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

December 8, 2023

[redacted]
EMERITUS CORPORATION
[redacted]

RE: BROOKDALE GRAYSON VIEW
29 GRAYSON VIEW COURT
SELINSGROVE, PA, 17870
LICENSE/COC#: 22793

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/11/2023 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE GRAYSON VIEW* **License #**: *22793* **License Expiration**: *07/02/2024*

Address: *29 GRAYSON VIEW COURT, SELINSGROVE, PA 17870*

County: *SNYDER* **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**: *01/19/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *77* **Waking Staff**: *58*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *10/11/2023*

Inspection Dates and Department Representative

10/11/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *24* **Residents Served**: *15*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *59*

Diagnosed with Mental Illness: [redacted]

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *18*

Have Physical Disability: *0*

Inspections / Reviews

10/11/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/27/2023*

10/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/06/2023*

Inspections / Reviews *(continued)*

12/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/08/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The outdoor vents for the memory care laundry room dryers were clogged with a build up of lint.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

10/11/2023 – Outdoor dryer vents for the memory care dryers were cleaned by the Maintenance Director. An audit was conducted of other outside vents to verify there were no other vents with lint build up by the Maintenance Director. The other outdoor dryer vents were found to be in compliance.
10/12/2023 – Community dryer vents were professionally cleaned including the memory care dryer vent by an outside vendor.
10/12/2023 – Appropriate maintenance staff who perform dryer vent cleaning as well as key community staff were re-trained on this regulation as well as additional fire safety.
Ongoing – Audits will be conducted weekly for 3 months by the Maintenance Director or designee to verify outside dryer vents are free from lint and debris starting November 1, 2023 and ending February 1, 2024.
The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024. The Executive Director (ED) or designee will review results of audits to determine if any further action is warranted.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audit, Record of staff Training & work order from cleaning vendor.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] - 12/08/2023)

121a - Unobstructed Egress

2. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit door located near the library was stuck and did not open without excessive force applied to the panic bar.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept[redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

10/11/2023 – Maintenance Director lubricated the rubber seals on the library exit door to make the door easier to open. An audit was conducted of outside exit doors to verify there were no further doors requiring excessive force to open and other doors were found to be compliant.

10/12/2023 –Appropriate maintenance and housekeeping staff were re-trained on this regulation by the ED.

On or before 11/1/2023 – Maintenance Director will replace "plastic" seals with a foam seal allowing the seal not stick in warmer or hot temperatures.
Ongoing – Audits will be conducted weekly for 3 months by the Maintenance Director or designee to verify outside exit doors are easily able to be opened without excessive force starting November 1, 2023 and ending February 1, 2024. The ED or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024.

Licensee's Proposed overall Completion Date: 2/1/2024
Supporting Documentation: Documentation of audit, Record of staff training, receipt and picture of updated door seals.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented[redacted] - 12/08/2023)

125a - Combustible Storage

3. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A pair of green pants were found behind dryer #1 in the memory care laundry room.

Plan of Correction ***Accept[redacted] - 10/30/2023)***

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125a - Combustible Storage (continued)

remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

10/11/23 – Green pants were immediately removed from behind dryer #1 by the Maintenance Director. The Maintenance Director completed an audit of laundry room dryers and found no additional items near or behind dryers.

11/16/23 – Appropriate clinical and maintenance staff with access to dryers will be re-trained on the community policy as well as additional fire safety.

Ongoing – Audits will be conducted weekly for 3 months by the Maintenance Director or designee to verify dryers and laundry rooms are free from combustibles starting November 1, 2023 and ending February 1, 2024.
The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024. The ED or designee will review results of audits to determine if any further action is warranted.

Licensee's Proposed overall Completion Date: 2/11/2024
Supporting Documentation: Documentation of audits, record of staff training.

Licensee's Proposed Overall Completion Date: *02/11/2024*

Implemented [redacted] - 12/08/2023)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 1 does not have a completed annual Documentation of Medical Evaluation (DME) for [redacted]. The prior DME was completed on [redacted].

Plan of Correction ***Accept[redacted] - 10/30/2023)***

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10/11/2023 – Physician was contacted by the Health and Wellness Coordinator (HWC) to receive a copy of the front page that was missing from the DME. Physician did not keep a copy.

10/12/2023 – An audit was conducted by the [redacted] to verify other DME's in resident charts were complete with

141b1 - Annual Medical Evaluation (continued)

both pages present and they were found to be compliant.

10/26/2023 – Physician completed a new DME which has been placed in the medical record by the [redacted]. Appropriate clinical and community staff were retrained by the ED on the community policy regarding DME's.

