Department of Human Services
Bureau of Human Service Licensing

February 16, 2022

CREEK SENIOR CARE LLC
1000 LEGION PLACE, SUITE 1600
ATTN
ORLANDO, FL, 32801

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

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 09/21/2021, 09/22/2021, 09/23/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *THE BRIDGES AT BENT CREEK* **License #**: *33355* **License Expiration**: *10/31/2022*

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

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

Administrator

Name: **Phone**: *7177951100* **Email**:

Legal Entity

Name: *CREEK SENIOR CARE LLC*

Address: *1000 LEGION PLACE, SUITE 1600, ORLANDO, FL, 32801*

Phone: *7177951100* **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/16/2011* **Issued By**: *Silver Spring Township*

Type: *C-2 LP* **Date**: *01/03/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *09/23/2021*

Inspection Dates and Department Representative

09/21/2021 - On-Site:

09/22/2021 - On-Site:

09/23/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Gardens* **Capacity**: *31* **Residents Served**: *28*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *26* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *33* **Have Physical Disability**: *1*

Inspections / Reviews

09/21/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/11/2021*

02/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/04/2022*

26a - Quality Management Plan

1. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The most recent quality management review was conducted on 7/7/2020.

Plan of Correction ***Directed***

Education was given to the directors regarding the quality management plan, and a quality management plan meeting was held on 11/7/2021. New administrator and wellness director was educated on regulation 2600.26a,b.
Person responsible: Executive Director or designee

Directed -
Quality Management training was provided to administrator and wellness director on 9/30/21. - [redacted] 2/16/22

Completion Date: *11/07/2021*

60b - Additional Staffing

1. Requirements

2600.
60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

On Thursday 9/9/21, from 10:30 PM until 5:00 AM, the home was staffed with three staff persons, one nurse and two resident assistants, and from 5:00 AM until 6:30 AM on 9/10/21 only one nurse and one resident assistant. There are currently 88 residents in the home, 34 of whom are immobile and unable to evacuate the building without total assistance. Based on the size and layout of the building the staffing provided is not adequate to meet the needs of the residents in the event of an emergency evacuation.

Plan of Correction ***Directed***

Staffing requirements for fire safety were reviewed with each department head (see attachment). Staffing patterns were adjusted to support this requirement (see attachment).
Person responsible: Executive Director, Wellness Director or their designee
Date addressed: 9/30/2021

Directed -
The administrator will review staffing schedules weekly beginning 2/21/22 to ensure sufficient staff are present to assist residents in the event evacuation is required. [redacted] - 2/16/22

Completion Date: *12/10/2021*

82c - Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

The cleaning products OT-TB cleaner/deodorizer and TB-Cide Quat cleaner/deodorizer/disinfectant were unlocked and accessible in the closet across from Room #157 in the secured dementia care unit. The manufacturer's label for both of these products indicate, "call poison control."

Plan of Correction ***Accept***

Staff were educated on the need for poisonous materials to be locked up (see attachment). Memory Care Director checked daily for a week, weekly for a month, and it is now checked monthly. See attached signature sheet.
Person responsible: Memory Care Director, med tech or designee
Addressed 10/7/2021 and ongoing

Completion Date: *10/07/2021*

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

The glucometer for Resident #1 was used to test the blood glucose level of another resident. The glucometer for Resident #1 recorded a blood sugar level of 181 on 9/16/21 at 9:11 AM which is not listed on the medication administration record for Resident #1 as the reading was for Resident #2.

Plan of Correction ***Directed***

All med techs and nurses were in serviced on the importance of not sharing glucometers. Stock glucometers were ordered to have at the ready in the event a glucometer was inadvertently shared.
Person responsible: Wellness Director or designee
Addressed 10/7/2021

Directed -
Beginning 2/21/22, the administrator will audit a sample of glucometers and MARs weekly to ensure staff are not sharing glucometers and are administering and documenting insulin per prescriber's orders. [redacted] - 2/16/22

Completion Date: *10/07/2021*

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

1. Requirements

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface *(continued)*

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, hand rail or assist bar at the toilet in the first stall of the Women's restroom near the mailboxes.

