person C's annual practicum sheet for 2018 was not signed or dated by the trainer.*
- *Staff person D's annual practicum for 2018 was completed 2/2018. Staff person D's 2019 annual practicum is overdue.*

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 Attached.

Legal Entity Representative

[Signature]
Signature

Lennie C. Boop, Senior Exec. Director 6/14/19
Printed Name and Title Date

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Regulation 2600.182.b (b).4

Immediately, 5/9/2019 –Executive Director procured a Medication Administration Trainer from another Brookdale community to provide required training for staff Person A, B, C and D.

5/10/2019 - An audit was conducted of all Medication Technician training records and updates were completed following additional training.

5/12/2019 – Staff persons A and D was retrained by the Medication Administration Trainer. Effective 5/30/2019, Staff Person B no longer is employed at Grayson View.

6/1/2019 – Executive Director enrolled 2 community management staff in the Medication Administration Train the Trainer class.

6/11/2019 – Executive Director retrained the appropriate clinical staff on the community policy regarding administration of medications by Medication Technicians and required training documentation. All Medication Technician training records will reviewed and updated as necessary.

7/15/2019 and ongoing – Grayson View Train the Trainer Staff will have completed the training requirements and will oversee medication administration training and documentation.

Evidence: Staff Training

Completion Date: 6/14/2019

6-20-19

MM

183d - Prescription Current

Regulations

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

The Advair Diskus for resident #2 had two different 'date opened' dates listed on the disk: 4/1/19 and 4/6/19. According to the manufacturer's instructions, Advair inhalers are to be discarded 30 days after the date they are removed from the foil package for use. Therefore, the medication was expired at the time of the med cart audit.

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.)

5/9/2019 - The Advair disk for resident #2 was immediately discarded. This was corrected on site at the time of the inspection.

5/20/2019 - Medication Cart audits were completed by the Health and Wellness Coordinator and Clinical Specialist to verify there were no expired medications.

6/14/2019 - Appropriate LPN and Medication Technician staff were re-educated on the community medication administration policy regarding use of expired medications by the Clinical Specialist and Executive Director.

6/14/2019 - The Health and Wellness Coordinator or designee will review medication cart audit results as part of the quarterly quality assurance meetings.

Evidence: Staff Training, Medication Cart Audit

Completion Date: 6/14/2019

Legal Entity Representative

[Signature]
Signature

Lennie C. Boop, Senior Exec. Director 6/14/19
Printed Name and Title Date

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BROOKDALE GRAYSON VIEW

227930

184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 has a physician's order for Flomax, one .4mg capsule daily. The pharmacy label on the medication found in the cart stated the dosage is two .4mg capsules per day. The label did not match the current order.

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.)

Immediately, 5/9/2019 – Physician order for the Flomax was clarified with the prescriber. A change of direction order was placed on Flomax order. This was corrected on site at the time of the inspection.

5/20/2019 – Medication Cart audits were completed by the Health and Wellness Coordinator to verify that the medication orders matched the labels.

6/14/2019 – LPN and Medication Technician staff were re-educated on the community policy on medication labels by the Clinical Specialist.

6/14/2019 - The Health and Wellness Coordinator or designee review medication cart audits as part of the quarterly quality assurance meetings to verify if any further action is warranted.

Evidence: Staff Training, Medication Cart Audit

Completion Date: 6/14/2019

Legal Entity Representative

[Handwritten Signature]
Signature

Lennie C. Boop, Senior Exec. Director
Printed Name and Title

6/14/19
Date

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187c - Refusal of Medication

Regulations

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #4 refused her Valsartan 80mg medication on 3/16/19, 3/17/19, and 3/27/19. The home did not notify the resident's physician of the refusals on these days.

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.)

3/18/19 - Valsartan refusal information was faxed to resident #4's prescribing physician.

3/28/19- Physician order received to discontinue Valsartan medication order.

6/14/2019 – LPN and Medication Technician staff were re-educated on the community policy regarding medication labeling by the Clinical Specialist.

6/14/2019 - The Health and Wellness Coordinator or designee will review all resident refused medications when they occur to verify the prescriber has been notified.

6/14/2019 - The Executive Director and/or Clinical Management Staff will review medication errors and reporting as part of the collaborative care review meetings and the quarterly quality assurance meetings.

Evidence: MD fax/order, Staff Training

Completion Date: 6/14/2019

Legal Entity Representative


Signature

Lennie C. Boop, Senior Exec. Director
Printed Name and Title

6/14/19
Date

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BROOKDALE GRAYSON VIEW

227930

227d - Support Plan Medical/Dental

Regulations

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. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #5's DME dated 2/14/19 indicates the resident requires a mechanical soft diet. The resident's Resident Assessment and Support Plan (RASP) dated 1/16/19 was not updated to reflect this change.

Also, on 2/8/2019 the resident began receiving hospice services. The RASP was not updated to reflect this change in services.

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.)

Immediately, 5/19/2019 – Support plan/ RASP was updated to include hospice services and the updated diet order. This was corrected on site at the time of the inspection.

5/20/2019 – Support plan/ RASP audits were completed to verify there were no additional discrepancies and all current information was added.

6/14/2019 – Appropriate clinical management staff were re-educated by the Executive Director.

6/14/2019 - The Executive Director and/or Clinical Management Staff will review support plans/ RASP documentation as part of the collaborative care review biweekly meetings and the quarterly quality assurance meetings. The Executive Director will review the results of the reviews to determine if any further action is warranted.

Evidence: Support Plan/ RASP for Resident #5, updated diet order, Staff Training

Completion Date: 6/14/2019

Legal Entity Representative


Signature

Henric C. Boop, Senior Exec. Director
Printed Name and Title

6/14/19
Date

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BROOKDALE GRAYSON VIEW

227930

233c - Key-Locking Devices

Regulations

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 two exit doors leading to the memory care unit's courtyard had the codes posted near the keypad but the codes were incomplete because only the passcode number was posted and didn't indicate the need to press the asterisk (*) button after the code.

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.)

5/9/2019 - The asterisk (*) was immediately added to the code. This was corrected on site at the time of the inspection.

5/9/2019 - The Maintenance Director reviewed all other posted codes to verify the numbers and asterisk was present. There were no other signs missing the complete information.

6/11/2019 - Appropriate management staff were retrained on this regulation by the Executive Director.

6/11/2019 and ongoing - The Maintenance Director or designee will review these posted code signs weekly. The Executive Director will review the results of these audits to verify if any further action is warranted. Audit results will be reviewed at quarterly Quality Review meetings.

Evidence: Staff Training, Picture of updated signage

Legal Entity Representative

[Handwritten Signature]
Signature

Honnie C Boag, Senior Exec. Director
Printed Name and Title

6/14/19
Date

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