

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

November 29, 2023

[REDACTED], ADMINISTRATOR  
EMERITUS CORPORATION  
[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 09/06/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]  
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *BROOKDALE BLOOMSBURG* License #: *21120* License Expiration: *07/10/2024*  
 Address: *420 SHAFFER ROAD, BLOOMSBURG, PA 17815*  
 County: *COLUMBIA* Region: *NORTHEAST*

**Administrator**

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

**Legal Entity**

Name: *EMERITUS CORPORATION*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C 2 LP* Date: *10/17/1996* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *43* Waking Staff: *32*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *09/06/2023*

**Inspection Dates and Department Representative**

09/06/2023 On Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: *67* Residents Served: *40*

Secured Dementia Care Unit  
 In Home: *No* Area: Capacity: Residents Served:

Hospice  
 Current Residents: *5*

Number of Residents Who:  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *40*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*  
 Have Mobility Need: *3* Have Physical Disability: *0*

**Inspections / Reviews**

09/06/2023 - Full  
 Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *10/06/2023*

Inspections / Reviews (*continued*)

## 10/18/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2023

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/25/2023

## 10/31/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/16/2023

## 11/29/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

1. Requirements

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.

Description of Violation

At approximately 3:52pm the electronic records of the residents were left unlocked and accessible on the computer located on the medication cart near Room #1. The records contain confidential information of the residents.

Plan of Correction

Accept (█ - 10/18/2023)

The laptop on the medication cart had the gray security 'This Screen is hidden' noted on the screen. Point Click Care is designed to not open back up until the user hits the hidden unlock place (in this case the 'i' in Hidden. However, it was determined during inspection that when the mouse is used to click a different tab at the top, that screen then does open up to reveal what was last viewed on the screen.

9/8/23- Met with HWD and HWC to discuss what is needed for PCC security.

9/13/23- Health and Wellness Director (HWD) and Health and Wellness Coordinator (HWC) retrained appropriate clinical staff that all other tabs on the PCC screen must be closed for the lock and open function to be effective.

Appropriate clinical staff were educated that all tabs other than PCC EMAR must be closed to prevent someone from walking up, using the mouse to click on that tab which then can reveal resident information. This will be included in training and orientation of new Medication Technicians going forward.

10/1/23- HWC or designee will monitor compliance weekly for 2 months to verify the lock continues to be used and that there are no tabs at the top of the screen that could be opened with the mouse.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented (█ - 11/29/2023)

29a SOPb2 - Hospice Care: Informed Consent

2. Requirements

2600.

- 29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 2. The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

Description of Violation

There is no statement of informed consent from Resident #1 regarding the resident not evacuating during fire drills. The resident was not evacuated during the fire drill conducted on 8/31/23.

Plan of Correction

Accept (█ - 10/18/2023)

9/8/23- The resident signature was not able to be obtained due to his health status. HWD and HWC witnessed and documented that he was unable to sign but that he did give verbal consent.

9/8/23- Executive Director (ED) retrained the HWD and HWC on the community policy regarding obtaining written informed consent for residents under the care of hospice regarding evacuation during fire drills.

10/1/23- An audit was completed by the ED of the other 4 residents on hospice services and they were able to

29a SOPb2 - Hospice Care: Informed Consent (continued)

safely evacuate during a fire drill.

10/1/23- Going forward, when the community elects to not evacuate an actively dying hospice resident, all sections of this regulation will be obtained and checked by the ED to verify compliance when determined the resident is unable to safely evacuate.

10/1/23- HWD or designee will monitor compliance monthly for 2 months then quarterly thereafter. To assist with ongoing compliance going forward, the HWD or designee will review the results of these audits quarterly to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented ( ) - 11/29/2023

29a SOPb4 - Hospice Care: Inform Non-Participating

3. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

- 4. During a fire drill, the one designated person at the home who has knowledge in advance of the fire drill is to immediately upon setting off the fire alarm to begin the fire drill, go to the room of the resident who meets the conditions of paragraphs (1)—(3), and notify the affected resident and any staff person who attempts to evacuate the resident, that this is a fire drill and the resident is not to be evacuated.

Description of Violation

Staff person A who conducted the fire drill on 8/31/23, did not inform resident #1 or the staff person responsible for evacuating the resident, that the alarm indicated a fire drill rather than an actual fire. Resident #1 meets the conditions for not participating in fire drills.

Plan of Correction

Accept ( ) - 10/18/2023

9/8/23- HWD and HWC were retrained by the ED on the DHS regulatory requirements regarding participation in fire drills as related to hospice residents who meet the criteria for non-participation.

10/2/23- Staff person A (conductor of fire drills) was retrained by the ED on the community policy relating to fire drill participation for hospice residents who meet the criteria for non-participation including notification of the resident that the alarm indicated a drill was in process and notification to the staff that arrive to the room to evacuate the resident that we are going to reasonably simulate the evacuation.