Plan of Correction ***Accept***

A grab bar was installed in the ladies room stall referenced. An audit of the restrooms was completed to ensure no other grab bars were missing. (See attached photo).
Person responsible: Director of Engineering or designee
Addressed 10/7/2021

Completion Date: *10/07/2021*

141a 1-10 Medical Evaluation Information

1. Requirements

2600.
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

The most recent medical evaluation for Resident #5 did not include the resident's blood pressure, weight, temperature, pulse rate and the date the resident was evaluated.
The most recent medical evaluation for Resident #6 did not include the resident's pulse rate, blood pressure, temperature and the date the resident was evaluated.

Plan of Correction ***Directed***

All care staff were in serviced on the need for an annual medical evaluation and what needs to be on the DME. A chart audit was completed and adjustments made to how reminders to staff about annual medical evaluations are handled to ensure that timely appointments are made.
Person responsible: Wellness Director or designee
Addressed 10/7/2021

Directed -
Beginning 2/21/22, the administrator will audit all new medical evaluations upon completion to ensure the

141a 1-10 Medical Evaluation Information (continued)

required information is present. ████ - 2/16/22

Completion Date: *10/07/2021*

171b5 - First Aid Kit

1. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the 2019 Ford Bus, used to transport residents, does not include scissors, tweezers, a thermometer, a CPR breathing shield and eye coverings.

Plan of Correction ***Accept***

A complete first aid kit was placed in the vehicle on 10/4/2021, and the first aid kit was added to the monthly and daily safety checklist driver is to complete prior to driving to ensure all required items are present. Drivers and maintenance staff in serviced regarding first aid kit (see attached).
Person responsible: Director of Engineering or designee to review safety check list
Addressed 9/27/2021 through 10/4/2021 and ongoing

Completion Date: *10/07/2021*

183e - Storing Medications

1. 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

The Levemir Flextouch insulin for Resident #8 was not marked with the date opened to determine the expiration date in accordance with the manufacturer's instructions.

Two loose pills, 1 round, white tablet and one small salmon-colored tablet, were found in Medication Cart #2.

Plan of Correction ***Directed***

All care staff were in serviced on the need for medications to be stored securely, with appropriate opening date, expiration date, and initials (see attached). Cart audits are done routinely to ensure that this is taking place (see attached).
Person responsible: Wellness Director or designee
Addressed 10/7/2021 and ongoing

Directed -

183e - Storing Medications (continued)

Cart audits began 11/24/21 and will be completed weekly going forward. NSC - 2/16/22

Completion Date: *10/07/2021*

185a - Implement Storage Procedures

1. 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

On 9/12/21 at 7 AM, the blood glucose reading recorded on the glucometer of Resident #8 was 115. The reading was incorrectly recorded in the resident's medication administration record (MAR) as 116.
On 9/18/21 at 8 PM, the blood glucose reading recorded on the glucometer of Resident #9 was 142. The reading was incorrectly recorded in the resident's MAR as 149.
The MAR for Resident #9 has a blood glucose reading of 192 recorded for 9/14/21 at 4:30 PM. The glucometer for Resident #9 does not have that reading recorded.

Plan of Correction ***Directed***

All med techs and nurses were inserviced on the importance of not sharing glucometers. Stock glucometers were ordered to have at the ready in the event the resident's glucometer is faulty or non-operable. Staff were also in serviced on the importance of accurately recording all glucometer readings (see attached).
Person responsible: Wellness Director or designee
Addressed 10/7/2021 and ongoing

Directed -
Beginning 2/21/22, the administrator will audit a sample of glucometers and MARs weekly to ensure staff are not sharing glucometers and are administering and documenting insulin per prescriber's orders. [redacted] - 2/16/22

Completion Date: *10/07/2021*

225a - Assessment 15 Days

1. 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

Resident #1 was admitted on [redacted] however, the resident's assessment was not completed until [redacted]
Resident #3 was admitted on [redacted] however, the resident's assessment was not completed until [redacted]
Resident #4 was admitted on [redacted] however, the resident's assessment was not completed until [redacted]

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept***

All care staff were in serviced on the need for an assessment to be completed within 15 days (see attached). A chart audit was completed and adjustments were made to how staff is notified of an incomplete evaluation. (See attached photo)
Person responsible: Wellness Director or designee
Addressed 10/7/2021 through 1/9/2022