Ongoing – An audit of DME's will be conducted monthly for 3 month by the [redacted], Resident Care Coordinator or designee to verify DME's are completed in the proper time frame and both pages are included starting November 1,2023 and ending February 1, 2024. Ongoing [redacted] or designee will review newly received DME's for completion according to community policy.
The ED or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality
Assurance Meeting on January 19, 2024 by the ED.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audit & Record of staff training, completed DME.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] - 12/08/2023)

182b - Prescription Medication

5. Requirements

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

Staff person A is a med tech and completed annual practicums on the following dates:
[redacted]
Staff person B is a med tech and completed annual practicums on the following dates:
[redacted].
The annual practicums for both staff person A and staff person B were completed more than 12 months apart.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

182b - Prescription Medication (continued)

10/12/2023 – An audit was conducted by the Medication Train the Trainer of other Medication Technicians training documentation to verify annual practicums were in compliance and none were found out of compliance. Community Medication Administration Trainer was re-trained on this regulation as well as compliance for annual practicums by the ED.

[redacted] *– Staff person A and B will have a medication administration observation completed by the Medication Administration Trainer as well as a MAR review.*

Ongoing – An audit of annual practicums will be conducted every 3 months for 6 months by the Medication Administration Trainer starting November 1, 2023 and ending February 1, 2024 to verify completion according to the community policy.
The ED, [redacted] *or designee will review results of audits to determine if any further action is warranted as well as review training completions annually going forward. The results of the audits will be presented at the next Quality Assurance Meeting on January 19 and April 19, 2023 by the ED.*

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audits, Record of staff Training, documentation of Staff Person A and Staff Person B's annual practicums

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] ***12/08/2023)***

183d - Prescription Current

6. Requirements

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

A prescription bottle of [redacted] *tablets was stored in the cart for resident #2. Resident #2 does not have a current order for this medication.*

Plan of Correction ***Accept*** [redacted] ***- 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

10/11/2023 – Medication was immediately removed from the medication cart by the [redacted]*. Physician was*

183d - Prescription Current (continued)

contacted to verify that medication was discontinued.

10/16/2023 – Medication carts were audited by the [redacted] and Medication Technician to verify compliance with this regulation with no other medications were found out of compliance without an order.

11/16/23 – Appropriate clinical staff, and Medication Technicians will be re-trained on this regulation by the [redacted] and ED.

Ongoing – Medication cart audits will be conducted weekly for 3 months by the [redacted] or designee to verify medications have current orders starting November 1, 2023 and ending February 1, 2024. The HWC or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audits, Record of staff Training.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] - 12/08/2023)

183e - Storing Medications

7. 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

Resident #2 has an order for [redacted]. The pharmacy label on the prescription bottle for this medication indicates it contains [redacted]. The bottle contained tablets that were cut in half and placed back in the medication bottle. The bottle contained crumbled bits of the broken tablets along with the tablets. Staff stated that the resident's family cut all of the tablets in half before placing the tablets back in the bottle and providing the bottle of tablets to the home.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

[redacted] – Family of Resident #2 was re-educated by the [redacted] on the community policy that the home requires the proper dosage and medication on hand. Physician was also notified by the [redacted] to work with the family on

183e - Storing Medications (continued)

providing medication that is scored and able to be cut or for a medication that is the dosage ordered.

[redacted] *– Medication carts were audited by the* [redacted] *and the Resident Care Coordinator (RCC) to verify compliance with the community policy with no other medications being found out of compliance.*

[redacted] *– Family provided the medication at the proper dosage for administration.*

[redacted] *– Appropriate clinical staff and Medication Technicians will be re-trained on this regulation by the ED and* [redacted] *as well as expectations to discuss with families if they choose to provide the home with medications.*

Ongoing – Medication cart audits will be conducted weekly for 3 months by the HWC, RCC or designee to verify medications are stored according to community policy starting November 1, 2023 and ending February 1, 2024. The ED, [redacted] *or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024.*

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audits & Record of staff Training.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] ***- 12/08/2023)***

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 has an order for [redacted] *daily. The pharmacy label on the bottle states the order is for* [redacted] *daily. The pharmacy label did not match the order for the medication on the Medication administration record (MAR).*

Plan of Correction ***Accept*** [redacted] ***- 10/30/2023)***

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184a - Resident's Meds Labeled (continued)

10/11/2023 – "Change in order" sticker was immediately applied to the medication label by the [redacted]. Physician was contacted by the [redacted] to verify the current order which was verified.

10/16/2023 – Mediation carts were audited by the [redacted] and RCC to verify compliance with the community policy and no other labels were found out of compliance.