10/2/23- HWD or designee will monitor compliance monthly for 2 months then quarterly thereafter.

To assist with ongoing compliance going forward, the ED or designee will review the results of these audits quarterly to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented ( ) - 11/29/2023

29a SOPb5i - Hospice Care: Safe Transportation

4. Requirements

2600.

29a SOPb5i - Hospice Care: Safe Transportation (continued)

- 29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
  - 5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
    - i. Access a mode of transport such as a bed on wheels, a chair on wheels or a drag mat in the resident’s bedroom or nearby area, which is not currently occupied by the resident.

**Description of Violation**

*During a fire drill on 8/31/23 the staff person who is responsible for evacuating resident #1, did not access and use a mode of transportation that would be safe for the movement of the resident when simulating the evacuation of the resident.*

**Plan of Correction**

**Accept** [redacted] - 10/31/2023)

*9/8/23- HWD and HWC were retrained by the ED on the community policy regarding fire drills for residents who are determined appropriate not to evacuate. Reviewed the need to for staff to access a mode of transport and simulate the evacuation*

*9/8/23- An audit was completed by the ED, HWD and HWC of the other 4 residents on hospice services and they were able to safely evacuate during a drill.*

*10/2/23- Maintenance Manager was retrained by the ED on the community policy regarding evacuation of residents meeting the criteria for non-participation. Discussed need for staff to access a safe mode of transport and simulate the evacuation*

*10/2/23- Going forward, if the community elects to not evacuate an actively dying hospice resident, all sections of this regulation will be obtained and performed. This will be audited by the ED to verify compliance monthly for 2 months then quarterly thereafter to determine if any further action is warranted.*

*10/11/23- ED trained all direct care staff at staff meeting. See attached.*

**Licensee's Proposed Overall Completion Date:** 10/31/2023

**Implemented** [redacted] - 11/29/2023)

29a SOPb5ii - Hospice Care: Fire Drill Simulation

**5. Requirements**

2600.

- 29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
  - 5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
    - ii. Reasonably simulate the level of effort required to move the resident and proceed to practice evacuation to the nearest unblocked exit or fire safe area. The simulation will include the number of staff persons that is required during an evacuation to safely move the resident.

**Description of Violation**

*During the fire drill on 8/31/23 the staff did not reasonably simulate the level of effort required to move Resident #1 and proceed to practice evacuation to the nearest exit or fire safe area.*

**Plan of Correction**

**Accept** [redacted] - 10/31/2023)

*9/8/23- HWD and HWC were retrained by the ED on the community policy regarding fire drill simulation for residents on hospice who meet the criteria for non-participation in fire drills.*

*9/8/23- An audit was completed by the ED of the other 4 residents on hospice services and each was able to safely*

29a SOPb5ii - Hospice Care: Fire Drill Simulation (continued)

evacuate during a drill.

10/2/23- Maintenance Manager was retrained by the ED on the requirements for residents not being evacuated during a fire drill if non-participation criteria is met. The staff must reasonably simulate the evacuation process.

10/2/23- Going forward, if the community elects to not evacuate an actively dying hospice resident, all sections of this regulation will be obtained and performed. This will be audited by the ED to verify compliance monthly for 2 months then quarterly thereafter to determine if any further action is warranted.

10/11/23- ED trained all direct care staff at staff meeting. See attached.

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented ( ) - 11/29/2023)

29a SOPb11 - Hospice Care: Records

6. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Resident #1 was not evacuated during the fire drill conducted on ( ). The hospice agency's license, the certification from the physician, the written informed consent and the documentation of consideration of relocation of Resident #1's bedroom was not kept with the fire drill record.

Plan of Correction

Accept ( ) - 10/18/2023)

9/6/23- The required documentation which was located was in the clinical file but not in the fire drill log has been copied and placed in the fire drill log as well.

9/8/23- HWD and HWC were retrained by the ED on the community policy regarding location of the required documentation to be kept in the fire drill log as well as the medical record. The required documentation was placed in the fire drill log by the HWD.

10/2/23- Maintenance Manager was retrained by the ED on the community policy regarding fire drill evacuation documentation for hospice residents who meet the criteria for non-participation during a fire drill. The required documentation will be stored with the fire drill log- hospice license, certification from the physician, written informed consent and the documentation of consideration of relocation of the bedroom.

Going forward- The documentation relating to non-participation of identified residents will be audited by the ED or designee to verify compliance monthly for 2 months then quarterly thereafter to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented ( ) - 11/29/2023)

81b - Resident Personal Equipment

7. Requirements

2600.

