





**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: DECEMBER 27, 2024

[REDACTED]  
Assistant Secretary  
Emeritus Corporation  
[REDACTED]

RE: Brookdale Grayson View  
29 Grayson View Court  
Selinsgrove, Pennsylvania 17870  
License # 227931

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 27, 2024, August 28, 2024, September 23, 2024, October 7, 2024, October 11, 2024, October 17, 2024, October 21, 2024 and October 30, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 22793) dated July 2, 2024 to July 2, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued. The license dated July 2, 2024 to July 2, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 27, 2024 to June 27, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
105g	III	76	\$3	\$228	15 calendar days from mailing date of this letter
141b1	III	76	\$3	\$228	15 calendar days from mailing date of this letter
185a	II	76	\$5	\$380	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

██████████, Workload Manager  
 Pennsylvania Department of Human Services  
 Bureau of Human Services Licensing

Room 631, Health and Welfare Building  
625 Forster Street  
Harrisburg, Pennsylvania 17120  
[REDACTED]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summary

cc:

[REDACTED]

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

**Facility Information**

Name: *BROOKDALE GRAYSON VIEW* License #: *22793* License Expiration: *07/02/2025*  
Address: *29 GRAYSON VIEW COURT, SELINSGROVE, PA 17870*  
County: *SNYDER* Region: *NORTHEAST*

**Administrator**

Name: *Julie Heeter* Phone: *215-519-8445* Email: *julie.heeter@brookdale.com*

**Legal Entity**

Name: *EMERITUS CORPORATION*  
Address: *6737 W. WASHINGTON STREET, SUITE 2300, MILWAUKEE, WI, 53214*  
Phone: *5703742923* Email: *CSTRASBURG@BROOKDALE.COM*

**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: *76* Waking Staff: *57*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint, Incident* Exit Conference Date: *10/30/2024*

**Inspection Dates and Department Representative**

10/30/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *95* Residents Served: *76*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *1st floor* Capacity: *24* Residents Served: *18*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *76*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

**10/30/2024 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/01/2024*

Inspections / Reviews *(continued)*

12/10/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/30/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

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 [REDACTED] Resident #1 had an unwitnessed fall which resulted in the resident needing to be sent out to get stitches for a laceration above the left eyebrow, The incident was reported to the Department on [REDACTED] at 10:30pm, greater than 24 hours after the incident occurred.

Plan of Correction

Directed ([REDACTED] - 12/10/2024)

11/1/2024 - Appropriate clinical and management staff were retrained by Executive Director (ED) on the community policy and regulation 2600.16c.

11/4/2024 & Ongoing compliance- The ED, HWD or designee will review any potential reportable incidents as they occur for 3 months starting immediately. The review will include a daily review of all internal incidents.

Supporting Documentation: record of staff training

Proposed Overall Completion Date: 02/04/2025

(Directed)

**The Administrator will train all staff in reportable incidents and conditions, as well as the homes internal policy on who is responsible for reporting the incidents to the Department as required including weekends and holidays. All future incidents will be reported as required.**

Proposed Overall Completion Date: 01/08/2025

Directed Completion Date: 01/08/2025

141b1 - Annual Medical Evaluation

2. Requirements

2600.

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

Description of Violation

Resident #1 had a medical evaluation completed on [REDACTED] The resident's last medical evaluation was completed [REDACTED]

Resident #2's most recent medical evaluation was completed on [REDACTED]. The previous medical evaluation was completed on [REDACTED] greater than 1 year and 15 days from the most recent evaluation.

Resident #3's most recent medical evaluation was completed on [REDACTED] The previous medical evaluation was completed on [REDACTED]

Repeat Violation: 10/11/23

## 141b1 - Annual Medical Evaluation (continued)

**Plan of Correction**

Accept (█ - 12/02/2024)

11/5/ 2024 Executive Director retrained the HWD and direct clinical staff on the community policy regarding securing medical evaluations.

11/5/2024- An audit was conducted by the HWD or designee on current resident charts to verify the medical evaluations are completed annually.

11/5/2024 HWD or designee implemented a tracking system to verify that medical evaluations going forward are completed within the guideline of the community policy,

11/8/2024 & ongoing - HWD, Health and Wellness coordinator (HWC) and or designee will audit a sample of six (6) resident medical evaluations monthly for three (3) months to verify compliance with the community policy.

