

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

April 3, 2025

[REDACTED]
PARK CREEK MC, LLC
[REDACTED]
[REDACTED]

RE: PARK CREEK PLACE MEMORY CARE
1089 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 15085

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/05/2025 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: PARK CREEK PLACE MEMORY CARE License #: 15085 License Expiration: 06/14/2025
Address: 1089 HORSHAM ROAD, NORTH WALES, PA 19454
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: mcampagna@seniorlifestyle.com

Legal Entity

Name: PARK CREEK MC, LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 07/19/1996 Issued By: PA L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 62 Waking Staff: 47

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident Exit Conference Date: 03/05/2025

Inspection Dates and Department Representative

03/05/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 48 Residents Served: 31

Secured Dementia Care Unit

In Home: Yes Area: Entire Home Capacity: 48 Residents Served: 31

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 31
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 31 Have Physical Disability: 0

Inspections / Reviews

03/05/2025 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/29/2025

03/28/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/02/2025
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 04/03/2025

Inspections / Reviews *(continued)*

04/03/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/02/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

15b - Supervisor Plan

1. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [REDACTED], staff person A, the home's administrator, suspended staff persons B and C, based on accusations of abuse made by staff person D. As the home was experiencing a staffing shortage, the administrator contacted staff persons B and C on [REDACTED] and reinstated them, before the Department had conducted an investigation.

Plan of Correction

Accept ([REDACTED] - 03/28/2025)

Immediate action was taken by the Executive Director, suspending staff persons B and C on 2-26-25, staff persons B and C were reinstated on 2-28-25. The Health and Wellness Director or the Manager On Duty will immediately inform the Executive Director of any incident of alleged abuse, the procedure was reviewed with all managerial staff by the Executive Director. The Executive Director will immediately determine to suspend or provide immediate supervision. If immediate supervision occurs, the Executive Director will then prepare and implement a plan of supervision for any staff person suspected in alleged abuse, including but not limited to pairing said staff person with another staff person for the duration of the shift. In addition, the Executive Director will contact the Department in writing of either the suspension plan or plan of supervision, to request approval of the plan or adjustment of the plan as directed by the Department. All staff were provided education and training on the topic of Incident Reporting on 2-26-25 and 2-27-25 by the Executive Director, the Health and Wellness Director, and the Home Office Operations Specialist utilizing the DHS regulation 2600.16 and our Senior Lifestyle Policy and Procedure on Abuse and Neglect Reporting, including suspected/ confirmed Resident-Resident Abuse. The Ombudsman provided training to all staff on 3-24-25 on Abuse, Resident Rights, and Sensitivity. On 3-27-25 the Executive Director provided managerial directors training on regulation 2600.15b: the Home shall immediately develop and implement a plan of supervision or suspend the staff involved in the alleged incident, the Home is not to reinstate suspended staff until the Department completes their investigation. The Abuse and Neglect investigation process will be discussed at the quarterly Quality Assurance review on 4-1-25 by the Executive Director with managerial directors in attendance.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented [REDACTED] 04/03/2025)

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 [REDACTED] at approximately 6:00-6:30 pm, staff person D assisted staff person B in changing resident [REDACTED], who was sitting in their wheelchair. Staff person D reported that staff person B asked staff person D to hold down resident [REDACTED] arms as the resident was resisting being changed. Staff person D alleged that on the same evening, staff person B put resident [REDACTED] and [REDACTED] to bed in a rough manner, pushing the residents' head down onto their beds. Staff person C did not report these incidents until [REDACTED] at 5:30 pm, during a routine check-in with staff person A, who then reported it to the Department.

16c Written Incident Report (continued)

Plan of Correction

Accept (█ - 03/28/2025)

Training on Mandatory Abuse Reporting to all staff began on 2 26 25 and was completed on 3 24 25. The Executive Director reviewed the requirements for DHS reportable Incident events, regulation 2600.16 with current managerial directors. It was verified staff person C received all required trainings upon completing orientation. The Ombudsman provided training on Abuse, Resident Rights, and Sensitivity training on 3 24 25 with all staff. The Business Office Manager will continue to complete orientations of all new hires to include Abuse Training and Reporting within 40 hours of their date of hire. Abuse, Neglect investigation process and reporting will be discussed at the next quarterly Quality Assurance review on 4 1 25 by the Executive Director with current managerial directors in attendance. The Executive Director will monitor ongoing and continuous.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented (█ - 04/03/2025)

60a - Staff/Support Plan

3. 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 █, from 8:22 pm to 10:45 pm, there were only two staff persons working in the home. Several residents in the home at this time, including residents █ and █ had current support plans requiring two person assistance for transferring in/out of bed/chair. Resident █ support plan, dated █, requires turning/positioning in bed every two hours. There was not sufficient staff to meet these needs.