**81b - Resident Personal Equipment (continued)**

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

*Resident #2 utilizes a grab assist bar on the residents bed. The grab assist bar was not securely attached to the bed, posing a possible limb or head entrapment.*

**Plan of Correction**

**Accept (█ - 10/18/2023)**

*9/7/23- Conference was held with the ED, Resident #2 and her responsible party to review use of the grab bar including the intended purpose, potential risks and Resident #2's ability to use the device as intended.*

*9/8/23-Retraining of HWD and HWC by the ED on community policy on bedside mobility devices.*

*9/8/23- Audit was conducted by the Medication Technician of resident rooms to verify location of any other grab bars/bed mobility devices. All other devices were found to be known to us and in compliance.*

*9/11/23- Physical Therapist screened resident to verify the device would be beneficial to assist with bed mobility. It was determined that Resident #2 would benefit from its intended purpose. An order was obtained from physician, documentation updated on the resident support plan/RASP and negotiated risk agreement signed by resident and responsible party.*

*9/12/23 Maintenance Manager reviewed the placement of the bedside mobility device according to the manufacturer's instructions and secured it to the bed. The grab bar was measured to have an opening greater than 4.75 inches so a cover was applied to the grab bar and documented in the chart by the HWC. Maintenance Manager documented that the device was secured according to manufacturer's instructions*

*9/13/23-ED retrained the appropriate clinical staff at the staff meeting on the community policy for use of bedside mobility devices. In addition, care staff were reminded to report any new devices to HWD or HWC for further evaluation.*

*Ongoing- HWD/HWC or designee will complete monthly audits of apartments for compliance for 6 months to verify location of any new devices that may have been brought in by resident/family members and semi-annually thereafter to determine if any further action is warranted.*

**Licensee's Proposed Overall Completion Date: 12/01/2023**

**Implemented (█ - 11/29/2023)**

**88a - Surfaces****8. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*A green rectangular rug was located outside the shower in Room #2. The rug did not have a slip resistant backing, posing a possible fall hazard.*

**Plan of Correction**

**Accept (█ - 10/18/2023)**

*9/6/23- The rug was removed by the HWD.*

*9/7/23-Resident #2 and her responsible party were educated by the ED regarding the hazards of utilizing a small rug that does not have a slip resistant backing.*

*9/8/23- Audit completed by the Medication Technician of resident apartments for area rugs without slip resistant backings. There were 2 other rugs identified in audit. These 2 rugs were removed immediately with consent of the resident and their responsibility. They intend to replace with one that has the slip resistant backing.*

88a - Surfaces (continued)

9/8/23- ED retrained the HWD and HWC on the community policy regarding surfaces being free of hazards- specifically that all area rugs must have a slip resistant backing.  
9/13/23- ED retrained the appropriate staff at the monthly meeting to monitor surfaces for any potential hazards. Staff were trained to report any observation of area rugs in resident apartments that do not have a slip resistant backing.  
Ongoing- HWD/HWC or designee will audit resident rooms to verify compliance monthly for 2 months then quarterly thereafter to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented ( ) - 11/29/2023

102i - Soap Dispenser

9. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

A bar of soap with no label on it was located in the shared bathroom of Room #18.

Plan of Correction

Accept ( ) 10/18/2023

9/6/23- A labeled soap container was provided for room #18 by the HWC which is in addition to the liquid soap dispenser available for both residents.  
9/8/23- The other shared bathrooms were audited by the Medication Technician to verify that soap dispensers were available and filled. The 4 other shared bathrooms were in compliance.  
9/8/23- ED retrained HWD and HWC regarding community policy on labeling equipment and products in shared bathrooms. All bathrooms have a liquid soap dispenser that is filled and working.  
9/13/23- ED and HWD retrained appropriate staff at monthly meeting regarding shared bathrooms and personal items. Appropriate staff were reminded to report any shared bathroom containing unlabeled resident items.  
Ongoing- HWD/HWC or designee will complete monthly audits of shared apartments weekly for 2 months to verify shared bathroom items are labeled and continue to have a filled liquid soap dispenser.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented ( ) - 11/29/2023

132d - Evacuation

10. 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

It has been determined through an interview with Ancillary staff member A that during fire drills, the evacuation time noted on the fire drill logs is only the time it takes to evacuate the residents in the fire affected area. The home is

132d Evacuation (continued)

split into 3 fire zones. If the drill is run in zone 1, only the time for the residents to evacuate in zone 1 are measured by a stopwatch. The residents in zone 2 and 3 are not included in the final time calculation of residents to evacuate. The home should be recording the total time of all residents to evacuate to the outside of the building or to an internal fire safe area outside of the residents room.