The ED or designee will review the results of these audits to verify compliance.

Supporting Documents: Record of staff training

Licensee's Proposed Overall Completion Date: 02/05/2025

## 182c - Medication Administration

**3. Requirements**

2600.

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

1. Identify the correct resident.

**Description of Violation**

On 9-23-24, Staff Member A had administered Resident #2 a dose of .5mg Lorazepam belonging to Resident #3 instead of the resident's prescription for Oxycodone 2.5mg. Resident #2 does not have an order for Lorazepam. Staff Member A did not identify the medication was being given to the correct resident when administering the medication.

**Plan of Correction**

Accept (█ - 12/02/2024)

9/23/2024- Staff member A retrained on medication administration and medication observation pass completed by HWD.

11/25/2024- Med tech staff retrained on the 7 rights of medication administration.

11/25/24- HWD or designee to monitor 3 different med techs administer medication each week for the next 3 months.

12/25/24- ED will review medication pass monitoring sheets monthly x 3 months to verify compliance.

Supporting Documents: Record of staff training

Licensee's Proposed Overall Completion Date: 02/25/2025

## 187d - Follow Prescriber's Orders

**4. Requirements**

2600.

187.d. The home shall follow the directions of the prescriber.

**Description of Violation**

On 9-23-24 at 8pm Staff Member A administered .5mg of Lorazepam to Resident #2 which belonged to Resident #3. Resident #2 does not have a current order for this medication, and the medication was administered in error.

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Accept (█ - 12/02/2024)

9/23/2024- Staff member A retrained on medication administration and medication pass observation completed by HWD.

11/25/2024- Med tech staff retrained on the 7 rights of medication administration.

11/25/24- HWD or designee to monitor 3 different med techs administer medication each week for the next 3 months.

12/25/24- ED will review medication pass monitoring sheets monthly x 3 months to verify compliance.

Supporting Documents: Record of staff training

Licensee's Proposed Overall Completion Date: 02/25/2025

[REDACTED]

WITHDRAWN █ 12/20/24

[REDACTED]

[REDACTED]

[REDACTED]



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

**Facility Information**

Name: *BROOKDALE GRAYSON VIEW* License #: *22793* License Expiration: *07/02/2025*  
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: *DLI*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *102* Waking Staff: *77*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Incident* Exit Conference Date: *10/25/2024*

**Inspection Dates and Department Representative**

08/27/2024 - On-Site: [REDACTED]  
8/28/2024 - On-Site: [REDACTED]  
9/23/2024 - Off-site: [REDACTED]  
10/7/2024 - Off-site: [REDACTED]  
10/11/2024 - Off site: [REDACTED]  
10/17/2024 - Off site: [REDACTED]  
10/21/2024 - Off site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *95* Residents Served: *77*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Care* Capacity: *24* Residents Served: *18*

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *77*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

08/27/2024 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *11/08/2024*

12/11/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *12/11/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Bypass Document Submission*

12/11/2024 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: *12/11/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

## 42b - Abuse

**1. Requirements**

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 # 11 sustained a head injury from an unwitnessed fall at approximately [REDACTED] Staff member A did not follow the home's policy in Section 5 part ii to contact the Health and Wellness Director, nurse, designee and ED after a resident has a fall. The on-call LPN was not contacted until 10pm when staff member B was informed of the fall when reporting for scheduled shift. Staff member B did not document assessing resident # 11 or document the fall so other staff members would have the information available to them. Staff member B did not inform the oncoming staff that resident #11 had a head injury from the fall. On the morning of [REDACTED] resident #11 was found to have a change in mental status and was sent out to [REDACTED] Hospital for treatment. Resident #11 was [REDACTED] from the [REDACTED] fall and passed away. The death certificate showed the cause of death was [REDACTED]

**Plan of Correction****Directed ( [REDACTED] - 12/10/2024)**

The following is the Plan of Correction for Brookdale Grayson View in regard to the Statement of Deficiency dated 10/29/24 for an annual inspection survey on 8/27-8/28/24. 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] Health and Wellness Director (HWD) and Executive Director (ED) reviewed internal investigation with Human Resources, staff person A & B were placed on corrective action. Staff person B was terminated.

