

Department of Human Services
Bureau of Human Service Licensing

July 1, 2022

[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 03/01/2022, 03/02/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: CREEK SENIOR CARE LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

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: 134 Waking Staff: 101

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #: 0
Reason: Complaint, Incident, Interim Exit Conference Date: 03/02/2022

Inspection Dates and Department Representative

03/01/2022 - On-Site: [REDACTED]
03/02/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 130 Residents Served: 94

Secured Dementia Care Unit

In Home: Yes Area: The Gardens Capacity: 31 Residents Served: 22

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 94
Diagnosed with Mental Illness: 33 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 40 Have Physical Disability: 1

Inspections / Reviews

03/01/2022 - Partial

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

Inspections / Reviews (*continued*)

04/19/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *04/26/2022*

06/22/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/01/2022*

07/01/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

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, full time contracted employee, did not receive orientation on the following topics listed under this regulation:

- *Evacuation procedures*
- *Staff duties during fire drills, emergency evacuation and transportation*
- *Designated meeting places and/or fire safe zones*
- *Smoking safety procedures and smoking areas*
- *Location of fire extinguishers and their use*
- *Smoke detectors and fire alarms*
- *Use of telephone and notifying emergency services*

Plan of Correction**Directed**

The contracted employee in question was not employed by the community after [REDACTED]

A review of contracted staff training was conducted by the Executive Director on 3/5/2022. This revealed that while the contracted staff were receiving general fire safety training from their agency employers, they were not receiving community specific training on or prior to or during the first work day.

As a result of the audit, it was determined that a training program was to be implemented by the Executive Director on 3/7/2022 to ensure current contracted employees and incoming contracted employees received required fire safety training.

The Executive Director in conjunction with the fire expert facilitated a community orientation train the trainer course for community training designees on 4/7/2022.

The hiring director will be responsible to ensure that all substitute personnel scheduled have completed orientation on or prior to first day worked.

Beginning 4/29/2022 audits of training documents, comparing them with the scheduled staffing, will be conducted weekly by the Wellness Director and documented on attachment.

Directed -

65a - FS Orientation 1st Day (continued)

Staff training needs and the results of the training audits will be discussed at the home's next quality management review, to be held by 7/15/22. ■ 6/16/22

Completion Date: 04/07/2022

Document Submission**Implemented**

The contracted employee in question was not employed by the community after ■■■■■■■■■■

A review of contracted staff training was conducted by the Executive Director on 3/5/2022. This revealed that while the contracted staff were receiving general fire safety training from their agency employers, they were not receiving community specific training on or prior to or during the first work day.

As a result of the audit, it was determined that a training program was to be implemented by the Executive Director on 3/7/2022 to ensure current contracted employees and incoming contracted employees received required fire safety training.

The Executive Director in conjunction with the fire expert facilitated a community orientation train the trainer course for community training designees on 4/7/2022.

The hiring director will be responsible to ensure that all substitute personnel scheduled have completed orientation on or prior to first day worked.

Beginning 4/29/2022 audits of training documents, comparing them with the scheduled staffing, will be conducted weekly by the Wellness Director and documented on attachment.

Directed -

Staff training needs and the results of the training audits will be discussed at the home's next quality management review, to be held by 7/15/22. ■ 6/16/22

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 has completed his/her 40th scheduled work hour. However, this staff person did not complete the following trainings listed under this regulation:

- Resident rights
- Emergency medical plan
- Mandatory reporting of abuse and neglect under OAPSA

65b - Rights/Abuse 40 Hours (continued)

Reportable incidents

Plan of Correction**Directed**

The contracted employee referenced was not employed by the community after [REDACTED]
A review of contracted staff training was conducted by the Executive Director on 3/5/2022. This revealed that while contracted staff were receiving training from their agency employers on resident rights, abuse and neglect, and reportable incidents, they were not receiving specific training on the 2600 regulations related to personal care homes.

- A training program was implemented by the Executive Director on 3/7/2022 to ensure current contracted employees received required training on resident rights, the emergency medical plan, mandatory reporting of abuse and neglect, and reporting of reportable incidents and conditions.
- The hiring director will be responsible to ensure that all substitute personnel scheduled have completed orientation on or prior to first day worked.

Beginning 4/29/2022 audits of training documents, comparing them with the scheduled staffing, will be conducted weekly by the Wellness Director and documented on attachment.

Directed -

Staff training needs and the results of the training audits will be discussed at the home's next quality management review, to be held by 7/15/22. [REDACTED] 6/16/22

Completion Date: 03/07/2022

Document Submission**Implemented**

The contracted employee referenced was not employed by the community after [REDACTED]
A review of contracted staff training was conducted by the Executive Director on 3/5/2022. This revealed that while contracted staff were receiving training from their agency employers on resident rights, abuse and neglect, and reportable incidents, they were not receiving specific training on the 2600 regulations related to personal care homes.

