



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**Sent via e-mail to: lennie.boop@brookdale.com**  
**MAILING DATE: February 20, 2020**

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 Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 20, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Moskalczyk".

Michele Moskalczyk  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

# Violation Report

## Facility Information

Name: *BROOKDALE GRAYSON VIEW*

License Number: 22793

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: *6737 W. WASHINGTON STREET, SUITE 2300, MILWAUKEE, WI, 53214*

## Certificate(s) of Occupancy

Type: *C-2 LP*

Date:

Issued By:

## Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *79*

Waking Staff: *59*

## Inspection

Type: *Partial*

BHA Docket #:

Notice: *Unannounced*

Reason: *Complaint,Incident*

## Inspection Dates and Department Representative

*12/20/2019 - On-Site: Amy Deluca*

## 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:

Residents Served: *14*

### Hospice

Current Residents: *1*

### Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *64*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *1*

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 01/22/2020 for complaint/ incident inspection on 12/20/2019. 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.

16d - Final Incident Report

Regulations

2600.

16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

Resident #1 suffered a fall on 11/15/2019 in the dining room of the home. The home reported the fall to the department's regional office. However, the home failed to report that the resident suffered a fracture to the skull which resulted in a significant decline in health as a result of the fall in the incident report and did not submit a follow up incident report to the department to indicate the same.

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

Lennie C. Boop, Exec. Director 1/31/2020  
Printed Name and Title Date

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

The above plan of correction is approved as of 2-11-2020  
(Date)

Plan of correction implementation status as of 2-11-2020  
(Date)

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

Implemented  
 Not Implemented

**Regulation 2600. 16.d**

12/30/2019 – Final reportable incident was submitted stating that on 11/17/20 the hospital called to report the skull fracture. On 11/18/19 the family came in to remove belongings per the original plan to transfer to the skilled nursing unit already identified for transfer prior to the fall.

1/27/2020 – An audit was conducted of all reportable incidents for the past 6 months to verify any outcomes or information that was not updated/reported as a final report. The audit found none.

1/28/2020 – Appropriate staff were retrained on the community policy regarding necessary information to document in a reportable incident as well as completing final reports when additional information becomes available after the initial required reporting time.

1/28/2020 and ongoing – Executive Director or designated clinical manager will review reportable incidents to determine if and when a final report is needed and/or additional information needs to be provided or updated. Reportable incidents will continued to be reviewed at monthly collaborative care review meetings and quarterly quality assurance meetings.

**Evidence:** Final incident Report, Reportable Incident audit results, Staff Training

**Completed:** January 28, 2020

2-11-2020

MM

42b - Abuse

Regulations

2600.

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

Description of Violation

Resident #1 was admitted to the home's secure dementia unit on 10/21/2019. The resident suffered numerous falls while a resident of the home and on 11/1/2019 the family of the resident was informed that the resident needed a higher level of care. On 11/15/2019 the resident suffered an unwitnessed fall in the dining area resulting in a skull fracture and a significant decline in health. The resident needed additional supervision to prevent falls, and the home failed to provide this supervision.

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

Lennie C. Boop, Exec Director 1/31/2020  
Printed Name and Title Date

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The above plan of correction is approved as of 2-11-2020 (Date) Plan of correction implementation status as of 2-11-2020 (Date)

The above plan of correction was approved by MM (Initials)  Implemented  Not Implemented

**Regulation 2600.42.b**

1/28/2020 – Appropriate managers were retrained by the Executive Director on the community policy regarding the need to ensure necessary services are provided and documented to prevent harm or risk to a residents.

1/28/2020 – Executive Director and Clinical Managers will continue to review resident falls as well as those residents with cognitive or medical decline to determine if they are in the appropriate setting and that the home can provide required services and or supervision such as one on one care.

Resident’s care needs will continue to be reviewed monthly at team collaborative care review meetings, quarterly quality assurance meetings, and when otherwise indicated. The Executive Director will review the results of these meetings and verify if any further action is warranted.

**Evidence:** Staff Training

**Completion Date:** January 28, 2020

2-11-2020

MM

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

Resident #1's documentation of medical evaluation (DME) form dated 10/18/2019 was missing the following information: health status and pulse.

Resident #1's DME form dated 10/18/19 contained information, including medical diagnoses, that was written in after the physician signed the form. There were medications listed on the form that had been crossed off. There was no documentation available to document that the physician had authorized the changes and/or that a registered nurse documented the changes on the form.

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

*Hennie C. Buep, Exec. Director* 4/31/2020  
Printed Name and Title Date

141a 1-10 Medical Evaluation Information *(continued)*

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(Date) (Date)

Implemented  
 Not Implemented

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

**Regulation 2600.141.a**

12/20/2019 - Resident #1 no longer resides at the home and a new DME could not be obtained.

1/27/2020 – An audit was conducted of all current residents DME’s by the Health and Wellness Director for completion of all required areas.

1/28/2020 – Appropriate management staff were retrained on the community policy regarding DME completion by the Executive Director.

1/28/2020 – The Health and Wellness Director or designee will review all newly received DME’s for 3 months to verify all sections are completed according to community policy. 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:** Staff Training and DME audit results.

**Completion Date:** January 28, 2020

2-11-2020

MM

234d - Support Plan Revision

Regulations

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1's support plan dated 10/31/2019 was not updated to reflect that the resident had a significant risk of falls and needed additional supervision to prevent his falls. The resident also had combative behaviors that occurred during the 2nd shift that were not addressed on his support plan.

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

Leanne C. Boyd, Exec. Director  
Printed Name and Title

4/31/2020  
Date

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(Date)

Plan of correction implementation status as of 2-11-2020  
(Date)

Implemented

Not Implemented

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

**Regulation 2600. 234. d**

12/20/2019 - Resident #1 no longer resides at the home and a support plan could not be updated.

1/27/2020 – An audit was conducted of all current resident’s support plans by the Health and Wellness Director to identify any changes in condition that were in need of updating the plan or adding additional information.

1/28/2020 – Appropriate management staff were retrained on the community policy regarding the need for accurate support plans along with documentation of additional interventions when changes arise.

1/28/2020 – The Health and Wellness Director or designee will review all support plans for 3 months to verify they have been updated accordingly, to reflect falls and interventions, along with any other significant changes. Support Plans audits 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 support plan audits to determine if any further action is warranted.

**Evidence:** Staff Training and Support Plan Audit Results

**Completion Date:** January 28, 2020

2-11-2020

MM