[REDACTED]-Staff person A was retrained on communities fall management policy and head injury policy by the HWD and ED.

[REDACTED] The Health & Wellness Director (HWD) and Executive Director (ED) retrained the direct care staff on the community's fall management policy/ flowsheet and head injury policy. The fall flowsheet was posted in the Health & Wellness office and medication rooms.

[REDACTED] and Ongoing compliance- Monthly for four (4) months, the HWD and or designee will review the falls documentation for compliance with Community policy.

To assist with ongoing compliance, the HWD or designee will review incident reports within 24 hours to verify compliance.

Completion Date: 11/19/2024

Supporting documents: staff training

Proposed Overall Completion Date: 11/19/2024

**(Directed)**

**All staff, including the administrator, will receive training in Resident Rights and The Older Adults Protective Service Act (OAPSA) from an outside source.**

42b - Abuse (continued)

Directed Completion Date: 01/08/2025

88a - Surfaces

2. 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

During the kitchen inspection at approximately 3pm on 8-27-24, it was noted the kitchen floor appeared discolored, had multiple tiles that were cracked or broken, and the floor was very sticky.

Plan of Correction

Accept (█) - 12/02/2024)

8/27/24- The kitchen floor was immediately cleaned by housekeeping.

9/4/24- The Dining Service Manager and Maintenance Manager were retrained on the community policy regarding the Fresh Impression Floor Care policies and cleaning schedule by the ED.

9/20/24- Dining Service Manager retrained dining staff on the community policy, Fresh Impression Floor Care policies and cleaning policy.

9/20/24- To assist with ongoing compliance, The Dining Service Manager or designee will audit the kitchen floors for cleanliness, and or cracked or broken tiles weekly for the next 3 months.

The Executive Director (ED) or designee will review results of audits.

Supporting documents- training attendance

Completion Date: 12/20/24

Licensee's Proposed Overall Completion Date: 12/20/2024

105g - Lint Removal and Duct Cleaning

3. 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 laundry room outside room 218 had approximately 1/8 inch of lint on the floor behind a natural gas dryer, posing a fire hazard.

Repeat Violation: 10/11/23

Plan of Correction

Accept (█) - 12/02/2024)

8/28/24- The lint was immediately removed from the dryer in 200 hallway located near room 218. The additional dryers in the community were audited and found to have no lint inside or around the dryer.

9/4/24- The ED retrained the Maintenance Director and Maintenance Tech on regulation 2600.105g.

9/18/24- The ED reviewed the violation and regulation 2600.105g. The maintenance staff were re-educated by the ED or designee to remove all lint after every load and inspect the areas around the dryer to verify the area is clean and without lint.

11/15/24 – to assist with ongoing compliance – The Maintenance Director and or designee will conduct weekly audits for 3 months of the dryers to verify the lint has been removed and the area around the dryer is clean and

105g - Lint Removal and Duct Cleaning (continued)

without lint.

The Executive Director (ED) or designee will review results of audits.

Licensee's Proposed Overall Completion Date: 2/15/2025

Supporting Documentation: Record of Maintenance Department training and General Staff Meeting Agenda

Licensee's Proposed Overall Completion Date: 02/15/2025

132c - Fire Drill Records

4. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The Fire Drill Log for 10-27-23 indicates 58 residents were present and 58 residents were evacuated, when only 57 residents were evacuated. The Fire Drill Log for 11-28-23 indicates there were 70 residents present and 70 residents evacuated, when only 69 residents evacuated. On the above noted fire drills one resident refused to evacuate, and the fire drill log is not accurately documented.

Plan of Correction

Accept (█) - 12/02/2024)

8/30/24- 10/27/23 and 11/28/23 – The fire drill log was corrected by the Executive Director and Maintenance Manager to reflect actual number of residents evacuated.

9/4/24- ED retrained the Maintenance Manager on community policy and regulation regarding fire drill procedures.

9/10/24- to assist with ongoing compliance – the ED or designee will review monthly fire drill documentation for 3 months to verify fire drills are completed according to community policy.

