Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
email: [redacted]

MAILING DATE: MAY 9, 2025

Creek Senior Care LLC
[redacted]

RE: The Bridges at Bent Creek
2100 Bent Creek Boulevard
Mechanicsburg, Pennsylvania 17050
Certificate #: 333550

Dear Creek Senior Care LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on 3/24/2025, 3/25/2025, 3/26/2025, 3/27/2025 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (License #333550) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility(s) and failure to submit an acceptable plan to correct noncompliance items and is made pursuant to <62 P.S. § 1026 (b)(4);(5) and 55 Pa. Code § 20.71(a)(2);(3);(4);(5);(6) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. The Bridges at Bent Creek is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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**: *09/12/2025*

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: *C-2 LP* **Date**: *01/03/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *135* **Waking Staff**: *101*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *03/27/2025*

Inspection Dates and Department Representative

03/24/2025 - On-Site: [redacted]*eal*

03/25/2025 - On-Site: [redacted]

03/26/2025 - On-Site: [redacted]

03/27/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *101*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lilac Trace* **Capacity**: *31* **Residents Served**: *23*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *101*

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

Have Mobility Need: *34* **Have Physical Disability**: *1*

Inspections / Reviews

03/24/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/27/2025*

05/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

05/05/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *05/05/2025*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 3/24/25 at 9:45 AM and again at 12:29 PM, resident #1's March 2025 medication administration record (MAR), and current physician's orders were requested by Agents of the Department. However, the records were not provided until 12:59 PM.

On 3/24/25 at 2:15 PM, resident #2's December 2024 and January 2025 MARs were requested by Agents of the Department. However, the records were not provided until 3/26/25, at 9:00 AM.

Plan of Correction ***Accept (- 05/05/2025)***

By 4/30/25, The Executive Director shall re-educate all staff on the requirements of this regulation of providing records requested by agents of the department immediately upon request and who to go to if Electronic Health and Electronic Medication Administration Record (EHR/EMAR) information is requested.

By 4/30/25, the Executive Director or designee will secure HER/EMAR login credentials for designated associates to ensure there is always a staff member available 24 hours per day to prevent a delay in providing requested information and/or documentation to agents of the Department. The Executive Director will maintain a list of who has access and adds access as needed do to staff attrition.
By 4/30/25, all designated staff members given access to the digital records shall be trained on how to access the systems and print any requested documentation. Documentation of this in-service shall be kept.
Once a week for 30 days, Starting 5/1/25. The Executive Director or designee shall randomly request resident information from a staff member on the access list to measure compliance with this regulation.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented (- 05/05/2025)

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 , a home health agency staff member caring for resident #3 responded to the resident's complaint of pain in leg. The resident's left shin was wrapped with a large bandage that covered entire shin, and the home health agency staff member noticed a strong odor coming from the area. When the shin was unwrapped, a large wound was found covering approximately 3-4 inches of the resident's left tibia. . Staff member the Director of Wellness, was informed of the wound and shown a picture of the wound by the home health agency staff member and Staff

16c - Written Incident Report (continued)

member [redacted] the home's Training and Wellness Coordinator. After receiving instructions from the home health agency staff member, the home contacted Emergency Medical Services and resident #3 was transported to the local hospital. The resident was admitted from [redacted] and diagnosed wit [redacted].
However, this incident was not reported to the to the Department.

Resident #4 was prescribed the following medications and treatments that were not administered to the resident in accordance with the prescriber's orders on the following dates and times:

- *Epsom Salt- soak bilateral feet daily for 20 minutes, not completed on 3/9/25, at 8:00AM.*
- *Eucerin Original Lotion- apply topically to bilateral feet twice daily for dry skin, not completed on 3/9/25, at 8:00AM.*
- *Lidocaine 4% patch- apply topically to lower back every morning and remove every evening, not completed on the morning of 2/16/25.*

The home was aware of and documented the medication errors; however, the incidents were not reported to the Department.

