pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CREEK SENIOR CARE LLC**
LEGAL ENTITY

To operate **THE BRIDGES AT BENT CREEK**
NAME OF FACILITY OR AGENCY

Located at **2100 BENT CREEK BOULEVARD, MECHANICSBURG, PA 17050**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **130**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 31**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 12, 2023** until **September 12, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333550**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: SEPTEMBER 12, 2023

Creek Senior Care LLC
[redacted]

RE: The Bridges at Bent Creek
License #: 33355

Dear to whom it concerns:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on July 6th, 2023, and July 7th, 2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
<Licensing Inspection Summaries>

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

August 31, 2023

[redacted]
CREEK SENIOR CARE LLC
[redacted]

RE: THE BRIDGES AT BENT CREEK
2100 BENT CREEK BOULEVARD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33355

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/06/2023, 07/07/2023 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: *THE BRIDGES AT BENT CREEK* **License #**: *33355* **License Expiration**: *08/07/2023*

Address: *2100 BENT CREEK BOULEVARD, MECHANICSBURG, PA 17050*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CREEK SENIOR CARE LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/03/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *07/07/2023*

Inspection Dates and Department Representative

07/06/2023 - On-Site: [redacted]

07/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *62*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Gardens* **Capacity**: *31* **Residents Served**: *16*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

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

Have Mobility Need: *30* **Have Physical Disability**: *1*

Inspections / Reviews

07/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/23/2023*

07/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/02/2023*

Inspections / Reviews *(continued)*

08/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/01/2023*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 07/06/2023 a copy of the PA Chapter 2600 Regulations was not posted in a conspicuous and public place in the home.

Repeat Violation- 09/12/2022

Plan of Correction ***Accept [redacted] - 07/26/2023)***

The Chapter 2600 Regulations were posted immediately on 7/6/23. (See attachment) Executive Director or designee will monitor weekly to ensure the Chapter 2600 Regulations are posted in a conspicuous and public space and documented weekly. (See attachment). Weekly documentation will be reviewed during monthly QA meetings until 12/31/23.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/31/2023)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 07/06/2023, there was no thermometer in the freezer section of the refrigerator located in the "Bistro Area" of the Home.

Plan of Correction ***Accept ([redacted] - 07/26/2023)***

On 7/6/2023, a thermometer was placed in the freezer section of the refrigerator located in the Bistro Area. (See attachment 7) Executive Director or Designee will monitor weekly to ensure the thermometer is placed in the freezer/refrigerator in the Bistro Area. (See attachment 8) Documentation to be reviewed at the monthly QA meeting until12/31/2023.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ([redacted] - 08/31/2023)

107d - Procedure Emergency Management Agency Submission

5. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The Home's Emergency Preparedness Procedure is updated annually. However, the Home has not submitted their updated Emergency Preparedness Procedure to the local Emergency Management Agency (EMA) since 08/09/2021.

107d - Procedure Emergency Management Agency Submission *(continued)*

Plan of Correction ***Accept [redacted] - 07/26/2023)***

The Homes Emergency Preparedness Procedure was forwarded to the Local EMA on 7/8/2023. (See attachment 9) Executive Director will ensure the Emergency Preparedness Procedure is forwarded to the Local EMA on a yearly basis. Emergency Preparedness Procedure to be reviewed at the monthly QA to ensure yearly submission. to the Local EMA.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ([redacted] - 08/31/2023)

121a - Unobstructed Egress

6. 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

On 07/06/2023, during the initial walk through of the Secure Dementia Care Unit (SDCU), Representatives of the Department observed an unattended housekeeping cleaning cart obstructing the emergency exit located next to resident room 174.

Plan of Correction ***Accept [redacted] - 07/26/2023)***

On 7/6/2023 the housekeeping cart located by Apartment 174 exit was relocated away from the exit immediately. All housekeeping staff trained on 7/10/2023 by the Director of Maintenance to ensure the housekeeping carts are not obstructing any emergency exits at any given time. (See attachment 10) Executive Director or Designee will complete random audits 5x weekly for 12 weeks to monitor egress obstructions. (See attachment 11) Audits to be reviewed monthly during QA until 12/31/2023.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/31/2023)

132d - Evacuation

7. 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

During the fire drill on 06/20/2023 at 5:05 am, there were 61 residents in the home. However, only 25 residents were evacuated.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

On 7/18/2023 10:30pm to 6:30am staff were trained on proper fire evacuation when the fire alarms sound in the building. (See attachment 12) Director of Maintenance or Designee to ensure all residents are evacuated to the fire safe areas during monthly fire drills within the allotted time period provided by the Fire Expert. Monthly Fire Drills to be reviewed at monthly QA meetings.

132d - Evacuation *(continued)*

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/31/2023)

181c - Self-administration Assessment

8. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On 07/07/2023, a bottle of Tums Antacids was observed in Resident 8's bathroom. However, Resident 8 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability keep and to self-administer medications.

