

Department of Human Services  
Bureau of Human Service Licensing

March 31, 2022

[REDACTED]  
NORTH WALES 1091 PCH BG OPCO LLC  
[REDACTED]  
[REDACTED]

RE: PARK CREEK PLACE - PERSONAL  
CARE  
1091 HORSHAM ROAD  
NORTH WALES, PA, 19454  
LICENSE/COC#: 14257

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/18/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Shawn Parker

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *PARK CREEK PLACE - PERSONAL CARE* License #: *14257* License Expiration: *01/30/2023*  
Address: *1091 HORSHAM ROAD, NORTH WALES, PA 19454*  
County: *MONTGOMERY* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: *215-542-9670* Email: [REDACTED]

**Legal Entity**

Name: *NORTH WALES 1091 PCH BG OPCO LLC*  
Address: *330 N WABASH AVENUE, SUITE 3700, CHICAGO, IL, 60611*  
Phone: *2155429670* Email: [REDACTED]

**Certificate(s) of Occupancy**

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *49* Waking Staff: *37*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint, Incident* Exit Conference Date: *02/18/2022*

**Inspection Dates and Department Representative**

*02/18/2022 - On-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *72* Residents Served: *37*

**Secured Dementia Care Unit**

|                    |       |           |                   |
|--------------------|-------|-----------|-------------------|
| In Home: <i>No</i> | Area: | Capacity: | Residents Served: |
|--------------------|-------|-----------|-------------------|

**Hospice**

Current Residents: *1*

**Number of Residents Who:**

|  |  |
|--|--|
| Receive Supplemental Security Income: <i>0</i> | Are 60 Years of Age or Older: <i>37</i>          |
| Diagnosed with Mental Illness: <i>0</i>        | Diagnosed with Intellectual Disability: <i>0</i> |
| Have Mobility Need: <i>12</i>                  | Have Physical Disability: <i>0</i>               |

**Inspections / Reviews**

**02/18/2022 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/01/2022*

**03/30/2022 - POC Submission**

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *04/08/2022*

Inspections / Reviews (*continued*)

03/31/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's RASP dated [REDACTED], indicates that resident has a need for total assistance for toileting and that two staff are to assist resident overnight for transferring. On 2/7/22 at approximately 5:30am, resident #1 requested assistance to the restroom but only staff person A came to the room to assist the resident. As a result, Staff Person A had difficulty transferring resident from their wheelchair back into bed, resulting in injury to resident #1's leg.

Plan of Correction

Accept

- On 2/8/22, Staff Person A, an agency CNA, was no longer employed by the home.
- On 02/07/2022, The Executive Director, (ED) in serviced care staff to provide resident ADL assistance as per their Resident Assessment and Support Plan (RASP). (Attachment #1)
- On 3/23/2022 Regional Director of Care Services (RDCS) educated the ED, Care Services Manager (CSM) and Assistant Care Services Manager (ACSM) on the requirements set within regulation 2600.23(a). (Attachment #2)
- On 3/23/2022 the CSM audited current residents RASPs and task sheets to ensure that current resident's level of ADL assistance was reflected accurately in the RASP and task sheet. The CSM validated compliance. (Attachment #3)
- The CSM and/or designee will audit the RASP and task sheets and observe care rendered for five current residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to ensure ADL assistance is documented and provided in accordance with the RASP and task sheet. (Attachment #4)
- Results of the audit will be discussed during the monthly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: 06/24/2022

Document Submission

Implemented

See attachment

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

On 2/7/22 at approximately 5:30am, resident one was subjected to verbal abuse and negligence by agency staff person A. On 2/7/22 Resident #1 required assistance getting out of bed and into the restroom. Resident #1's current assessment and support plan indicates that resident requires a two person assist for transfers and toileting during the over night shift, from 11pm-7am. On 2/7/22 only agency staff person A arrived in residents room to provide assistance to the restroom. Agency staff person A struggled to transfer resident #1 back into bed as there was not a second person to assist with the transfer and while sitting resident back in their chair, agency staff person A told resident 1 [REDACTED] " and indicated to the resident that they were too difficult to put back in bed without help. Agency staff person A neglected to call for an additional aide to assist with the transfer back to bed and made two more attempts to transfer resident themselves. On the third attempt, resident #1 was handled in a rough and rushed manner during transfer so that the residents foot became entangled in the wheelchair footrest/seat. When agency staff person A went to remove residents leg from the chair, both resident #1 and the agency aide heard a pop/crack noise, and resident #1 experienced pain in her leg.