Completion Date: *01/09/2022*

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #5's most recent assessment was completed on
Resident #6's most recent assessment was completed on

Plan of Correction ***Accept***

All care staff were in serviced on the need for an assessment to be completed annually (see attached). A chart audit was completed and adjustments were made to how staff is notified of an incomplete assessment. (See attached photo).
Person responsible: Wellness Director or designee
Addressed 10/7/2021 and ongoing

Completion Date: *01/09/2022*

227a - Support Plan 30 Days

1. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on however, the resident's support plan was not completed until
Resident #3 was admitted on however, the resident's support plan was not completed until
Resident #4 was admitted on however, the resident's support plan was not completed until 7/14/21.

Plan of Correction ***Accept***

All care staff were in serviced on the need for a care plan to be implemented within 30 days (see attached training). A chart audit was completed and adjustments made to how staff is notified of an incomplete RASP (see attached photo).

227a - Support Plan 30 Days (continued)

Person responsible: Wellness Director or designee
Addressed 10/7/2021

Completion Date: *10/07/2021*

227d - Support Plan Medical/Dental

1. 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

The Resident Assessment and Support Plan (RASP) for Resident #7, dated [redacted] indicates the resident has non-insulin dependent Diabetes. The resident is prescribed sliding scale insulin for the treatment of their Diabetes.

Plan of Correction ***Accept***

The incorrect information was addressed at the time of the survey and discussed with surveyor. All nurses were educated on the support plan process. (see attachment for corrected RASP and training). 10 percent of charts will be audited for the next three months to verify accuracy.
Person responsible: Wellness Director or designee
Addressed 9/21/2021 and ongoing

Completion Date: *03/07/2022*

231e - No Objection Statement

1. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the home on 1/27/21 and subsequently admitted to the Secure Dementia Care Unit (SDCU) on 2/9/21. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept***

The missing signature was addressed as soon as possible. (See signed addendum). A chart audit was conducted to ensure no other signatures were missing, and these were addressed as well. The Business Office Director, Memory Care Director, and Executive Director reviewed the need to obtain the signatures from the residents as well as POAs/responsible party (see attached training). Instituted the use of an audit tool to ensure the business file is complete (see attached sample).
Persons responsible: Business Office Director, Memory Care Director, Executive Director or designee

231e - No Objection Statement (continued)

Completion Date: *11/10/2021*

231h - Resident-Home Contact

1. Requirements

2600.
231.h. The resident-home contract specified in § 2600.25 (relating to resident-home contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Description of Violation

Resident #1 was admitted to the home on [redacted] and subsequently admitted to the SDCU on [redacted] There is no addendum to the contract of [redacted] or a new resident-home contract, which reflects the requirements for admission to an SDCU including a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Plan of Correction ***Accept***

Updated resident agreement and obtained signature (see attached signed addendum). The Business Office Director, Memory Care Director, and Executive Director reviewed the need to obtain the signatures from the residents as well as POAs/responsible party (see attached training). Instituted the use of an audit tool to ensure the business file is complete (see attached sample).
Persons responsible: Business Office Director, Memory Care Director, Executive Director or designee
Addressed 9/30/2021 and 10/4/2021

Completion Date: *10/04/2021*

234a - Admission Support Plan

1. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was not completed until [redacted].

Plan of Correction ***Accept***

Staff were in serviced on the 72 hour admission requirement (see attached training). Additionally, a chart audit was conducted to ensure no other support plans were missing, and adjustments made to how staff is alerted to a missing support plan (see attached photo).
Persons responsible: Memory Care Director, Wellness Director or designee
Addressed 11/10/2021
Completion Date: *11/10/2021*

234d - Support Plan Revision

1. Requirements

2600.

234d - Support Plan Revision *(continued)*

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

The support plan for Resident #6 was not revised at least annually, as it was completed on

Plan of Correction ***Accept***

Staff were in serviced on the need for an annual revision of the support plan. A chart audit was conducted to ensure no other annual revisions were missing, and adjustments were made to how staff is alerted to the need for a support plan revision (see attached photo).
Person responsible: Wellness Director or designee
Addressed 10/7/2021 and ongoing

Completion Date: *10/07/2021*