- A training program was implemented by the Executive Director on 3/7/2022 to ensure current contracted employees received required training on resident rights, the emergency medical plan, mandatory reporting of abuse and neglect, and reporting of reportable incidents and conditions.
- The hiring director will be responsible to ensure that all substitute personnel scheduled have completed orientation on or prior to first day worked.

Beginning 4/29/2022 audits of training documents, comparing them with the scheduled staffing, will be conducted weekly by the Wellness Director and documented on attachment.

Directed -

Staff training needs and the results of the training audits will be discussed at the home's next quality management review, to be held by 7/15/22. [REDACTED] 6/16/22

183e - Storing Medications**1. Requirements**

2600.

183e - Storing Medications (continued)

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

On [redacted] /22, 5 loose pills; [redacted] were found in Med Cart T1.

On [redacted] /22, 4 loose pills; [redacted] were found in Med Cart 2

On [redacted] /22, 1 loose pill; [redacted] found in The Garden cart.

Plan of Correction

Accept

All loose pills found in the carts noted in the survey were disposed of in accordance with medication disposal policy on 3/2/2022 by the Executive Director.
 Education of employees authorized to give medications regarding proper storage of medications based on 183e was completed on by the Wellness Director on 3/16/2022.
 Weekly audits of medication carts are ongoing, and are reviewed by the Executive Director or designee. Deficiencies noted during these audits are immediately addressed through direct education and progressive discipline.
 Twice weekly audits are being conducted by the Wellness Director and Executive Director or designee are also ongoing.

Completion Date: 03/16/2022

Document Submission

Implemented

All loose pills found in the carts noted in the survey were disposed of in accordance with medication disposal policy on 3/2/2022 by the Executive Director.
 Education of employees authorized to give medications regarding proper storage of medications based on 183e was completed on by the Wellness Director on 3/16/2022.
 Weekly audits of medication carts are ongoing, and are reviewed by the Executive Director or designee. Deficiencies noted during these audits are immediately addressed through direct education and progressive discipline.
 Twice weekly audits are being conducted by the Wellness Director and Executive Director or designee are also ongoing.

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 03/02/22, The following discrepancies between the residents' glucometers and their medication administration records (MARs) were noted:
 Resident 3- [redacted] - a reading of [redacted] was not found in the glucometer, however a glucometer reading of [redacted] pm was not recorded in MAR.

185a - Implement Storage Procedures (continued)

Resident 4- [redacted]/22- a recorded MAR reading of [redacted] was not found in glucometer. [redacted]/22- a reading of [redacted] was on the MAR g at [redacted] am but was not found in glucometer.

Resident 5- The following documented readings at 8pm were not found in glucometer: [redacted]/22 - [redacted] [redacted]/22 - [redacted] [redacted]/22 - [redacted] at 8 am. On [redacted]/22, a glucometer read of [redacted] was incorrectly recorded as [redacted]

Plan of Correction

Accept

Executive Director gave verbal education to 3 staff members on February 26, 2022 regarding the safe storage of glucometers.

Wellness Director gave education based on 185a to med techs and nurses on 3/16/2022.

Diabetic education for med techs was held on 3/21/2022 by a diabetic educator.

Staff were in serviced by the Executive Director on 185a on 3/24/2022.

The method for storing glucometers was changed by 3/15/2022 to decrease the likelihood of a glucometer being misused. Each glucometer is individually labeled.

Glucometer audits began 3/3/2022 are being conducted three times a week. Results are reviewed by the Executive Director or designee weekly. Direct education and progressive discipline are being used for non-compliance.

Completion Date: 03/25/2022

Document Submission

Implemented

Executive Director gave verbal education to 3 staff members on February 26, 2022 regarding the safe storage of glucometers.

Wellness Director gave education based on 185a to med techs and nurses on 3/16/2022.

Diabetic education for med techs was held on 3/21/2022 by a diabetic educator.

Staff were in serviced by the Executive Director on 185a on 3/24/2022.

The method for storing glucometers was changed by 3/15/2022 to decrease the likelihood of a glucometer being misused. Each glucometer is individually labeled.

Glucometer audits began 3/3/2022 are being conducted three times a week. Results are reviewed by the Executive Director or designee weekly. Direct education and progressive discipline are being used for non-compliance.

187c - Refusal of Medication

1. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted]/22, [redacted]/22, [redacted]/22 and [redacted]/22 at [redacted] pm, Resident 8 refused to take a scheduled dose of [redacted] mg. There was no documentation verifying that the prescriber had been notified.

On [redacted]/22, [redacted]/22, [redacted]/22, [redacted]/22, [redacted]/22, [redacted]/22 and [redacted]/22 at 8 pm, Resident 8 refused to take a scheduled dose of [redacted] There was no documentation verifying that notice was given to the physician.

On [redacted]/22, [redacted]/22, [redacted]/22, [redacted]/22 and [redacted]/22 at 12 pm, Resident 8 refused to take a scheduled dose of [redacted]

187c - Refusal of Medication (continued)

██████████ No documentation verifying that the prescriber was notified was provided.