Plan of Correction

Accept ( ) - 10/31/2023)

10/20/23 ED retrained Staff Person A on the community policy how time is measured and recorded. The procedure is to record the total time of ALL residents to evacuate to the outside of the building or to an internal fire safe area where they are up and ready to move if necessary. Residents in the fire safe zones will come out of their apartments, close the door and meet in the hallway of their safe zone. The hallway is the designated meeting spot. They will be awake and ready to evacuate from the fire safe area, if necessary, should the fire spread or should fire officials recommend evacuation. Timing of the drill will begin when the alarm sounds and end when the last resident enters the fire safe area or exits the outside door.

10/23/23 ED is scheduled to meet with a new fire safety expert in November to come into the community to inspect and evaluate the fire plan to ensure all regulations are met in the best possible manner.

10/20/23 ED or designee will participate and observe Staff Person A conducting and timing fire drills monthly for the next 3 months in order to verify compliance and determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented ( ) - 11/29/2023)

132g - Fire Drills Days/Times

11. Requirements

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

All of the fire drills conducted in 2023 are conducted on or near the end of the month.

Plan of Correction

Accept ( ) - 10/18/2023)

10/2/23 an audit was conducted by the ED of the 2023 fire drills. They were conducted on different days of the week, at different times of the day and night, and not routinely held when additional staff persons are present and not routinely held when resident attendance is low. However, all were held toward the end of each month.

10/2/23 ED retrained the Maintenance Manager regarding scheduling fire drills at different weeks/times of the month.

Going forward starting 10/2/23 ED or designee will review fire drill schedules in advance to verify compliance monthly for 3 months then quarterly thereafter to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented ( ) - 11/29/2023)

132h - Designated Meeting Place

12. Requirements

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.

Description of Violation

All Residents are not evacuating to an outside area or to an internal fire safe area during fire drills. Ancillary staff member A reported that he/she conducts fire drills. He/she indicated that only the residents involved in the fire affected area of the fire drill are fully evacuating their zone. Residents not in the zone of the fire drill are only evacuating to their doorways and not out of their bedrooms into the fire safe area in the hallway.

Plan of Correction

Accept (█ - 10/31/2023)

10/20/23- ED retrained Staff Person A on the community policy of where residents must evacuate to. Residents in the fire area zone will evacuate that zone either to the outside or into an internal fire safe area. Residents in the fire safe zones will come out of their apartments, close the door and meet in the hallway of their safe zone. They will be awake and ready to evacuate from the fire safe area, if necessary, should the fire spread or should fire officials recommend evacuation.

10/23/23- ED is scheduled to meet with a new fire safety expert in November to come into the community to inspect and evaluate the fire plan to ensure all regulations are met in the best possible manner.

10/20/23- ED or designee will participate and observe Staff Person A conducting fire drills monthly for the next 3 months in order to verify compliance with ALL residents evacuating to a designated meeting place and determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented (█ - 11/29/2023)

144c2 - Smoking Area Distance

13. Requirements

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:

- 2. 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: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The designated outdoor smoking area of the home had concerns with combustible and flammable materials. Two propane tanks and a plastic garbage can with garbage in it was located below the smoking area sign. Also, in the smoking area were 4 patio chairs covered with a hard nylon material that did not contain a tag on it confirming that it meets the California standards in regards to fire resistant products. The above noted items pose a possible fire hazard.

Plan of Correction

Accept (█ - 10/18/2023)

9/6/23-The 4 nylon seating chairs, propane tanks and plastic garbage can were removed from near the smoking area by the ED.

9/8/23- The ED verbally retrained the Maintenance Manager regarding the community policy on combustible materials located close to the designated smoking area. The immediate location near the smoking area was

144c2 Smoking Area Distance (continued)

assessed by the ED for any other combustible materials and none were found. (10/2/23 formal written document of training completed once violation report received)  
9/11/23 Maintenance Manager assembled a new metal picnic table and benches to the smoking area.  
10/1/23 ED or designee will review compliance in the smoking area monthly for 2 months then biannually thereafter to verify if any further action is warranted.

Licensee's Proposed Overall Completion Date: 12/01/2023

Implemented (█ - 11/29/2023)

253c - Records Log

14. Requirements

2600.

253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

The destroyed records log dated 10/28/22 does not include the residents date of birth.

Plan of Correction

Accept (█ - 10/18/2023)

9/8/23 ED retrained HWD and HWC on the community policy for recording on the record destruction log. Old forms were discarded by the HWD and the revised log form was implemented going forward which includes a column for resident date of birth.

9/8/23 ED audited the forms currently in use and immediately implemented the revised log form which has a column for date of birth.

Ongoing effective 10/1/23 ED will review destruction logs upon completion to review information during annual removal of records process to verify if any further action is warranted.

Licensee's Proposed Overall Completion Date: 11/01/2023

Implemented (█ - 11/29/2023)