Plan of Correction ***Accept [redacted] - 07/28/2023)***

On 7/7/2023 Resident 8 was educated on the need to have all medications administered by the appropriate trained staff. The bottle of Tums was removed from Resident 8 bathroom. Resident 8's [redacted] was notified to ensure appropriate trained staff receive any medications needing administered to Resident 8. Nursing contacted Resident 8; s physician and received an order to administer Tums PRN. (See attachment 13) Housekeeping will monitor resident apartments weekly for any medications in apartments and notify nursing. (See attachment 14) Weekly monitoring to be reviewed at monthly QA meeting.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/31/2023)

183b - Meds and Syringes Locked

9. 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 07/06/2023 at 10:25 am, Resident 1's Nystatin Topical Powder was observed unattended and accessible on top of one of the med carts located on the first floor of the home.

Repeat Violation- 07/28/2022

Plan of Correction ***Accept [redacted] - 07/28/2023)***

On 7/6/2023 the Nystatin Topical Powder was removed from the top of the medication cart and placed securely into the medication cart by medication technician. Medication Technician was educated on the importance of securing all medications in the locked medication cart when not physically present at the medication cart. (See attachment 15) Director of Wellness or Designee to conduct random daily observation of the medication cart to ensure no

183b - Meds and Syringes Locked (continued)

medications are left unattended on top of the medication cart. (See attachment 16)

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/31/2023)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident 7 is prescribed Buspirone 5mg tablet daily. However, resident did not receive medication on 06/17/2023 as it was not available in the home.

Resident 6 is prescribed Rivastigmine DIS 9.5mg/24 patch for dementia. However, resident was administered 4.5mg/24 during the month of June.

Repeat Violation- 09/12/2022, 11/15/2022

Plan of Correction ***Accept [redacted] - 07/28/2023)***

Resident 7 prescribed Buspirone 5mg tablet daily was received by the home and administered per physician orders as of 6/18/2023.
Resident 6 prescribed Rivostigmine DIS 9.5mg/24 patch for dementia was identified.
All medication technicians were retrained on 7/18/2023 and 7/20/2023 by the Director of Wellness on proper medication administration in regard to ensuring the 7 Rights, medication re-order process, and documentation and process to follow when a medication is not available to administer to a resident. (See attachment) Director of Wellness or designee to monitor Missed Medications in electronic medication administration record, eMAR system to ensure proper documentation for any missed medications on a daily basis. (see attachment) Missed medications audits to be reviewed at monthly QA meeting until 12/31/2023.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 08/31/2023)

227b - Support Plan Content

14. Requirements

2600.
227.b. A home may use its own support plan form if it includes the same information as the Department's support plan form.

Description of Violation

The home does not use the Department's support plan form. The home's support plan does not include if the resident is able to safely use and avoid poisonous materials. This is reflected in Resident 3's support plan dated 03/23/2023, and Resident 4's support plan dated 06/16/2023.

Plan of Correction ***Accept [redacted] - 07/28/2023)***

The home connected with the Regional Nursing Director and discovered that the company's assessment can be converted and printed in the Departments support plan, RASP, which does indicate the president's ability to safely use and avoid poisonous materials for Resident 3 and Resident 4. (See attachments) Director of Wellness printed

227b - Support Plan Content (continued)

the current RASP from the company system for each resident and placed in resident's chart. Monthly assessment. RASP, audits to be reviewed at monthly QA meeting until 12/31/2023.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 08/31/2023)

227g -Support Plan Signatures

16. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 2 participated in the development of [redacted] support plan dated 09/07/2022. However, the resident did not date the support plan.

Resident 3 participated in the development of [redacted] support plan dated 03/23/2023. However, the Resident and assessor did not sign and date the support plan till 06/05/2023.

Resident 5 participated in the development of his/her support plan dated 10/17/2022. However, the resident did not date the support plan.

Repeat Violation- 09/12/2022, 11/15/2022

Plan of Correction ***Accept [redacted] - 07/28/2023)***

Director of Wellness completed a complete resident chart audit on 7/19/2023 and reviewed all current resident support plans to ensure the residents who participated in the development of the support plan signed and dated the support plan. (See attachment) Director of Wellness or Designee to conduct monthly resident chart audits of support plans to ensure those residents who participate in the development of the support plan sign and date the support plan. Monthly support plan audits to ensure residents have signed and dated support plans to be reviewed at monthly QA meeting until 12/31/2023.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented [redacted] - 08/31/2023)

231f - Assessed Annually

17. Requirements

2600.
231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident 7's Assessment and Support Plans dated 04/06/2023 and 10/13/2022 have no documentation regarding the resident's need for continued secure dementia care.

Plan of Correction ***Accept [redacted] - 07/28/2023)***

Resident 7's assessment and support plans dated 4/6/2023 and 10/13/2023 were reviewed and amended by the Director of Wellness as well as reviewed with Resident 7 to reflect the residents need for continued secure dementia care. (See attached) Director of Wellness completed a complete resident chart audit on 7/19/2023 including

231f - Assessed Annually (continued)

ensuring residents residing in the secured dementia care unit have the need for continued secure resident care indicated on the assessment and support plans. Monthly SDCU resident chart audits to be completed and then reviewed during the monthly QA meeting until 12/31/2023.

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 08/31/2023)