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

January 7, 2025

EMERITUS CORPORATION

RE: BROOKDALE GRANDON FARMS
1100 GRANDON WAY
MECHANICSBURG, PA, 17055
LICENSE/COC#: 31612

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/03/2024, 12/04/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE GRANDON FARMS* **License #**: *31612* **License Expiration**: *01/17/2025*

Address: *1100 GRANDON WAY, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *EMERITUS CORPORATION*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/15/2005* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *103* **Waking Staff**: *77*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/04/2024*

Inspection Dates and Department Representative

12/03/2024 - On-Site:

12/04/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Clare Bridge* **Capacity**: *30* **Residents Served**: *23*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

12/03/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/26/2024*

12/30/2024 - POC Submission

Submitted By: **Date Submitted**: *01/06/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/03/2025*

Inspections / Reviews *(continued)*

01/02/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *01/06/2025*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *01/07/2025*

01/07/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *01/06/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarms Standards Act, Carbon Monoxide (CO) alarms must be installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On 12/3/24, the main laundry room was found to have two gas-powered commercial dryers; there was no CO detector/alarm observed.

Plan of Correction ***Accept - 12/30/2024)***

On 12/3/2024, The Maintenance Director immediately corrected and placed a carbon monoxide detector within 15 feet of the gas operated dryers.
On 12/5/2024- The Executive Director retrained the maintenance team in regards to Carbon Monoxide Alarms Standards.
Starting on 12/5/2024, The Maintenance Director will do weekly checks for 2 months to ensure compliance and ending on 2/5/2025.
Ongoing- The Maintenance Director will do random checks to ensure compliance and will review any compliance issues with the Executive Director.
To assure ongoing compliance the Executive Director will review checks for compliance.
We are asking for this to be withdrawn- immediately corrected on site.

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

Implemented - 01/07/2025)

81b - Resident Personal Equipment

2. Requirements

2600.
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 utilizes an enabler bar. On , the enabler bar was partially covered with an opening measuring 13 inches by 7 inches and was not secured to the bedframe posing potential entrapment and fall hazards.

Plan of Correction ***Directed (CR - 01/02/2025)***

12/4/2024- The Maintenance Assistant immediately looked at the enabler bar and secured it to the frame and covered the opening.
12/5/2024- The executive retrained the all staff on the importance of the enable bar securement and openings.
12/5/2024 The maintenance assistant did an audit of all rooms for enabler bars and were found to be on compliant.
Ongoing- starting on 12/5/2024 any enabler bar that is new the Maintenance Director will evaluate and make sure for securement and openings are covered.
To assist with ongoing compliance when any new enabler bar is warranted, the Executive Director will ensure compliance when needed. For continue compliance, the Executive Director will do random checks of all current

81b Resident Personal Equipment (continued)

enable bars in the home to ensure they are needed and are compliant.

(Directed)
In addition to the above plan of correction, beginning no later than 1/5/25, the Administrator or designee will complete monthly audits of all bedside mobility devices in the home to ensure they remain properly secured and covered. Documentation of completed audits and staff education will be kept by the home and available for review by the Department.

Directed Completion Date: *01/05/2025*

Implemented [redacted] - 01/07/2025)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted], Resident [redacted] bedroom had an odor of urine.

Plan of Correction ***Accept [redacted] 12/30/2024)***

12/5/2024 The housekeeper immediately cleaned room [redacted] to remove any odor from the room.
ON 12/5/2024 The Executive Director retrained the direct care staff and housekeeping regarding the community policy on maintaining a clean environment and reporting when a room has a smell of urine are identified.
12/5/2024 The Maintenance Assistant audited the [redacted] hall for any odor from any rooms and were found to be compliant.
12/7/2024 The Maintenance Director or designee will audit the [redacted] hall for any odors, to occur weekly starting on 12/7/2024 for 2 months ending on 2/7/2025.
To assist with ongoing compliance, The Executive Director or designee will review the audits starting 12/07/2024 and ending on 2/7/2025 to ensure compliance.

