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**: *10/31/2023*

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]

Email: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *11/16/2022*

Inspection Dates and Department Representative

11/15/2022 - On-Site: [redacted]

11/16/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Gardens* **Capacity**: *31* **Residents Served**: *20*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

11/15/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/25/2022*

11/30/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/16/2022*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/05/2022*

12/09/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/16/2022*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/16/2022*

12/19/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/16/2022*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 9/16/2022 at 6:15 PM, an alleged incident of abuse was reported where a staff member was accused of pushing Resident #1. However, this allegation of abuse was was not reported to the local area agency on aging (AAA) until 9/19/2022 at 1:15 PM.

Plan of Correction ***Directed (- 12/06/2022)***

All Local area agency on aging (AAA) Reportable events will be reported by the Director of Wellness (DOW) or Executive Director within the allocated time frame for compliance. All staff received training on Mandatory Abuse and Neglect reporting on 9/12/22, 9/13/22, 9/22/22, and 9/23/22 by the DOW and interim Licensed Executive Director. See attachment #T!. Mandatory Abuse and Neglect reporting will continue to be trained at the All-Staff Monthly Meetings. The next scheduled Monthly All-Staff meeting is scheduled for 12/07/22. Regional Director of Operations (RDO) and Vice President of Wellness (VPW) will be copied on all reportable incidents to review for accuracy. Reportable Incidents were reviewed during QA Meeting on 11/9/22 and will be reviewed at next scheduled QA Meeting on 12/14/22 to ensure appropriate actions have taken place. Incidents requiring reporting on the weekends to be completed and copied to the RDO, VPW, and or VPO then submitted to the Department of Human Services with in the 24hr time frame by the DOW and/or the Executive Director/and or designee to ensure compliance beginning 12/1/22.

(Directed)

- *The Administrator reviewed the existing policies from the home's legal department on 12/6/22 regarding reportable incidents.*

Directed Completion Date: *12/14/2022*

Not Implemented - 12/19/2022)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 9/16/2022, an alleged incident of abuse occurred where a staff member was accused of pushing Resident #1. The home did not report this incident to the Department until 9/19/2022 at 11:05 AM.

On 11/11/2022, Resident #4 received treatment at a hospital after an unwitnessed fall. The home did not report this incident to the department until 11/14/2022.

Plan of Correction ***Directed - 12/06/2022)***

All DHS Reportable events will be reported by the Director of Wellness (DOW) or Executive Director within the

16c - Written Incident Report (continued)

allocated time frame for compliance. All staff received training on Mandatory Abuse and Neglect reporting on 9/12/22, 9/13/22, 9/22/22, and 9/23/22 by the DOW and interim Licensed Executive Director. See attachment #T!. Mandatory Abuse and Neglect reporting will continue to be trained at the All-Staff Monthly Meetings. The next scheduled Monthly All-Staff meeting is scheduled for 11/22/22. Regional Director of Operations (RDO) and Vice President of Wellness (VPW) will be copied on all reportable incidents to review for accuracy. Reportable Incidents were reviewed during QA Meeting on 11/9/22 and will be reviewed at next scheduled QA Meeting on 12/14/22 to ensure appropriate actions have taken place. Incidents requiring reporting on the weekends to be completed and copied to the RDO, VPW, and or VPO then submitted to the Department of Human Services with in the 24hr time frame by the DOW and/or the Executive Director to ensure compliance beginning 12/1/22. MODs trained by Executive Director on incident reporting to the Department of Human Services on the weekends to ensure 24hr reporting compliance of incident reports on 12/6/22. (Attachment T #2)

(Directed)

- *The Administrator reviewed the existing policies from the home's legal department on 12/6/22 regarding reportable incidents.*

Directed Completion Date: *12/14/2022*

Not Implemented [redacted] - 12/19/2022)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for Resident #2 was not signed by the resident.

