

Department of Human Services
Bureau of Human Service Licensing

July 25, 2022

[REDACTED], ADMINISTRATOR
[REDACTED]
[REDACTED]

RE: BROOKDALE BLOOMSBURG
420 SHAFFER ROAD
BLOOMSBURG, PA, 17815
LICENSE/COC#: 21120

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/07/2022, 06/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

[REDACTED]
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *BROOKDALE BLOOMSBURG* License #: *21120* License Expiration: *07/10/2023*
Address: *420 SHAFFER ROAD, BLOOMSBURG, PA 17815*
County: *COLUMBIA* Region: *NORTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *02/26/1997* Issued By: *PALI*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *50* Waking Staff: *38*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *06/08/2022*

Inspection Dates and Department Representative

06/07/2022 - On-Site: [REDACTED]
06/08/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* Residents Served: *45*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *5* Have Physical Disability: *1*

Inspections / Reviews

06/07/2022 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *07/07/2022*

07/20/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *07/27/2022*

07/25/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

87 - Lighting

1. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

There was no exterior lighting at the door exiting from the home to the garden area.

Plan of Correction

Accept

Immediately- On June 7, 2022 a new light fixture was purchased and installed by the Maintenance Manager. This was verified by the Department Representative at time of survey. All other external lights were found to be in working order.

June 7th- Executive Director retrained Maintenance staff on the regulation on outdoor lighting which allows safe movement to evacuate in an emergency.

The light fixture has been added to our TELs electronic maintenance system and will be inspected on a routine schedule with the other exterior light fixtures.

To assist with ongoing compliance, the Executive Director or designee will review results of the audits to verify compliance.

Evidence- In-service training sheet (attachment #1)

Completion Date: 06/08/2022

Update: 07/20/2022

Please send proof of compliance (picture).

Document Submission

Implemented

Immediately- On June 7, 2022 a new light fixture was purchased and installed by the Maintenance Manager. This was verified by the Department Representative at time of survey. All other external lights were found to be in working order.

June 7th- Executive Director retrained Maintenance staff on the regulation on outdoor lighting which allows safe movement to evacuate in an emergency.

The light fixture has been added to our TELs electronic maintenance system and will be inspected on a routine schedule with the other exterior light fixtures.

To assist with ongoing compliance, the Executive Director or designee will review results of the audits to verify compliance.

Evidence- In-service training sheet (attachment #1)

103i - Outdated Food

1. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a dented can of spaghetti sauce stored in the home's pantry.

Plan of Correction

Accept

Immediately- On June 8, 2022 the dented can of spaghetti was discarded by the Dining Service Coordinator upon being found on shelf. This was verified by the Department Representative at time of survey. A review was conducted by the DSC of all stored cans for dents and none were found.

103i - Outdated Food (continued)

June 9, 2022- Dining Service Coordinator was retrained by the Executive Director on the community policy regarding storage of canned food.

Dining Services Coordinator or designee will perform weekly audits for 3 months to identify and remove any dented cans per community policy.

To assist with ongoing compliance, the Executive Director or designee will review results of the audits to verify compliance.

Evidence- In-service attendance sheet (attachment #2)

Completion Date: 06/09/2022

Document Submission

Implemented

Immediately- On June 8, 2022 the dented can of spaghetti was discarded by the Dining Service Coordinator upon being found on shelf. This was verified by the Department Representative at time of survey. A review was conducted by the DSC of all stored cans for dents and none were found.

June 9, 2022- Dining Service Coordinator was retrained by the Executive Director on the community policy regarding storage of canned food.

Dining Services Coordinator or designee will perform weekly audits for 3 months to identify and remove any dented cans per community policy.

To assist with ongoing compliance, the Executive Director or designee will review results of the audits to verify compliance.

Evidence- In-service attendance sheet (attachment #2)

162c - Menus Posted

1. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 6/7/2022, the home's menus were only posted up until 6/11/2022.

Plan of Correction

Accept

Immediately- June 7, 2022 the menus were posted by the Dining Services Coordinator for a 2 week period of time. This was verified by the Department Representative at time of survey.

June 9, 2022- The Executive Director retrained the appropriate dining staff regarding the regulation and community policy on menu posting.

Ongoing- The Dining Coordinator or designee will post the menus per community policy weekly.

To assist with ongoing compliance, the Executive Director or designee will review audits to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet (attachment #2)

Completion Date: 06/09/2022

Update: 07/20/2022

Please send proof of staff training.

Document Submission

Implemented

Immediately- June 7, 2022 the menus were posted by the Dining Services Coordinator for a 2 week period of time. This was verified by the Department Representative at time of survey.