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

Implemented [redacted] - 01/07/2025)

89b - Hot Water Temperature

4. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On [redacted] at 10:05 AM, the hot water temperature in the bathroom of Resident [redacted] measured 132.8 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 01/02/2025)***

Immediately on 12/4/2024, The regional nurse spoke with the regional Maintenance Director and adjusted the mixing valve and determined that there was no other areas of concern.
ON 12/5/2024 The Executive Director retrained the appropriate maintenance staff regarding the community

89b - Hot Water Temperature (continued)

policy on hot water temperature control in resident's rooms.
Ongoing- The Maintenance Director or designee will audit hot water temperatures weekly X1 week starting on 12/5/2024 then monthly thereafter. The log used for documentation was updated on 12/5/2024 by the Maintenance Director with temperature range parameters noted for compliance.
To assist with ongoing compliance, The Executive Director or Designee will review the audit weekly for 3 months to verify compliance starting on 12/5/2024.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented (- 01/07/2025)

101o - Walls, Floors, Ceilings

5. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On Resident bedroom floor was observed to be heavily stained and covered in debris.

Plan of Correction ***Accept - 01/02/2025)***

On 12/5/2024, The Maintenance assistant vacuumed the carpet then shampooed the carpet in room
Resident's apartments on the hall were audited by the Maintenance Director for stains and additional cleaning, stains identified were addressed by the maintenance assistant.
On the 12/5/2024- The Executive Director retrained the the direct care staff regarding the community policy on maintaining a clean environment and reporting when the carpet stains are identified. A reminder in the TELS (Electronic Maintenance Application) has been include carpet cleaning,
12/5/2024- The Maintenance Director or designee will establish an audit schedule of the 500 hall apartments for any carpet stains, to occur monthly for 2 months using the Common Area Audit form ending on 2/5/2025. Random audits will be completed as indicated.
12/30/2024- The Maintenance Director did audit of all apartments and found all other apartments to be compliant. The Maintenance Director will do random audits to all apartments for 2 months starting on 12/30/2024 and ending on 2/28/2025.
12/5/2024- To assist with ongoing compliance, The Executive Director or designee review the audits monthly to see further action is warranted for 2 months ending on 2/5/2024.
12/30/2024- The assist with ongoing compliance, The Executive Director will review audits weekly of all apartments for 2 months to ensure compliance ending on 2/28/2025.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented 01/07/2025)

183a - Original Containers and Injections

6. Requirements

183a - Original Containers and Injections *(continued)*

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On [redacted] a blue pill box containing various pills belonging to Resident [redacted] was observed in the [redacted] Hall medication cart.

Plan of Correction ***Accept [redacted] - 01/02/2025)***

On 12/4/2024- The blue pill box was immediately removed from the [redacted] hall cart by The Health and Wellness Director.
On 12/5/2024, the appropriate clinical staff was retrained by the Executive Director on the community policy and storing of medication in its original container.
12/5/2024-The Health and Wellness Director completed an audit of med carts which were found in compliance.
12/5/2024- The Health and Wellness Director or designee will do weekly med cart audits starting on 12/5/2024 for 2 months and ending on 2/5/2024 then monthly thereafter.
To assist with ongoing compliance The Executive Director or designee will review the med cart audits weekly and review the results for 2 months ending on 2/5/2025.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented ([redacted] - 01/07/2025)

183b - Meds and Syringes Locked

7. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted] at 9:30 AM, a ½ fluid oz bottle of [redacted] was observed on a table in Resident [redacted] bedroom. Resident [redacted] is not assessed to self-administer medications.