Licensee's Proposed overall Completion Date: 12/10/24

Supporting Documentation: training attendance

Licensee's Proposed Overall Completion Date: 12/10/2024

Not Implemented (█) - 12/11/2024)

132g - Fire Drills Days/Times

5. 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

Of the 12 fire drills reviewed (9-25-23 through 8-13-24) 10 of the drills were held between the 21st and the 29th of the month. The two drills held earlier in the month are both held on the 13, showing the facility is not varying the dates of the drills through out the month.

132g - Fire Drills Days/Times (continued)

Plan of Correction

Accept (█ - 12/02/2024)

9/4/24- ED retrained the Maintenance Manager on community policy and regulation regarding fire drill procedures.  
9/10/24- to assist with ongoing compliance – the ED or designee will review monthly fire drill documentation for 3 months to verify fire drills are completed according to community policy.

Going forward, the Maintenance Coordinator or designee will use the TELS tracking system to track and verify that unannounced fire drills occur monthly and according to the specifications in 2600.132.g

Supporting Documentation- Record of Maintenance Department training and Fire Drill log

Licensee's Proposed Overall Completion Date: 12/10/25

Licensee's Proposed Overall Completion Date: 12/10/2024

Not Implemented (█ - 12/11/2024)

132h - Designated Meeting Place

6. 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

On 10-27-23, 11-28-23 not all residents evacuated. On 10-27-23, one resident refused to leave the room. On 11-28-23, one resident hid in another resident's room during the drill.

Plan of Correction

Directed (█ - 12/10/2024)

9/4/24- ED retrained the staff on community policy and regulation regarding fire drill procedures and evacuation.  
9/10/24- to assist with ongoing compliance – the ED or designee will review monthly fire drill documentation for 3 months to verify fire drills are completed according to community policy.

Supporting Documentation- Record of Maintenance Department training and Fire Drill log

Licensee's Proposed Overall Completion Date:- 12/10/25

Proposed Overall Completion Date: 12/10/2024

(Directed)

**The Administrator will educate all residents that fire drill participation is mandatory, failure to participate in a fire drill can lead to a 30-day notice of discharge being issued. The Administrator will monitor for ongoing compliance**

Directed Completion Date: 01/08/2025

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

- 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 #2's medical evaluation, dated [REDACTED], was blank in the section for special health or dietary needs.

**Plan of Correction**

Accept ( [REDACTED] ) - 12/02/2024)

8/30/2024 – The HWD reviewed and verified section 4 with the residents PCP to verify accuracy of resident’s special health or dietary needs. Resident # 2 no longer resides in community.

9/1/2024- An audit was conducted by the HWD on current resident charts to verify sections of the medical evaluations were completed.

11/5/2024- The ED retrained the HWD and direct clinical staff on the community policy regarding completing all sections of the medical evaluations.

11/5/2024- The HWD or designee will use a tracking system for use for three (3) months, to verify that medical evaluations are completed.

10/30 to assist with ongoing compliance – The HWD and or designee will audit a sample of six (6) resident medical evaluations monthly for three (3) months.

The ED or designee will review the results of these audits to verify compliance.

Licensee's Proposed Overall Completion Date: 12/30/2024

Supporting Documents: Record of staff training

Licensee's Proposed Overall Completion Date: 12/30/2024

141b1 - Annual Medical Evaluation

**8. Requirements**

2600.

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

**Description of Violation**

Resident #6's most recent medical evaluation was completed [REDACTED] and did not include anything for the residents height or weight.

Resident #7's most recent medical evaluation was completed [REDACTED]; the previous DME was completed [REDACTED]

141b1 - Annual Medical Evaluation (continued)

Repeat Violation: 10/11/23

Plan of Correction

Accept ( ) - 12/02/2024

8/30/2024 – The HWD reviewed and verified Resident # 6’s DME with PCP to verify accuracy of resident’s height and weight.

9/8/2024- An audit was conducted by the HWD or designee on current resident charts to verify all sections of the medical evaluation were completed. Medical evaluations not completed or not in compliance will be completed.

11/5/24- The ED retrained the HWD and direct clinical staff on the community policy regarding completion of all sections of the medical evaluations annually.