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The Executive Director shall complete and submit late incident report forms to the Department by 4/25/25. The forms shall be submitted to establish preliminary compliance as part of the LIS POC.
The Executive Director or designee shall re-educate the Director of Wellness and Memory Care Director by 4/30/25, regarding Pennsylvania specific incident reporting requirements, including what is reportable, to whom, required time frames and any necessary follow-up actions that should be implemented.
By 4/30/25, The Health and Wellness Director will re-educate all direct care staff on the Department requirements for reporting reportable incidents.
Beginning 4/27/25, the Director of Wellness or designee shall review the electronic Medication Administration Record (EMAR) each morning to ensure any care-related concerns are addressed, and when applicable reported as required by this regulation. Documentation of the daily review shall be signed and kept. ***(Directed) The Director of Wellness or designee will review EMAR's for at least 10 residents daily-[redacted]***

Beginning 4/27/25, all community incidents shall be provided to the executive director or manager on duty every morning for 60 days to determine if it must be reported to the Department and other required parties. If so, the Executive Director or manager on duty will notify and report as required within the specified time frame established by this regulation.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented ([redacted] - 05/05/2025)

17 - Record Confidentiality

3. Requirements

2600.

17 - Record Confidentiality *(continued)*

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 3/24/25, at 9:40 AM, resident medications, medication orders and controlled substance medication count books for multiple residents were left unlocked, unattended, and accessible in the medication area by the dining room on the first floor to include the following:

- *Resident #1's medication orders for amlodipine, aspirin, atorvastatin, citalopram, memantine, senna-doc, vitamin B-12, and vitamin D-3 in the trash can attached to a medication cart.*
- *Resident #5's medications orders for hydrocellular foam dressing and nystatin powder were in the unlocked treatment medication cart.*
- *Resident #6's medication orders for diclofenac sodium gel were in the unlocked treatment medication cart.*

On 3/25/25, at 10:15 AM, controlled substance medication count books labeled T1 and T2 were unlocked, unattended, and accessible on top of the medication cart in an alcove by the dining room. The books contained resident names, prescribed medications, and diagnoses for multiple residents to include:

- *Resident #7 who is prescribed fentanyl 12 MCG/HR patch (no Dx listed).*
- *Resident #8 prescribed diazepam 5 MG tablet for anxiety.*
- *Resident #9's pregabalin 50 MG capsule for pain.*
- *In addition, there are numerous empty pillow packets with legible resident names and prescribed medications including: resident #10's Trintellix 10 MG; resident #11's folic acid, 1 MG for folate deficiency; metoprolol succinate 25 MG, take ½ tablet by mouth for HTN; and resident #12's amlodipine 5 MG, for hypertension; and citalopram HBR 40 MG for depression.*

Plan of Correction ***Accept ([redacted] - 04/30/2025)***

All identified items listed in the summary were immediately removed and secured to protect resident confidentiality by the Executive Director and Director of Wellness on 3/24/25 and 3/25/25.
By 4/30/25 the Executive Director or designee shall re-educate all staff members on maintaining confidentiality. This education shall include, at a minimum, confidential storage policies, how to properly dispose of items that contains confidential information and ensure all carts and offices that contain confidential information are locked when a staff member is not directly present.
For 30 days, starting 4/27/25, and then weekly for 60 days thereafter, The Director of Wellness or designee shall randomly check the entire community daily, including medication carts, storage areas, and office spaces to ensure confidentiality is being maintained. Any instances of non-compliance will be corrected immediately, and required interventions will be implemented to ensure ongoing compliance with this regulation.
Results of these checks shall be reviewed by the Executive Director at the Monthly Quality Management meetings beginning 5/28/25.

Licensee's Proposed Overall Completion Date: *05/28/2025*

25b - Contract Signatures

4. Requirements

2600.

25b - Contract Signatures *(continued)*

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 #3, and the resident-home contract dated [redacted], for resident #4, were not signed by the residents.

