

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

October 8, 2024

[REDACTED], ADMINISTRATOR
CREEK SENIOR CARE LLC

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 08/27/2024, 08/28/2024 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: 09/12/2024
 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]

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: 136 Waking Staff: 102

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 08/28/2024

Inspection Dates and Department Representative

08/27/2024 - On-Site: [REDACTED]
 08/28/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 130 Residents Served: 92

Secured Dementia Care Unit
 In Home: Yes Area: Liliacs Capacity: 31 Residents Served: 22

Hospice
 Current Residents: 18

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 0
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 44 Have Physical Disability: 1

Inspections / Reviews

08/27/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/15/2024

09/17/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 09/25/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 09/27/2024

Inspections / Reviews *(continued)*

10/08/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

54a Direct Care Staff

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff member A, hired [REDACTED] does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept ([REDACTED]) - 09/17/2024)

Staff A has education from [REDACTED] and approval to work in the U.S (see attached) A waiver was completed and submitted to DHS on Sept 6, 2024 (see attached) Business Office Director will audit current staff personal files to ensure staff meet the requirements of having a high school diploma or GED, or Nurse Aid registry by Oct 31, 2024. Audit to be reviewed at monthly Q&A meeting to ensure all newly hired staff meet the requirements until December 31, 2024.

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented ([REDACTED]) - 10/01/2024)

65f Training Topics

2. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self administration training.

Description of Violation

Staff members A and B did not receive the required annual Medication self-administration training during the 2023 training year.

Plan of Correction

Accept ([REDACTED]) - 09/17/2024)

Staff member A & B completed the required annual training of medication Self Administration training for the 2024 calendar year. (see attached) Business Office Director (BOD) to ensure all current staff complete the required annual trainings by the end of the 2024 training year. BOD to audit all current staff 2024 annual training record by December 1, 2024 to ensure all required trainings. Staff Training to be reviewed monthly during the Q&A meeting until December 31, 2024.

Licensee's Proposed Overall Completion Date: 12/01/2024

Implemented ([REDACTED]) - 10/08/2024)

81b Resident Personal Equipment

3. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The bed of resident #5, located in room [REDACTED], has an enabler bar with no covering and had a measured opening of 12 inches x 6 inches, which poses an entrapment risk.

81b - Resident Personal Equipment (continued)

Plan of Correction

Accept () - 09/17/2024)

Resident #5 bed enabler's cover placed immediately by staff for safety. Director of Wellness or Assisted Living Manager to conduct a weekly audit of all bed enablers to ensure compliance with opening size and covers in place until December 31, 2024. (see attached) Audits to be discussed at Monthly Q & A meetings until December 31, 2024.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 10/08/2024)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/28/24 at approximately 2:00 PM, room [REDACTED] assigned to resident #6 was observed having a bloodstain on the carpet floor measuring approximately 4x2 inches. Another larger area was observed on the carpet that appeared to be smeared or partially cleaned blood next to the head end of the resident's bed.

On 8/28/24 at approximately 2:30 PM, smeared fecal matter was observed on the toilet seat, toilet bowl and shower floor in the bathroom of room [REDACTED] occupied by resident #7.

Plan of Correction

Accept () - 09/17/2024)

Resident #6 carpet was extracted on 8/28/24 by maintenance technician. Lilac Trace Director will conduct weekly walk through of all Lilac Trace Apts-SDCU to ensure sanitary conditions through December 31, 2024. (see attached) Weekly audits to be reviewed at monthly Q&A until December 31, 2024.

Resident #7 bathroom was cleaned by Housekeeping on 8/28/24 upon discovery of the sanitary issues noted. Housekeeping will conduct daily monitoring of resident #7 Apt bathroom for sanitary issues until December 31, 2024. (see attached) Audits to be reviewed at the monthly Q & A meetings until December 31, 2024.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 10/08/2024)

101i - Access to Bedroom

5. Requirements

2600.

101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On [REDACTED] at approximately [REDACTED], the "Lilacs" Secure Dementia Care Unit (SDCU) was observed having the following resident rooms locked, prohibiting the residents from freely accessing their rooms: #160, #174, #175, #176 and #179.

Plan of Correction

Accept () - 09/17/2024)

On 8/27/24 all Lilac Trace (SDCU) apartment doors were unlocked allowing residents to have free access to their apartments. Executive Director provided training to Lilac Trace Director in regard to ensuring the residents apartment doors are unlocked allowing residents to have free access to their apartments. (see attached) Lilac Trace Director to ensure all Lilac Trace resident apartment doors are unlocked daily to ensure residents free

101i - Access to Bedroom (continued)

access to their apartments. (see attached) Daily monitoring sheet to be reviewed monthly at Q&A meeting until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 10/08/2024)

103c - Food Protected

6. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 8/28/24 at approximately 1:30 PM four uncovered serving cups containing vanilla ice cream were in the glass top ice cream freezer in the main kitchen. A box of "All Butter Croissant Buns" stored in the walk-in freezer was opened, uncovered and not protected from contamination.

Plan of Correction

Accept () - 09/17/2024)

On 8/28/24 the cups containing ice cream, and the Butter Croissant Buns were disposed of by the culinary staff. Dining Supervisor to conduct audits 3 times per week to ensure all food is protected from contamination while being stored until, prepared, transported, and served until 12/31/24. (See attached) Audits to be discussed monthly at the Q&A meeting until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 10/08/2024)

141b1 - Annual Medical Evaluation

7. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #6's most recent medical evaluation was completed on (). The resident's previous medical evaluation was completed on ().