11/5/24- HWD or designee will use a tracking system for use for three (3) months, to verify that medical evaluations are completed.

10/30/24 to assist with ongoing compliance- The HWD and or designee will audit a sample of six (6) resident medical evaluations monthly for three (3) months to.

The ED or designee will review the results of these audits to verify compliance.

Licensee's Proposed Overall Completion Date: 12/30/2024

Supporting Documents: Record of staff training

Licensee's Proposed Overall Completion Date: 12/30/2024

142a - Secure Medical Care

9. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident’s health status declines. The home shall document the resident’s need for the medical care, including updating the resident’s assessment and support plan.

Description of Violation

Resident #11 sustained a head injury from an unwitnessed fall at [redacted] The home did not secure the resident medical care until the morning of [redacted] when the resident presented with a change of mental status. Resident #11 was found to have [redacted] from the fall and passed away on [redacted] The death certificate showed the cause of death was [redacted]

Plan of Correction

Accept ( ) - 12/02/2024

[redacted] - The HWD retrained staff on community policy and regulation regarding notification to the HWD or designee in the event of a resident's medical decline.

10/30/24- District Director of Clinical Services (DDCS) completed a random chart audit of six (6) resident charts to verify resident assessment and support plans are updated to reflect any change in resident's condition.

142a - Secure Medical Care (continued)

10/31/24- DDCS retrained HWD and ED on community policy including resident assessments and support plan documentation for a residents change in condition.

11/15 and Ongoing- HWD and or designee will audit a sample of six (6) resident's change in condition, assessments and support plans monthly for the next 3 months.

The ED or designee will review the results of these audits.

Licensee's Proposed Completion Date: 2/15/2025

Supporting documents: Record of staff training

Licensee's Proposed Overall Completion Date: 02/15/2025

183e - Storing Medications

10. 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 #1's Milk of Magnesia was in the cart with an expiration date of 7/2024.

Repeat violation: 10/11/23

Plan of Correction

Accept ( [redacted] ) - 12/02/2024)

8/28/24- Expired Milk of Magnesium immediately removed and discarded.

11/4/24- The HWD will retrain clinical staff regarding the community policy on removal and discarding of expired medications.

11/4/24 to assist with ongoing compliance- The HWD and or designee will complete weekly medication cart audits for three (3) months to verify expired medications are discarded.

The ED or designee will review the results of these audits.

Supporting documents: Record of staff training

Licensee Proposed Completion Date: 2/4/25

Licensee's Proposed Overall Completion Date: 02/04/2025

185a - Implement Storage Procedures

11. 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 #8's Medication Administration Record (MAR) notes a blood glucose reading of 110 on 8-26-24 at 6 00am, however there was no reading located in the resident's glucometer.

Resident #3's MAR notes a blood glucose reading of 163 on 8-27-24 at 11am, however there was no reading located

185a - Implement Storage Procedures (continued)

in the residents glucometer.

Resident #3 has a Pro Re Nata (PRN) order for Glucagon Emergency Injection Kit, 1 mg, which was not available at the time of the inspection. '

Resident #2 has a PRN order for Baqsimi Two Pack Nasal Powder 3mg dose (Glucogon), which was not available at the time of the inspection.

Resident #4 has a PRN order for Nitroglycerin Tablet Sublingual 0.4 mg, which was not available at the time of the inspection.

Repeat Violation: 10/11/23

Plan of Correction

Accept ( [redacted] - 12/02/2024)

9/18/2024 -The HWD retrained the direct clinical staff on the regulation and community policy for reordering medications and calibration of the glucometer machines.

11/6/2024 -The HWD recalibrated the glucometer to verify the correct date and time. The HWD conducted an audit on other glucometers and the readings were found in compliance.

11/6/2024 - HWD reordered the Glugacon Emergency Injection Kit 1mg for Resident #3, Baqsimi Two Pack Nasal Powder 3mg dose for Resident # 2 and Nitroglycerin Tablet Sublingual 0.4mg for Resident #4 from the pharmacy and received.

11/6/2024- The HWD retrained the direct clinical staff on the regulation and community policy regarding the process of reordering medications.

11/15/2024 to assist with ongoing compliance - HWD and or designee will complete weekly glucometer audits for three (3) months.