On ████████/22, ████████/22, ████████/22, ████████/22 and ████████/22 at 8 pm, Resident 8 refused to take a scheduled dose of ██████████. The home did not produce documentation verifying that the prescriber was notified.

Plan of Correction**Accept**

After the exit conference on ████████/2022, a review of the mentioned omission of notifications was conducted by the Executive Director and the PCP was notified by fax.

Education was given to med techs and nurses based on 187c by the Wellness Director on 3/16/2022.

Education given to staff based on 187C by the Executive Director on 3/25/2022

E MAR audits weekly by Executive Director or designee began 3/8/2022 will continue weekly to ensure refusals are properly documented.

Completion Date: 03/25/2022

Document Submission**Implemented**

After the exit conference on ████████/2022, a review of the mentioned omission of notifications was conducted by the Executive Director and the PCP was notified by fax.

Education was given to med techs and nurses based on 187c by the Wellness Director on 3/16/2022.

Education given to staff based on 187C by the Executive Director on 3/25/2022

E MAR audits weekly by Executive Director or designee began 3/8/2022 will continue weekly to ensure refusals are properly documented.

187d - Follow Prescriber's Orders**1. Requirements**

2600.

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

Description of Violation

Resident 2 is prescribed ██████████. However, this medication was not administered to the resident on ████████/22 because the medication was not available in the home.

Resident 2 is prescribed ██████████. However, this medication was not administered to resident on ████████/22 and ████████/22 because the medication was not available in the home.

Plan of Correction**Directed**

After the exit conference on ████████/2022, the PCP was updated regarding the medication not being administered as per order.

Education was given to med techs and nurses based on 187d by the Wellness Director on 3/16/2022.

Education given to staff by ED based on 187d on 03/25/2022.

Education was given to med techs and nurses regarding procedures to follow in the event medication is not present by the Wellness Director on 3/16/2022.

E MAR audits weekly by Executive Director or Wellness Director began 3/8/2022 will continue weekly to ensure

187d - Follow Prescriber's Orders (continued)

medications are properly documented.

Directed -

The results of the E MAR audits will be discussed at the home's quality management reviews, the next meeting to be held by 7/15/22. [REDACTED] 6/16/22

Completion Date: 03/25/2022

Document Submission

Implemented

After the exit conference on [REDACTED] 2022, the PCP was updated regarding the medication not being administered as per order.

Education was given to med techs and nurses based on 187d by the Wellness Director on 3/16/2022.

Education given to staff by ED based on 187d on 03/25/2022.

Education was given to med techs and nurses regarding procedures to follow in the event medication is not present by the Wellness Director on 3/16/2022.

E MAR audits weekly by Executive Director or Wellness Director began 3/8/2022 will continue weekly to ensure medications are properly documented.

Directed -

The results of the E MAR audits will be discussed at the home's quality management reviews, the next meeting to be held by 7/15/22. [REDACTED] 6/16/22

227g -Support Plan Signatures

1. 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 7 participated in the development of his/her support plan on [REDACTED] /21. However, neither the resident, nor the assessor signed the support plan.

Plan of Correction

Accept

The noted missing signature was corrected on 3/2/2022.

A chart audit was conducted by the Executive Director to ensure signatures were present on all RASPs on 3/9/2022.

Education based on 227g was given to employees involved in writing RASPs to ensure that there is clear understanding of the need to have the RASP signed by the assessor, the resident, and/or the responsible party by the Executive Director on 3/25/2022.

Chart audits will begin monthly on 5/2/2022 and will be conducted by the Wellness Director or designee and will be focused on ensuring that RASPs are properly completed. Results will be reviewed with the Executive Director.

Completion Date: 03/25/2022

Document Submission

Implemented

The noted missing signature was corrected on 3/2/2022.

A chart audit was conducted by the Executive Director to ensure signatures were present on all RASPs on 3/9/2022.

Education based on 227g was given to employees involved in writing RASPs to ensure that there is clear understanding of the need to have the RASP signed by the assessor, the resident, and/or the responsible party by the Executive Director on 3/25/2022.

Chart audits will begin monthly on 5/2/2022 and will be conducted by the Wellness Director or designee and will

227g -Support Plan Signatures (continued)

be focused on ensuring that RASPs are properly completed. Results will be reviewed with the Executive Director.

254a - Records Discharge/Active

1. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 03/02/22, Resident 10's care plan notes were unlocked, unattended, and accessible at the front desk of the home.

Plan of Correction

Accept

The binder containing the care plan notes referenced in the POC was removed from the front desk by the Executive Director on 3/1/2022.

Education was given to associates by the Executive Director based on 254a on 3/25/2022.

Audits are conducted on a bi-weekly basis by the Executive Director or designee to ensure no PHI is unsecured.

Completion Date: 03/25/2022

Document Submission

Implemented

The binder containing the care plan notes referenced in the POC was removed from the front desk by the Executive Director on 3/1/2022.

Education was given to associates by the Executive Director based on 254a on 3/25/2022.

Audits are conducted on a bi-weekly basis by the Executive Director or designee to ensure no PHI is unsecured.