Plan of Correction ***Accept [redacted]/06/2022)***

The contract for Resident #2 was reviewed and signed by Resident with the assistance of the Business Office Manager on 11/ 16 /22. See attachment #C1. Business Office Director and/or Executive Director will perform financial file audits monthly on 10 resident files beginning 12/1/22. Findings from the audits will be discussed during Quality Assurance Meetings monthly and any findings will be amended. The next scheduled QA Meeting will be on 12/14/22

Licensee's Proposed Overall Completion Date: *12/14/2022*

Not Implemented [redacted] - 12/19/2022)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 11/6/2022 from 10:30 PM until 6:30 AM, there were no staff persons present in the home who were certified in CPR and/or First Aid.

63a - First Aid/CPR Training (continued)

On 11/11/2022, from 10:30 PM until 6:30 AM, there were no staff persons present in the home who were certified in CPR and/or First Aid.

On 11/12/2022, from 2:30 PM until 10:30 PM, there were no staff persons present in the home who were certified in CPR and/or First Aid.

Plan of Correction ***Accept (/29/2022)***

Community has contracted with In-Pulse CPR for on-site staff training services. Community had In-Pulse CPR conduct a class on 11/ 17 /22 to certify staff in CPR/First Aid. See Attachment #T2. The next scheduled classes with In-Pulse CPR is scheduled for 12/13/22 and 12/15/22. In-Pulse will continue to train 20 staff members and they will obtain a 2-year CPR certification. In-Pulse will then return every year to train new staff and or those staff members eligible for recertification to ensure community stays compliant with PA code 2600.63.a. Copies of staff CPR/First Aid certification's will be maintained at the community in staff files by the Business Office Director or DOW . The Administrator will ensure that the home has the appropriate number of staff members with the required certifications.

Licensee's Proposed Overall Completion Date: *12/15/2022*

Not Implemented 12/19/2022)

183d - Prescription Current

5. 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 11/16/2022 at approximately 12:25 PM, 4 unopened bottles of Diabetic Tussin LIQ, prescribed for Resident #2, were in the home's Memory Care medication cart; however, the medication was discontinued on 11/7/2022.

Plan of Correction ***Accept - 12/06/2022)***

All discontinued medications were removed from the medication cart for Resident #2 on 11/16/2022 by the Medication Technician. Weekly medication cart audits will be completed by the TDC, DOW, or Lead Medication Technician until 12/31/22. Pharmacy consultant will conduct audits on a monthly basis for the next six months, Findings from the cart audits will be reviewed at the monthly QA/Safety Meeting on 12/14/22. Beginning on 11/17/2022, weekly medication cart audits will be completed by the TDC, DOW, and or Lead Medication Technician for a minimum of 3 months. Beginning on 12/5/22, Pharmacy consultant will conduct audits on a monthly basis for the next six months.

Licensee's Proposed Overall Completion Date: *12/05/2022*

Not Implemented (- 12/19/2022)

185a - Implement Storage Procedures

6. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 11/16/2022 at approximately 10:07 AM, Resident #5's glucometer was not calibrated to the correct time. The glucometer indicated that it was 11:21 AM.

On 11/16/2022 at approximately 10:10 AM, Resident #6's glucometer was not calibrated to the correct time, and indicated 11:20 AM.

On 11/16/2022 at approximately 10:09 AM, Resident #7's glucometer recorded 11:15 AM, as it was not calibrated to the correct time.

Plan of Correction ***Accept (- 12/06/2022)***

The Glucometer's for Resident #5, Resident #6, and Resident #7 have been calibrated to the correct time on 11/17/22 by the Lead Medication Technician. See attachment #C2. Weekly med cart audits will be completed by TDC, DOW, or Lead Medication Technician. Findings from med cart audits will be reviewed at QA/Safety Meetings monthly. The QA/Safety Meeting is scheduled for 12/14/22. A training will be provided to Medication Technicians by the DOW no later than 12/15/22 to check the date/time on the glucometers for proper calibration. Weekly med cart audits will be completed by TDC, DOW or Lead Medication Technician beginning on 11/20/22 to include glucometers are calibrated to the correct date/time. if calibrations are found to be incorrect, they will be re-calibrated by the Medication Technician immediately.