The ED or designee will review the results of these audits.

Supporting documentation: Records of staff attendance

Licensee Proposed Completion Date: 2/15/2025

Licensee's Proposed Overall Completion Date: 02/15/2025

187d - Follow Prescriber's Orders

12. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 has an order for blood glucose readings to be taken at 7am, 11am, 4pm, and 8pm. On 8-27-24, the 7am blood glucose reading was taken at 331am, and recorded on the MAR at 7am.

Resident #3's blood glucose reading was not completed on 8-27-24 at 11am.

187d - Follow Prescriber's Orders (continued)

Resident #8's glucometer indicates a blood glucose reading of 97 at 1:56am on 8-16-24. However, the resident is prescribed to have blood glucose readings at 6am.

Resident #8's glucometer indicates a blood glucose reading of 34 at 4:56am on 8-12-24. However, the resident is prescribed to have blood glucose readings at 6am.

Resident #8's blood glucose reading was not completed on 8-26-24 at 6 00am.

Plan of Correction

Accept (█ - 12/02/2024)

9/18 /2024 – Direct clinical staff were retrained on the regulation and community policies and procedures regarding following the directions of a prescriber. The HWD retrained direct clinical staff to verify that the time of a glucose meter reading/administration is to be completed as per community policy. When a reading is not obtained within the community policy the clinical staff must notify the HWD or designee and prescriber.

11/15/2024 to assist with ongoing compliance - HWD and or designee will complete weekly glucometer audits to verify readings, times and administration of insulin for three (3) months.

The ED or designee will review the results of these audits.

Licensee Proposed Completion Date: 1/15/25

Supporting documentation: Records of staff attendance

Licensee's Proposed Overall Completion Date: 01/15/2025

231b - Medical Evaluation

13. 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 #10 resides in the home's Secure Dementia Care Unit (SDCU). The resident's current DME dated █ does not indicate the need for the resident to be served in the SDCU.

Resident #5 resides in the Secure Dementia Care Unit since █. The residents most recent DME dated █ does not include a diagnosis of Alzheimer's disease or other dementia.

Plan of Correction

Directed (█ - 12/10/2024)

11/6/2024- The HWD retrained the direct clinical staff on the community policy and regulation for DME completion prior to admission and annually to indicate the resident's diagnosis and need to be in a Secured Dementia Care Unit. (SDCU).

231b - Medical Evaluation (continued)

11/8/2024- The HWD and or designee will complete a sample audit of six (6) SDCU residents to verify the DME indicates the resident's diagnosis and need to be in a SDCU.

11/15/2024- To assist with ongoing compliance, the HWD or designee will review required admission move-in documents to the SDCU, weekly for three (3) months. HWD or designee will provide a final review.

ED or designee will review the audit results.

Licensee's Proposed Overall Completion Date: 2/15/2025

Supporting documentation: staff training attendance

Proposed Overall Completion Date: 02/15/2025

**(Directed)**

**The Administrator will audit all Documentation of Medical Evaluations (DME's) for current residents residing in the homes Secured Dementia Care Unit (SDCU) for accuracy and completion. Any DME's found out of compliance will be corrected. The Administrator will review all new DME's completed for residents residing in the SDCU for 3 months.**

Directed Completion Date: 01/08/2025

231c - Preadmission Screening

14. 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 #9 was admitted to the home's SDCU on [REDACTED] The home did not complete a cognitive preadmission screening within 72 hours of the resident moving into the homes SDCU.

Plan of Correction

Accept [REDACTED] - 12/02/2024)

11/6/2024- The HWD retrained the direct clinical staff on the community policy regarding cognitive prescreen completion prior to admission to Secured Dementia Care Unit. (SDCU).

11/8/2024 The HWD or designee will complete a sample audit of six (6) pre-admission screening forms for current residents in the SDCU.

11/15/2024- To assist with ongoing compliance, the HWD or designee will review required admission move-in documents to the SDCU for three (3) months. HWD or designee will provide a final review.

ED or designee will review the audit results.

Licensee's Proposed Overall Completion Date: 2/15/2025

Supporting documentation: staff training attendance

Licensee's Proposed Overall Completion Date: 02/15/2025

