Department of Human Services
Bureau of Human Service Licensing

May 13, 2022

[redacted], ADMINISTRATOR
[redacted]

RE: BROOKDALE HARRISBURG
3560 NORTH PROGRESS AVENUE
HARRISBURG, PA, 17110
LICENSE/COC#: 31611

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 02/15/2022, 02/16/2022, 02/15/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *BROOKDALE HARRISBURG* **License #:** *31611* **License Expiration:** *01/09/2023*

Address: *3560 NORTH PROGRESS AVENUE, HARRISBURG, PA 17110*

County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/20/1997* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *37* **Waking Staff:** *28*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal* **Exit Conference Date:** *02/16/2022*

Inspection Dates and Department Representative

02/15/2022 - On-Site: [redacted]
02/16/2022 - On-Site:
02/15/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served:** *27*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Clare Bridge* **Capacity:** *24* **Residents Served:** *9*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *27*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *10*
Have Physical Disability: *0*

Inspections / Reviews

02/15/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/08/2022*

Inspections / Reviews *(continued)*

05/13/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/18/2022*

65a - FS Orientation 1st Day

1. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person A, whose first day of work was [redacted], did not receive orientation on general fire safety and emergency preparedness until [redacted]
Staff person B, whose first day of work was [redacted], did not receive orientation on general fire safety and emergency preparedness until [redacted].

Plan of Correction ***Accept***

Immediately, Executive Director and Associate Executive Director completed an audit of current associate files for initial training completion on 2/17/22.
February 18, 2022- Appropriate management staff were retrained by the Maintenance Technician and Executive Director on the community policy regarding associates receiving Fire Safety training prior to or on the 1st day of work.
Going forward- The Associate Executive Director will audit associate files to ensure Fire Safety training is completed in accordance with regulation monthly for 3 months.
To assist with ongoing compliance, the Executive Director or designee, will review audit results for the next 3 months to verify compliance.
Evidence: In-service attendance sheet, copy of orientation checklist

Completion Date: *05/05/2022*

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home has a maximum safe evacuation time of six minutes as specified in writing on [redacted] by a fire safety expert. The home exceeded the evacuation time of six minutes during the drill conducted on [redacted] which had an evacuation time of ten minutes.

Plan of Correction ***Accept***

Immediately, Executive Director retrained the Maintenance Director on the community policy regarding Fire Safety drills on 2/18/22.
Going forward- The Maintenance Technician will rerun any fire drills exceeding the allotted time for safety and accuracy.
To assist with ongoing compliance, the Executive Director or designee, will review fire drill documentation results for the next 3 months to verify compliance.
Evidence: Copy of completed fire drill

Completion Date: *05/05/2022*

171c - Home's Vehicle Documents

1. Requirements

2600.
171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:
4. Current inspection.

Description of Violation

The state vehicle inspection for the 2012 Ford bus expired 1/31/22.

Plan of Correction ***Accept***

Immediately, Executive Director scheduled the Bus for inspection and service was completed on 2/28/22.
February 21, 2022- The Executive Director retrained the appropriate maintenance staff regarding the yearly required vehicle inspections.
Ongoing- The Maintenance Manager established a routine schedule in the TELS (Electronic Preventive Maintenance Schedule) to serve as a reminder to complete vehicle inspections annually.
To assist with ongoing compliance, the Executive Director or designee, will review vehicle inspection documentation to verify compliance.
Evidence: In-service attendance sheet, copy of bus inspection

Completion Date: *02/28/2022*

183e - Storing Medications

1. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/16/22 prescribed [redacted] *for Resident #1, which was opened on 1/7/22, was stored in the medication cart. The Novolog is to be discarded 28 days after opening.*

Plan of Correction ***Accept***

Immediately- The Health and Wellness Director discarded the Novolog pen medication that was expired. The medication was reordered through the pharmacy. There were no other expired medications identified on audit in the other carts.
February 17, 2022- The Health and Wellness Director retrained the appropriate clinical staff regarding the community policy on medication storage.
Ongoing- The Health and Wellness Coordinator established an audit schedule for the medication cart audits weekly and assigned responsibility.
To assist with ongoing compliance, the Health and Wellness Director or designee, will review audit results for the next 3 months to verify compliance.
Evidence: In-service attendance sheet, copy of audit form

Completion Date: *04/30/2022*

185a - Implement Storage Procedures

1. Requirements

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.

Description of Violation

The glucometer used to check the blood glucose level for Resident #1 is not calibrated to the correct date as the recordings for the current date of 2/16/22 have a date shown on the glucometer of 3/19.