11/16/23 – Appropriate clinical staff and Medication Technicians will be re-trained on the community policy by the HWC.

Ongoing – Medication cart audits will be conducted weekly for 3 months by the HWC, RCC or designee to verify medications have current orders starting November 1, 2023 until February 1, 2024. The ED or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audits & Record of staff Training.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] - 12/08/2023)

185a - Implement Storage Procedures

9. 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 #2 has a PRN order for [redacted] to be taken before dental appointments. Resident #2 also has a PRN order for [redacted] to be taken as needed. The home did not have either of these medications on hand to be administered if needed.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

10/11/2023 – Physician was contacted by the [redacted] for verification of the order and to provide an updated script for the PRN medication. Pharmacy was contacted by the [redacted] with the updated script to deliver medication to the home.

185a - Implement Storage Procedures (continued)

10/13/2023 – Medication arrived at the home and was placed in medication cart by the [redacted] *per PRN order.*

10/16/2023 – Mediation carts were audited by the RCC and [redacted] *to verify compliance with the community policy regarding availability of PRN medications. No other medications were found to be out of compliance.*

11/16/23 – Appropriate clinical staff including Medication Technicians will be re-trained on this regulation by the ED and HWC.

Ongoing – Medication cart audits will be conducted weekly for 3 months by the HWC, RCC or designee to verify medications have current orders starting November 1, 2023 and ending February 1, 2024. The ED or designee will review results of audits to determine if any further action is warranted. The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Documentation of audits, Medication acceptance documentation, record of staff Training.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] ***- 12/08/2023)***

227d - Support Plan Medical/Dental

10. Requirements

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 # 3 has an enabler bar attached to their bed. The mobility aid is not addressed in the resident's support plan dated [redacted].

Plan of Correction ***Accept*** [redacted] ***- 10/30/2023)***

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227d - Support Plan Medical/Dental (continued)

10/11/2023 – Resident #3's support plan/RASP was immediately updated by the [redacted] to reflect the use of the enabler bar.

10/16/2023 – Resident support plans/RASP's for those residents utilizing bedside mobility devices were audited by the [redacted] to verify compliance with the community policy and documentation was compliant for those with bedside devices.

10/20/2023 - An audit was conducted by the [redacted] of current resident support plans/RASP to verify documentation of enabler bar devices with none being found out of compliance.

11/16/23 – Appropriate clinical, maintenance and management staff will be re-trained on the community policy regarding use of bedside mobility devices by the ED and Health and Wellness Coordinator [redacted]

Ongoing – Weekly random audits will be conducted by the [redacted] RCC or designee of resident records for those using having mobility devices for 2 months for documentation according to community policy on the resident RASP/ Support Plan starting November 1, 2023 and ending January 1, 2024.
The Health and Wellness Coordinator or designee will review results of audits to determine if any further action is warranted.

Licensee's Proposed overall Completion Date: 1/01/2024

Supporting Documentation: Resident support plans, Documentation of audit, Record of staff Training.

Licensee's Proposed Overall Completion Date: *01/01/2024*

Implemented [redacted] - 12/08/2023)

233c - Key-Locking Devices

11. 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 memory care exit door that leads outside to the guest entrance did not have the code posted near the door with instructions on how to operate the key pad.
Repeat violation 7/26/22.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated October 17, 2023 for renewal/incident inspection survey on 10/11/2023. 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.

233c - Key-Locking Devices (continued)

10/11/2023 – Maintenance Director immediately posted the door code and instructions near the door. Later that day, Maintenance Director glued a frame to the wall which housed a permanent copy of the code and instructions to exit.

10/11/2023 – An audit was conducted by the Maintenance Director of the other Memory Care exit doors to verify code with exit instructions were posted. They were found in compliance.

10/12/2023, 11/16/23 – Appropriate community maintenance and clinical staff were retrained on the community policy regarding door signage for exiting with key locking devices by the ED.

Ongoing – Audits will be conducted weekly for 3 months by the Maintenance Director or designee to verify exit instructions are posted according to community policy for memory care exit doors with key locking devices starting November 1, 2023 and ending February 1, 2024.
The ED or designee will review results of audits to determine if any further action is warranted.
The results of the audits will be presented at the next Quality Assurance Meeting on January 19, 2024 by the ED or designee.

Licensee's Proposed overall Completion Date: 2/1/2024

Supporting Documentation: Picture of information by door/exit, Documentation of audit, record of staff training.

Licensee's Proposed Overall Completion Date: *02/01/2024*

Implemented [redacted] - 12/08/2023)