Licensee's Proposed Overall Completion Date: *12/15/2022*

Not Implemented (- 12/19/2022)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #3 is prescribed Nystatin Powder to be applied twice daily PRN to identified red areas. However, this medication has not been administered since prescribed by the physician on 9/23/2022.

Plan of Correction ***Directed (- 12/06/2022)***

The PRN medications are a part of the weekly medication cart audits conducted by the Medication Technicians, TDC or DOW. DOW will retrain Medication Technicians on the protocols for PRN medications and usage by 11/30/22. DOW will train Resident Assistants in regard to Resident skin assessments and documentation of Resident skin assessments on the daily shower sheets for all residents by 11/30/22. The findings from the medication cart audit will be reviewed at the next QA/Safety Meeting scheduled for 12/14/22.
Medication Technicians to review the skin assessments on the shower sheets on shower days for any noted skin

187d - Follow Prescriber's Orders (continued)

concerns for the residents beginning on 12/5/22.
Medication Technicians to review and document all PRN Medication usage on the shift-to-shift report to ensure proper medication administration for PRN medications beginning on 12/5/22.

(Directed)

- *Residents who are experiencing concerns with skin rashes/open areas will be assessed by the designated staff member daily to ensure PRN medications are being applied as ordered by the physician until healed.*
- *Staff will document their skin assessments daily in the resident's record to track the healing process.*
- *The Administrator or designee will monitor the resident skin assessments and medication administration record at least 3 times per week to ensure medications are being applied as ordered by the physician; documentation will be kept.*

Directed Completion Date: *12/14/2022*

Not Implemented (- 12/19/2022)

227g -Support Plan Signatures

8. 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 his/her support plan on 10/28/2022. However, the resident did not sign the support plan. Repeated Violation - 3/1/2022

Plan of Correction ***Accept - 12/06/2022)***

Resident #2 was unable to sign support plan on 11/16 /22 with the Memory Care Director due to dementia. Resident #2 support plan was updated indicating the inability to sign on 11/17/22. Support Plan chart audits will be completed on a monthly basis by TDC, or DOW and all plans will be updated with findings. Findings from audits will be reviewed during monthly QA/Safety meetings. The next QA/Safety Meeting is scheduled for 12/14/22. Beginning on 12/1/22, Support Plan chart audits will be completed on a monthly basis by TDC, or DOW and all plans to be updated with findings. Five Resident Chart audits will be completed monthly beginning on 12/5/22. The DOW will train the Medication technicians to obtain resident signatures on RASP's or to make a statement on the RASP regarding the resident's refusal or inability to sign by 12/15/22.

Licensee's Proposed Overall Completion Date: *12/15/2022*

Not Implemented 12/19/2022)

231e - No Objection Statement

9. 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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on 10/27/2022. The home has no documentation that the resident did not object to the admission. Repeated Violation - 9/21/2021 et. al.

231e - No Objection Statement *(continued)*

Plan of Correction ***Accept █ 12/06/2022)***

Resident #2 was afforded the opportunity to sign the Non-Objection Statement on 11/ 16/22 with the Memory Care Director but was unable to sign due to his dementia. See attachment #C3. Memory care disclosures will be completed prior to or upon move-in and will be obtained by ED, Director of Sales, or BOD. Any resident internal transfers will be discussed during the weekly At-Risk meetings by the DOW and ED. The need for a memory care disclosure statement will be reviewed at that time. At Risk Meeting review notes will be discussed during QA/Safety Meetings. The next scheduled QA/Safety Meeting is scheduled for 12/14/22. A Checklist will be utilized for new admissions and/or internal transfers for residents moving to the SDCU beginning on 12/5/22 and will be maintained in the residents file by the Business Office Director.

Licensee's Proposed Overall Completion Date: *12/14/2022*

Not Implemented █ - 12/19/2022)