Plan of Correction

Accept ()/17/2024)

Director of Wellness contacted Hospice provider to obtain a copy of the DME dated for 2023 and Hospice stated they do not obtain copies of medical forms for resident #6. Director of Wellness or Assited Living Manager to complete resident audit of DME to ensure residents have at least an annual medical evaluation by 10/31/24. Annual DME audit to be reviewed at monthly Q&A to ensure Residents have their annual medical evaluations until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 10/08/2024)

181d -Storing Medication

8. Requirements

2600.

181d - Storing Medication (continued)

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #1 self-administers medications and stores medications in their room. On [REDACTED], the door to the resident's room was unlocked. All of Resident #1's medications were found unlocked and unattended in the top right drawer of the residents' dresser.

Plan of Correction

Accept ([REDACTED] - 09/17/2024)

Resident # 1 apartment door was locked immediately to ensure medications were locked in a safe and secure location to protect against contamination, spillage and theft. Director of Wellness provided training to resident #1 on the importance to ensure [REDACTED] apartment door is locked when [REDACTED] is not physically in [REDACTED] apartment due to [REDACTED] self-medicating [REDACTED] medications. (see attached) Director of Wellness or designee will conduct random checks 3 times per week to ensure resident #1 apartment door is locked when not present in the apartment until 12/31/24. (see attached) Door audit to be reviewed monthly at the Q&A meeting until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([REDACTED] 10/08/2024)

185a - Implement Storage Procedures

9. 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

Resident #4 is prescribed [REDACTED] 4 times daily with meals. The Medication Administration Record (MAR) for resident #4 was found to have incorrect blood sugars documented on the MAR from the glucometer on the following dates and measurements.

[REDACTED] at evening the MAR recorded [REDACTED] and the glucometer recorded a reading of [REDACTED]
[REDACTED] at bedtime the MAR recorded [REDACTED] and the glucometer recorded a reading of [REDACTED]

Plan of Correction

Accept ([REDACTED] - 09/17/2024)

Resident #4 Accu Check for [REDACTED] recorded on the MAR as [REDACTED] and on the glucometer the reading was [REDACTED]. The report was pulled from Quick Mar which shows notation from the medication technician indicating an Accu check reading of 214 and noted error in original documentation. (See attached)
Director of Wellness provided training to the Medication technician on 8/30/24 on ensuring proper documentation of Accu Check readings on the MAR. (see attached)
Director of Wellness or Designee to conduct weekly audit of resident #4 Accu Check readings on the glucometer vs the MAR to ensure accuracy in transcription until 12/31/24. Accu Check audits to be reviewed monthly at Q&A meetings until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented [REDACTED] /08/2024)

224a - Preadmission Screen Form

10. Requirements

224a - Preadmission Screen Form (continued)

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #8 was admitted to the home on [redacted]; however, there was no preadmission screening form completed.

Plan of Correction

Accept ([redacted] - 09/17/2024)

Resident #8 preadmission screen form was completed on [redacted] by Director of Wellness. (See attached) Director of Wellness and Executive Director will ensure all newly admitted residents have a completed preadmission screen prior to admission date to the home. DOW and ED to conduct monthly audit of new admissions to ensure the preadmission screen completed within 30 days prior to admission to the home until 12/31/24. Audits to be reviewed monthly at Q&A meetings until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([redacted] - 10/08/2024)

227d - Support Plan Medical/Dental

11. 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 initial Department Medical Evaluation (DME) for resident #1 dated [redacted] reported a diagnosis of [redacted] with [redacted]. However, the initial support plan dated [redacted] did not document information related to [redacted]. Resident #1 was involved in an incident on [redacted] in which another resident was struck by resident #1.

Resident #6 was observed utilizing a [redacted] during the inspection on 8/27/24. However, the resident support plan did not document the need for this equipment.

Plan of Correction

Accept ([redacted] - 09/17/2024)

Resident # 1 support plan was updated by DOW to include diagnosis of [redacted] to match the DME diagnosis. (see attached) DOW or Designee to audit all initial support plans to ensure the DME diagnosis correlate with the initial support plan diagnosis by 10/31/24. Audit results to be reviewed at monthly Q&A until 12/31/24. Resident #6 support plan was updated by DOW to include the usage of the need for a [redacted]. (See attached) DOW or ALM to audit SDCU residents support plans to ensure the usage of any durable medical equipment by residents is indicated on their support plans by 10/31/24. Audits to be reviewed at monthly Q&A meeting to ensure resident support plans indicate utilization of durable medical equipment for SDCU residents until 12/31/24.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([redacted] - 10/08/2024)

234a - Admission Support Plan

12. 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 9/26/23. However, the resident’s initial support plan was completed on 10/16/23.

Plan of Correction

Accept ([redacted] - 09/17/2024)

Director of Wellness or Assisted Living Manager (ALM) to audit SDCU residents' charts to ensure initial support plans are completed within the allotted 72 hours of admission by [redacted]. Audit results to be reviewed at monthly Q&A meeting until [redacted].

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([redacted] - 10/08/2024)