Reading	*Glucometer date*	*MAR date*
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Plan of Correction ***Accept***

Immediately, the Health and Wellness Director recalibrated the glucometer to the correct date. An audit was completed for all glucometers and dates were verified to be correct.
February 18, 2022 – The Health and Wellness Director retrained the appropriate clinical staff on the community policy regarding use of medical equipment/ glucometers and importance of accurate calibration of the date.
Ongoing – A glucometer audit form was implemented. Glucometers will be audited twice weekly by the Health and Wellness Coordinator or designee for 2 months then weekly thereafter.
To assist with ongoing compliance, the Health and Wellness Director or designee, will review audit results for the next 2 months to verify compliance.
Evidence: Copy of audit form

Completion Date: *04/30/2022*

231b - Medical Evaluation

1. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] *however, the resident's medical evaluation indicating the need to be served in a secured dementia care unit was completed on* [redacted]

231b - Medical Evaluation *(continued)*

Plan of Correction ***Accept***

Immediately, Executive Director and Associate Executive Director completed an audit of current resident records in the secure dementia care unit (SDCU) for completion of medical evaluations. No discrepancies were found.
February 18, 2022- The Executive Director retrained appropriate clinical staff regarding the community policy on medical evaluation documentation.
Ongoing- The Health and Wellness Coordinator or designee will review all medical evaluations for timely completion for 3 months prior to admission to the SDCU.
To assist with ongoing compliance, the Health and Wellness Director or designee, will review documentation results for the next 3 months to verify compliance.
Evidence: In-service attendance sheet

Completion Date: *04/30/2022*

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's written cognitive preadmission screening was completed on [redacted].

Plan of Correction ***Accept***

Immediately, Executive Director and Associate Executive Director completed an audit of current resident records in the secure dementia care unit (SDCU) for completion of the cognitive preadmission prescreen. No discrepancies were found.
February 18, 2022- The Executive Director retrained the appropriate clinical leaders on the community policy regarding preadmission screening completion within timeframe of 72 hours for residents transitioning to secured dementia care unit.
Ongoing- The Health and Wellness Coordinator or designee will review resident records prior to admission to the SDCU for timely completion of the cognitive preadmission screen for 3 months
To assist with ongoing compliance, the Health and Wellness Director or designee, will review results for the next 3 months to verify compliance.
Evidence: In-service attendance sheet
Completion Date: *04/30/2022*

231h - Resident-Home Contact

1. Requirements

2600.
231.h. The resident-home contract specified in § 2600.25 (relating to resident-home contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Description of Violation

Resident #1 was transferred to the home's secured dementia care unit on [redacted]. A resident-home contract that includes a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs

231h - Resident-Home Contact (continued)

and fees specifically relating to the secured dementia care unit was not completed, nor was there an addendum to the prior contract dated 2/11/19, containing this information.

Plan of Correction ***Accept***

February 18, 2022- Executive Director retrained the Sales Manager and Associate Executive Director on residency documents needed prior to move in or admission. An audit of current residency agreements was completed by the Associate Executive Director for inclusion of necessary documents. No discrepancies were found. Going forward- Sales Manager/Associate Executive/Executive Director will verify that residency agreement documents are completed prior to admission or move within the community for 3 months.
To assist with ongoing compliance, the Executive Director or designee, will review results of audits to verify compliance.
Evidence: In-service attendance sheet

Completion Date: *04/30/2022*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 2/11/22 residents #1 and 2 engaged in a physical altercation which resulted in treatment for skin tears. Staff persons failed to report this allegation of resident to resident abuse in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27, until 2/15/22 when BHSL licensing staff inquired about the reporting.

Repeat Violation - 4/23/20

Plan of Correction ***Accept***

Immediately, Health and Wellness Director submitted incident report to Adult Protective Services.
February 18, 2022- Appropriate managers were retrained by the Executive Director on the community policy regarding submitting reportable events to both the Bureau of Human Services Licensing and Area on Aging agencies. Executive Director will schedule an additional training presentation with the Ombudsman through Area on Aging for June 2022.
Going forward- Health and Wellness Director or designee will review reportable events based on community policy.
To assist with ongoing compliance, the Executive Director or designee, will review results of audits to verify compliance.
Evidence: In-service attendance sheet, copy of report to Adult Protective Services

Completion Date: *05/15/2022*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/6/21 Resident #1 had a fall that resulted in the resident being admitted to the hospital for surgery due to a fracture of the right hip. The home did not report this incident to the Department.

Repeat Violation - 4/23/20

Plan of Correction ***Accept***

Immediately, Health and Wellness Director submitted incident report to the department.
February 18, 2022- Appropriate managers were retrained by the Executive Director on the regulation regarding submitting reportable events to the department.
Going forward- Health and Wellness Director or designee will submit reportable events based on community policy.
To assist with ongoing compliance, the Executive Director or designee, will review results of audits to verify compliance.
Evidence: In-service attendance sheet

Completion Date: *05/15/2022*

233c - Key-Locking Devices

1. Requirements

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 directions for operating the home's locking mechanism are not conspicuously posted near the courtyard gate.

Repeat violation: 10/30/2019

Plan of Correction ***Accept***

Immediately, Clare Bridge Program Coordinator reposted lock code signage by the gate exit in the secured dementia care unit (SDCU) courtyard.
February 18, 2022- Executive Director retrained the appropriate management staff on the community policy regarding lock code signage in secured dementia care unit (SDCU).
Going forward- Clare Bridge Program Coordinator or designee will audit and verify lock codes are posted by gate exit doors weekly for 2 months.
To assist with ongoing compliance, the Executive Director or designee, will review results of audits to verify compliance.
Evidence: In-service attendance sheet

Completion Date: *04/30/2022*