Plan of Correction

Accept (█ - 03/28/2025)

The Executive Director and Health and Wellness Director will review the current schedule daily during the week to verify there is adequate staffing to meet the needs of the Residents to establish ongoing compliance starting 2 28 25 and continue for 12 weeks. The Executive Director will meet weekly with the Health and Wellness Director and the Memory Care Director to discuss open staffing positions to be filled every Monday, the Executive Director will discuss same with the Home Office recruiter to post current openings. A job fair is tentatively scheduled for 4 10 25. The Executive Director will oversee ongoing and continuous.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented (█ - 04/03/2025)

62 - Contact List

4. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person D and staff person E, both hired █, were not on the staff list provided by the home on █.

Plan of Correction

Accept (█ - 03/28/2025)

Staff persons D and E were immediately added to the contact list. Memory Care Director added staff persons D and

62 - Contact List (continued)

E on 2-27-25. The contact list was verified by the Memory Care Director and audited by the Executive Director by 3-27-25. New employees will be added to the contact list upon completion of their orientation by the Memory Care Director or designee ongoing and continuous. An audit of new employees hired will be completed weekly x 12 weeks, beginning the week of 3-24-25 to verify that the contact information is up to date and accurate, the Memory Care Director will update the list and the Executive Director will audit the list. Results of audits will be reviewed monthly X 3 months or until compliance is established by the Executive Director from 04-01-25.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented [redacted] 04/03/2025)

82c - Locking Poisonous Materials

5. 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 home's residents, including residents [redacted] and [redacted], have been assessed as unsafe to use or avoid poisonous materials. On [redacted] at approximately 9:30 am, the door to the home's salon was unlocked, with numerous products containing poisonous materials unlocked, unattended, and available to residents. A bottle of Honey & Almond Shampoo had a manufacture's label indicating, "Avoid contact with eyes, Do not take internally."

Plan of Correction

Accept [redacted] - 03/28/2025)

The immediate action taken by the Executive Director was the door to the salon was locked on 2-26-25 while the inspectors were on site. Staff will be provided training on Senior Lifestyle's Safe Haven Policy to all staff, training will be completed by the Memory Care Director 3-28-25. Daily rounds will be conducted by the Maintenance Director, the Memory Care Director, or the manager on Duty to verify the salon door is locked for one month or until compliance is established. The Executive Director will discuss Senior Lifestyle's Safe Haven Policy at the next Quality Assurance review with current managerial directors on 4-1-25. The Executive Director will monitor for compliance ongoing and continuous.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented [redacted] - 04/03/2025)

231c - Preadmission Screening

6. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. However, the resident written cognitive preadmission screening was completed on [redacted]

Resident [redacted] was admitted [redacted]. However, the resident written cognitive preadmission screening was completed on [redacted]

231c - Preadmission Screening (continued)

Resident [REDACTED] was admitted [REDACTED]. However, the resident written cognitive preadmission screening was completed on [REDACTED].

Plan of Correction**Accept** [REDACTED] **03/28/2025)**

All Resident's preadmission screens were audited and completed by 3-28-25 to verify the form was accurately completed for each Resident within 72 hours prior to admission to the Home's Secured Dementia Care Unit by the Health and Wellness Director and the Memory care Director. Training was provided to the Health and Wellness Director, the Memory Care Director, the Community Relations Director and the Resident Care Coordinator on this regulation and completed on 3-28-25. The Executive Director will audit the Health and Wellness Director effective 2-27-25 and continue for twelve weeks. The Executive Director will oversee ongoing and continuous.

Licensee's Proposed Overall Completion Date: 03/28/2025

Implemented [REDACTED] **04/03/2025)**