42b - Abuse (continued)

Resident #1 was subsequently transferred to the emergency room that morning and was found to have sustained a fracture to their leg.

Plan of Correction

Accept

- On 2/8/22, Staff Person A, an agency CNA, was no longer employed by the home.
- On 2/11/2022, The ED in-serviced current staff on "Enlivant Abuse, Neglect and Exploitation Policy 02-1.3-PA" and Department of Human Services (DHS) Personal Care Home Regulation 2600.42(b)- "Pennsylvania Abuse and Neglect". (Attachment #5)
- On 3/22/2022, The ED queried current residents by asking them if they have experienced neglect, intimidation, physical or verbal abuse, or have been mistreated or subjected to corporal punishment or disciplined in any way while residing at the home. Current residents denied having been subject or experiencing any of the above. (Attachment #6)
- The ED and/or designee will query 4 current residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month, to ask if they have experienced neglect, intimidation, physical or verbal abuse, or have been mistreated or subjected to corporal punishment or disciplined in any way while residing in the home. (Attachment #7)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: 06/24/2022

Document Submission

Implemented

See attachment

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 2/7/22, resident #1, did not receive a two person assist to the restroom, as required by [redacted] assessment and support plan. According to staff interviews, these services could not be provided due to lack of available direct care staffing in the home.

Plan of Correction

Accept

- On 2/7/22, the homes direct care staffing level exceeded the minimum staffing coverage per DHS regulation 2600.57.(b)-(d) and exceeded the number of staff persons needed to meet Resident #1's transfer assistance of 2 staff persons. The Executive Directors investigation determined Staff Person A did not seek additional staff assistance when transferring Resident #1, despite having additional staff persons to call upon. (Attachment - #8 EEs Ultipro timecard) The home respectfully requests that this violation be withdrawn.
- On 2/7/2022, three direct care staff persons were present during the shift, exceeding the minimum staffing coverage per DHS regulation 2600.57(b)-(d). Staff Person A did not call for assistance in transferring resident #1, opting to transfer Resident #1 independently. (Attachment #8).
  - On 2/8/22, Staff Person A, an agency CNA, was no longer employed by the home.
  - On 3/29/2022 the ED audited the staffing schedule for the month to ensure that staffing would be provided each shift to meet the needs of the residents. The audit determined staffing levels met or exceeded DHS staffing requirements. (Attachment #9)
  - On 3/23/2022 RDCS educated the ED, CSM and ACSM on the requirements set within DHS regulation 2600.60(a).

60a - Staff/Support Plan (continued)

(Attachment #10)

- The ED and/or designee will audit staffing schedule weekly for x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month to validate that staffing is adequate to meet the needs of the residents. (Attachment #11)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: 6/24/2022.

Completion Date: 06/24/2022

Document Submission

Implemented

See Attachment

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work is undocumented by the home, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction

Accept

- On 2/8/22. Staff person A, agency CNA, was no longer employed by the home.
- On 3/23/2022, the ED implemented an orientation plan for ancillary staff persons, substitute personnel and volunteers that includes general fire safety and emergency preparedness that includes the following: 1) Evacuation Procedures, 2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation, 3) the designated meeting place outside of the building or within the fire safe area in the event of an actual fire. 4) Smoking safety procedures, the home's smoking policy and location of smoking areas. 5) Location and use of the fire extinguishers. 6) Smoke detectors and fire alarms. 7) Telephone use and notification of emergency services. (Attachment #23)
- On 3/23/2022, the RDCS educated the ED, CSM, and the Administrative Assistant (AA) on the requirements set within regulation 2600.65(a). (Attachment #12)
- On 3/23/2022 the ED audited personnel records of current direct care staff persons, including ancillary staff

65a - FS Orientation 1st Day (continued)

person's, substitute personnel and volunteers to ensure fire safety and emergency orientation has been completed. For instances identified where orientation was not been completed, the ED completed the orientation. (Attachment #13)

- The ED and/or designee will audit newly hired direct care staff, including ancillary staff persons, substitute personnel, and volunteers weekly x 4 weeks, then bi-weekly x 4weeks then monthly x1 to validate that fire safety and emergency orientation has been completed. (Attachment #14)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: 06/24/2022

Document Submission

Implemented

See attached

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, whose first day of work is undocumented by the home has worked multiple dates over multiple months having completed more than 40 hours in the home. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction

Accept

- On 2/8/22. Staff person A, agency CNA, was no longer employed by the home.
- On 3/23/2022, the ED implemented an orientation plan for direct care staff persons, ancillary staff persons, substitute personnel and volunteers that includes, 1) Resident rights, 2) Emergency medical plan, 3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. 10225.101-10225.5102). (Attachment #23)
- On 3/23/2022 the RDCS educated the ED, CSM, and the AA on the requirements set within regulation 2600.65(b). (Attachment # 15)
- On 3/23/2022 the ED audited the personnel records of current direct care staff persons, including ancillary staff person's, substitute personnel and volunteers to ensure Resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions orientation has been completed. For instances identified where orientation was not been completed, the ED completed the orientation. (Attachment #16)
- The ED and/or designee will audit newly hired direct care staff including ancillary staff persons, substitute personnel, and volunteers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1 to validate resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions orientation has been completed. (Attachment #17)

65b - Rights/Abuse 40 Hours (continued)

- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: 06/24/2022

Document Submission

Implemented

See attached

141a - Medical Evaluation

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.

Description of Violation

The medical evaluation for resident #1 was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction

Accept

- Resident #1 did not suffer an adverse effect related to this finding.
- On [REDACTED] the Documentation of Medical Evaluation (DME) for resident #1 was completed by a physician.
- On 3/23/2022 RDCS educated the ED, CSM and ACSM on the requirement set within regulation 2600.141(a). (Attachment #18)
- On 3/29/2022 the CSM audited current resident DMEs to validate completion dates were within 60 days prior to admission or within 30 days after admission. Audited DMEs were noted by the CSM as compliant. (Attachment #19)
- The CSM and/or designee will audit the DMEs of newly admitted residents weekly for x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate DME assessments dates do not exceed the regulated time frame of 60 days prior to admission or 30 days after admission. (Attachment #20)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion Date: 06/24/2022

Document Submission

Implemented

See attached

141a 1-10 Medical Evaluation Information

1. 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**

The resident #1’s medical evaluation dated [REDACTED] did not include residents current medical diagnosis of Von Willerbrand Disease, breast cancer and hyperlipidemia.

**Plan of Correction**

**Accept**

- Resident #1 did not suffer an adverse effect from this finding.
- Resident #1 no longer resides in the home, therefore the DME cannot be updated to reflect Resident #1’s diagnosis of Von Willerbrand Disease, breast cancer, and hyperlipidemia.
- On 3/23/2022 RDCS educated the ED, CSM and ACSM on the requirements set within regulation 2600.141(a)2. (Attachment #21)
- On 3/29/2022 the CSM completed an audit of current resident DMEs to ensure that residents diagnoses are accurately documented on their DME. The audit determined current medical diagnosis at the date of the practitioner’s signature were indeed accurate. (Attachment #19)
- The CSM and/or designee will audit new DME’s weekly for x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate the DME’s contain the resident’s current diagnoses. (Attachment #20)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

**Completion Date:** 06/24/2022

**Document Submission**

**Implemented**

See attachment

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 DME for resident #1, dated [REDACTED], indicates the resident has medical diagnoses of Osteoarthritis, Major Depressive Disorder, and Kyphosis. The resident’s support plan, dated [REDACTED] does not document how these needs will be met.

227d - Support Plan Medical/Dental *(continued)*

**Plan of Correction**

**Accept**

- Resident #1 did not suffer any adverse effect from this finding.
- Resident #1 no longer resides in the home, therefore the RASP cannot be updated to reflect Resident #1's diagnoses of Osteoarthritis, Major Depressive Disorder, and Kyphosis and corresponding care needs.
- On 3/23/2022 RDCS educated the ED, CSM and ACSM on the requirement set within regulation 2600.227(d). (Attachment #22)
- On 3/29/2022 the CSM conducted an audit of current resident DMEs and RASPs to ensure both comprehensively capture each resident's medical diagnosis and associated support plan needs. Upon identification of a discrepancy and or omitted diagnosis or support plan need, the CSM updated the DME or support plan accordingly. (Attachment #19).
- The CSM and/or designee will audit new resident RASPs and DMEs weekly for x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month to validate that RASPs comprehensively capture the resident's medical diagnoses and associated support plan needs. (Attachment #20)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

**Completion Date:** 06/24/2022

**Document Submission**

**Implemented**

*See attached*