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The Business Office Manager or designee shall meet with resident #2 to review the Resident-Home Contract and secure their signature by_4/4/25. Resident #1 is no longer a resident of the community; therefore, the Resident-Home contract could not be signed. ***(Directed) The Business Office Manager or designee will meet with Resident #4 to review and secure their signature-[redacted]***

The Executive Director shall re-educate the business office manager and designee on Resident-Home contract execution and required signatures by 4/4/25.
The Business Office Manager or designee will audit all Resident-Home contracts by 4/4/25 and correct any inaccurate or missing information, including securing required signatures, if found missing.
Beginning 4/27/25, The Executive Director or designee shall review all newly admitted Resident-Home Contracts withing 24 hours of the move-to ensure all required signatures have been obtained during the initial contract review and signing.
Beginning 5/28/25, and for a period of three months, The Business Office Manager shall bring the Resident-Home agreements for all new admissions since the previous monthly Quality Management meeting to the current Quality management meeting to review for any missing signatures. Any corrections shall be made, and documentation shall be kept as part of the meeting minutes.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

42b - Abuse

5. 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

Resident #3 was admitted to the home from the hospital on [redacted] The home's written description of services indicates as a criterion for admission that the resident may not have any stage 3 or stage 4 pressure wounds. The description of services also indicates that the operator is not staffed or authorized to perform skilled nursing services or acute care services and that if a resident develops a need for services beyond the scope of the agreement the resident will be discharged after prior written notice. Multiple staff interviews to include interviews with staff member [redacted] the home's Director of Wellness and staff member [redacted] the home's Executive Director/Administrator also indicated that home does not provide daily skilled level wound care. At the time of admission, the resident #3 had a history of [redacted] Resident #3's initial assessment, dated [redacted], indicates that resident requires prompting/cueing with managing healthcare and total assistance with securing healthcare and making and keeping appointments. Between resident 3#'s date of admission and resident #3's date of death, [redacted]

42b - Abuse (continued)

[redacted] by the home's staff, wound care specialists, physicians, and hospital staff and directions for the care of resident#3's wounds and managing [redacted] pain were provided to the home. However, the instructions were not followed by the home and the resident was never evaluated by the home to determine if resident #3's needs were beyond the scope of the care that could be provided by the home and required acute care or skilled nursing services.

On 2/15/25, resident #3 was sent to the emergency room after staff observed [redacted] the resident was unable to bear weight on [redacted] left leg. The resident was hospitalized from [redacted] for a [redacted] On [redacted] resident #3 was discharged back to the home with the discharge instructions to include: [redacted] Follow up with [redacted] outpatient center in 1 week. Resident #3 did not return to the [redacted] outpatient center within a week of discharge on [redacted] nor did the home weigh the resident daily or provide dietary needs as ordered.

On [redacted], resident #3 complained of left leg pain to staff member D and staff member E, [redacted] Staff member D, went to staff member F, the medication technician and they unwrapped the bandage on resident #3's left foot/left leg. [redacted] However, the staff members re-wrapped the wound and did not immediately notify any medical professionals or request additional emergency medical treatment for the resident. On [redacted] a hospice nurse evaluated resident #3 and discovered the following: [redacted] A strong odor is noted, [redacted] staff completely unaware of this wound. Resident #3 was sent to the hospital where [redacted] was diagnosed with [redacted] he resident was in serve pain and required a morphine drip while hospitalized to manage the pain.

On [redacted] resident #3 was again discharged back to the home and passed away at [redacted], on resident #3's date of death. The immediate cause of death was determined to be [redacted] he home failed to adequately assess the residents needs upon admission and admitted resident #3 whom they were unable to care for in accordance with their description of services, failed to provide prompt and appropriate medical interventions for the resident's [redacted] wounds, failed to provide care and services to the resident in medication management, dietary, repositioning needs, weight management, and failed to assist the resident with making and keeping medical appointments.

42b - Abuse *(continued)*

Plan of Correction ***Directed ([redacted] - 05/01/2025)***

Although The Bridges at Bent Creek does not agree with this violation, The Executive Director is examining every aspect in which personal care residents with complex medical conditions, who are receiving healthcare services at the community from supplemental health care providers and/or outpatient centers, are being managed effectively by all parties.