June 9, 2022- The Executive Director retrained the appropriate dining staff regarding the regulation and

162c - Menus Posted (continued)

community policy on menu posting.

Ongoing- The Dining Coordinator or designee will post the menus per community policy weekly.

To assist with ongoing compliance, the Executive Director or designee will review audits to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet (attachment #2)

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

Resident 3's glucometer had a blood sugar reading of [REDACTED] on 4/6/2022 at 9:28am. This reading was documented incorrectly in the MAR as [REDACTED]

Resident 4 is prescribed as needed [REDACTED] for [REDACTED]. This PRN medication was not available on the medication cart at the time of inspection on 6/8/2022.

Plan of Correction**Accept**

Immediately- June 8, 2022-Resident #3s glucometer was removed from the medication cart as [REDACTED] accu-checks were discontinued in April 2022.

June 8, 2022- Appropriate clinical staff were re- educated on the community policy regarding accurate documentation of the correct number in the MAR as noted on the glucometer by the Health and Wellness Director. All glucometer readings and MAR documentation will be audited by HWC or designee on a weekly basis. Any discrepancies will be documented, corrected and followed up on.

Resident #4- PRN [REDACTED] was ordered the night of 6/7/22 and delivered on 6/8/22.

An audit was completed by the Health and Wellness Coordinator of all medication carts for any medications that were not available and none were identified.

In addition to glucometer audits, the medication cart audits will include verifying that all current medications are in the cart and available for each resident. Medication cart audits to be completed weekly for 3 months by the Health and Wellness Coordinator or designee.

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet (attachment #3), pharmacy receipt for the delivered medication (attachment #4)

Completion Date: 06/08/2022

Update: 07/20/2022

Please send D/C order for resident 3's accu-checks.

Document Submission**Implemented**

Immediately- June 8, 2022-Resident #3s glucometer was removed from the medication cart as [REDACTED] accu-checks were discontinued in April 2022.

June 8, 2022- Appropriate clinical staff were re- educated on the community policy regarding accurate

185a - Implement Storage Procedures (continued)

documentation of the correct number in the MAR as noted on the glucometer by the Health and Wellness Director. All glucometer readings and MAR documentation will be audited by HWC or designee on a weekly basis. Any discrepancies will be documented, corrected and followed up on.

Resident #4- PRN Nitroglycerin was ordered the night of 6/7/22 and delivered on 6/8/22.

An audit was completed by the Health and Wellness Coordinator of all medication carts for any medications that were not available and none were identified.

In addition to glucometer audits, the medication cart audits will include verifying that all current medications are in the cart and available for each resident. Medication cart audits to be completed weekly for 3 months by the Health and Wellness Coordinator or designee.

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet (attachment #3), pharmacy receipt for the delivered medication (attachment #4)

182c - Medication Administration

1. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

- 6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

Description of Violation

Resident 1 states that it is not uncommon for their pills to be left for them on their nightstand next to their bed. Resident 2 states that pills are sometimes left for them in their room. Both residents stated that this has occurred within the last month. Repeat violation from 6/29/2021.

Plan of Correction

Accept

Immediately on June 8, 2022 the Health and Wellness Director and Health and Wellness Coordinator retrained the appropriate clinical staff on the community policy regarding medication administration. This review included the community policy regarding not leaving medications on a nightstand for the resident to take even if the resident requests this to be done. A review of residents allowed to self-administer medications was completed and resident # 1 requested to self-administer. Resident #1 was tested and determined able to self-administer.

DME was updated by their physician to indicate that the resident can self-administer. The assessment and Support Plan (RASP) were updated to include self-medication administration.

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet, copy of resident's ability to self-administer medicalizations (attachments #3 and #5)

Completion Date: 06/08/2022

Update: 07/20/2022

Please send physicians order for review.

Document Submission

Implemented

Immediately on June 8, 2022 the Health and Wellness Director and Health and Wellness Coordinator retrained the

182c - Medication Administration (continued)

appropriate clinical staff on the community policy regarding medication administration. This review included the community policy regarding not leaving medications on a nightstand for the resident to take even if the resident requests this to be done. A review of residents allowed to self-administer medications was completed and resident # 1 requested to self-administer. Resident #1 was tested and determined able to self-administer.

DME was updated by their physician to indicate that the resident can self-administer. The assessment and Support Plan (RASP) were updated to include self-medication administration.

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results to verify compliance weekly for 3 months.

Evidence: In-service attendance sheet, copy of resident's ability to self-administer medicalizations (attachments #3 and #5)