Plan of Correction ***Directed [redacted] - 01/02/2025)***

ia12/4/2024- The bottle of [redacted] was immediately removed by the Health and Wellness Director.
12/5/2024 Current staff were retrained on prescription medications that they shall be kept in an area or container that is locked.
Ongoing- The Health and Wellness Director or designee will do weekly cart audits and starting on 12/5/2024 to verify compliance ending on 2/5/2025. Random audits will be completed as indicated.
On 12/30/2024- The Health and Wellness or designee will perform bedroom audits for 2 months ending on 2/28/2024
To assist with ongoing compliance, The Executive Director or designee will review audits for 2months to verify compliance ending on 2/5/2025.
On 12/30/2024- The Health and Wellness Director did an initial audit of all resident's room and found no other medications in any rooms.

183b - Meds and Syringes Locked (continued)

(Directed)
In addition to the above plan of correction, beginning on 12/30/24, the Health and Wellness Director or designee will complete weekly bedroom audits for 2 months. Documentation of completed audits and staff education will be kept by the home and available for review by the Department.

Directed Completion Date: *01/02/2025*

Implemented (- 01/07/2025)

183d - Prescription Current

8. 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

On a and wound and burn dressing, prescribed for Resident was a observed in the Hall Medication Cart. Resident has not resided in the home since .

On , a bottle of prescribed to Resident , was observed in the Hall Medication Cart. However, this medication was discontinued on

On , , prescribed for Resident was observed in the SDCU Medication Cart. However, this medication was discontinued on .

Plan of Correction ***Accept - 01/02/2025)***

12/4/2024- The Health and Wellness Director immediately removed discontinued medications and any medications that did not belong in the cart.
12/5/2024-The Health and Wellness Director did an audit of current medications in the medication carts and verified medications were active when comparing them with the MAR and medications in the cart.
12/5/2024-The Executive Director retrained the appropriate clinical staff on the company policy on the discontinued medications.
12/5/2024- Ongoing- The Health and Wellness Director will do weekly audits of all discontinued medications of residents that no longer live in the home and discontinued by the physician starting on 12/5/2024 to verify compliance for 2 months ending on 2/5/2025, then monthly thereafter.
To assist with ongoing compliance the Executive Director will review audits for 2 months starting on 12/5/2024 to verify compliance ending on 2/5/2025.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented - 01/07/2025)

184b - Labeling OTC/CAM

9. Requirements

2600.

184b - Labeling OTC/CAM *(continued)*

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted] a bottle of [redacted] and a bottle of generic brand [redacted] were found in a resident's "bin" in the SDCU Medication Cart. However, these bottles were not labeled with a resident's name.

On [redacted], a bottle of [redacted] was found in the [redacted] Hall Medication Cart. However, the bottle was not labeled with a resident's name.

Plan of Correction ***Accept [redacted] - 01/02/2025)***

12/5/2024- Immediately the medication technician labeled the medication on the SDCU cart and [redacted] hall with the resident's name that was found in the violation.
12/5/2024- The Health and Wellness Director did and audit of OTC medications to verify medications were properly labeled with the resident's name and were found to be compliant.
12/5/2024- The Executive Director retrained the appropriate clinical staff on OTC medications and identifying with the resident's name,
12/5/2024- Ongoing- The Health and Wellness Director will do weekly med cart audits starting on 12/5/2024 for 2months ending on 2/5/2025 and then monthly thereafter.
To assist with ongoing compliance, The Executive Director will review the results of the audits to determine if any further action is warranted, Random audits will be performed as indicated.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented [redacted] 01/07/2025)

185a - Implement Storage Procedures

10. 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 [redacted] is prescribed [redacted] as needed. On [redacted], this medication was not available in the home.

Repeat Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 12/30/2024)***

12/5/2024- The Executive Director called the pharmacy to obtain the PRN [redacted] and the pharmacy stated that the medication would be delivered on 12/5/2024.
12/5/2024- Executive Director the appropriate Clinical staff on the community policy regarding the availability of prn medications.
12/5/2024- Ongoing- The Health and Wellness Director or designee will perform weekly med cart audits for 2 Months to verify PRN medications are available for the residents medications as ordered by the physician ending on 2/7/2025 then monthly thereafter.

185a Implement Storage Procedures (continued)

To assist with ongoing compliance, the Executive Director will review the results of the audits to determine if any further action is warranted. Random audits will be performed as indicated.

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

Implemented - 01/07/2025)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
8. Frequency of administration.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident is prescribed aplet take 2 tablets by mouth every 6 hours as needed for pain. However, Resident November 2024 Medication Administration Record states "Mapap Tablet) Give 1 tablet by mouth every 4 hours as needed for fever".

Plan of Correction ***Accept - 01/02/2025)***

12/5/2024 The Health and Wellness Director immediately corrected the order for resident . Resident MAR was updated to reflect the correct order.
12/30/2024 the Executive Director trained the appropriate clinical staff and medication technicians on medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
8. Frequency of administration.
12. Diagnosis or purpose for the medication, including PRN.
12/5/2024 The Health and Wellness director did an audit of all resident's MARS to verify compliance and no other MARS were found to be incorrect.
12/5/2024 The Executive Director retrained the appropriate clinical staff and medication technicians on the process of reordering medications and having them available.
12/6/2024 A med cart audit review was completed by the Health and Wellness Director and med tech that current meds were available and compared the resident's EMAR and were found in compliance.
12/11/2024 Ongoing An audit of proper medications available will be implemented to review and track availability matching the documentation with the EMAR. This will be completed by the Health and Wellness Director or designee for 2 months ending on 2/11/2025.
12/11/2024 To assist with ongoing compliance, The Executive Director will review the results of the audit to determine if any further action is warranted. Random audits will be performed as indicated.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented (- 01/07/2025)

187d - Follow Prescriber's Orders

12. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] -give 1 tablet by mouth in the evening for supplement. However, this medication was not administered to Resident [redacted] on [redacted] because the medication was not available in the home.

Repeat Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 01/02/2025)***

12/5/24- Executive Director notified the pharmacy to have the medications that weren't available to be delivered on 12/6/2024.
12/6/2024- The Executive Director retrained the appropriate clinical staff and the medication technicians on the process of reordering medications and having them available.
12/6/2024- A med cart audit review was completed by the Health and Wellness Director and med tech that all meds were available and compared the resident's EMAR and the remainder were found in compliance.
12/11/2024- An audit of current medications available will be implemented to review and track availability matching the documentation with the EMAR. This will be completed by the Health and Wellness Director or designee weekly for 2 months ending on 2/11/2025.
12/11/2024- To assist with ongoing compliance this process will be reviewed weekly by the Executive Director for 2months ending on 2/11/2025 and then monthly thereafter. Random audits will occur as indicated

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented [redacted] - 01/07/2025)

225a - Assessment 15 Days

13. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The assessment and support plan for Resident [redacted], dated [redacted], indicates that the resident has a need for a HALO bar. The assessment does not reflect the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, nor correct identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept [redacted] - 01/02/2025)***

[redacted] - Resident [redacted] was assessed by the Health and Wellness Director as to their need for the bedside mobility device. The Health and Wellness and designee audited the other Halo devices in the community and those were

225a Assessment 15 Days (continued)

found in compliance.
12/6/2024 The appropriate management and clinical staff were retrained by the Executive Director regarding the community policy on bedside mobility devices. The need for the devices and The Health and Wellness Director was educated on what is needed for the rasp.
On 12/6/2024 The support plan for resident 1 was updated to reflect the required documentation and protocol for bedside mobility devices in the Personal Service plan.
Ongoing starting 12/6/2024 The Health and Wellness Director or designee will continue to monitor appropriateness of any bedside mobility devices in use as they are initiated and ensure that it is included in their rasp, then according to the community policy monthly for the appropriateness for 2 months or with change of resident condition ending on 2/6/2025, then Quarterly thereafter.
12/30/2024 The Health and Wellness did an audit of all rasp's for current enabler bars and ensure that they are updated with their current need for device, risk involved, ability to use the device and . All other devices were found compliant with regulations.
To assist with ongoing compliance, The Executive Director will monitor the results for compliance to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented ██ - 01/07/2025)