All staff will receive training on how to identify and report abuse and neglect on 5/9/25 by Cumberland County Ombudsman.
The Executive Director or designee will re-educate the Sales and Marketing Director, Director of Wellness, Memory Care Director and any other staff responsible for approving admissions and readmissions by 4/30/25 on the Community's admission and discharge criteria, requirements for safe returns from the hospital, communication and collaboration with third party health care providers and family, the regulations regarding who can provide health care services, medications and treatments in a licensed personal care home and direct care staff limitations.
The Director of Wellness will review all residents receiving services from supplemental health care providers to ensure their needs are being managed effectively by 5/26/25.
The Executive Director and Director of Wellness or designee will meet with all active supplemental health care providers on the Community's policies, procedures and expectations for service delivery and a new communication process by 5/26/25.
Beginning 5/26/25, The Director of Wellness will hold individual weekly meetings with active supplemental Health Care Providers to discuss continuity of care and address any clinical changes to create and foster a more collaborative relationship.
Any recommendations shall be immediately implemented. Documentation of all training and audits shall be kept.

(Directed)
In addition to the above plan of correction:

- *The Administrator or designee will complete a review of each resident residing in the home to determine if their needs can continue to be met by the home in accordance with the home's description of services. This review will be completed by 5/31/25.*
- *Education will be provided to all staff on proper wound care treatment and prevention by the Administrator or designee by 5/31/25. Education will also include how to complete proper skin assessments as necessary and who to notify if any areas of concern are identified for prompt treatment and follow-up.*
- *Education will be provided to staff responsible for scheduling medical appointments on scheduling medical consultations as recommended by a physician promptly by 5/31/25.*
- *Beginning 5/31/25, the Administrator or designee will review at least 10 resident records per month to ensure follow-up appointments are being scheduled and attended to as well as any in-house documentation on resident status to ensure services are being provided based on a resident's need.*

Directed Completion Date: *05/31/2025*

82c - Locking Poisonous Materials

6. 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.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On 3/26/25, at 10:06 AM, the following items were unlocked, unattended, and accessible in the cabinet above the toilet in resident #4's bedroom: a box of Polydent Denture Cleaner with a label stating "IF SWALLOWED: Call a Poison Control Center or doctor" and a tube of McKesson Thera Calazinc Body Shield with a label that states, "If swallowed, get medical help or contact a poison control center right away." Resident #4 is not assessed to be safe around poisonous materials.

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

The Memory Care Director secured the identified items immediately on 3/26/25.

The Memory Care Director or designee shall thoroughly check every resident room for hazardous products by 4/30/25. They will secure or remove any unsecured items. A log of the room checks shall be kept.
The Executive Director or designee shall and notify the family or responsible parties of all Lilac Trace residents of the requirements of the regulation and require that all products that are supplied by the family be given to staff to properly secure instead of placing the products in the resident's room. A log of this check shall be kept. ***(Directed)***
The Executive Director to notify family by 5/20/25 with documentation of notification to be kept by the home - [redacted]
The Memory Care Director or designee shall re-educate all staff who work in the secure memory care neighborhood on the safe storage of potentially hazardous products and what to look for when checking resident rooms and common areas. ***(Directed) Education to be completed by 5/20/25-*** [redacted]
Beginning 5/1/25, The Memory Care director or designee shall complete a random daily inspection of different memory care rooms, at different times, for 30 days and then weekly for 60 days to ensure ongoing compliance of this regulation. A log of these checks shall be kept. ***(Directed) At least 5 different bedrooms will be audited daily, then weekly for 60 days-*** [redacted]
Documentation of all training and audits shall be kept.

Directed Completion Date: *05/20/2025*

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/26/25 at 10:08 AM, the water in the bathroom sink in bedroom 179 measured 126.5 degrees Fahrenheit and at 10:14 AM, the water measured 132.3 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The Maintenance Director Immediately contact the contracted plumbing company on 3/26/2025 to request service.

The Plumbing Company Assessed the problem and determined that hot water mixing valve failed and replaced it on 3/29/2025.

89b - Hot Water Temperature (continued)

The Executive Director or Designee shall re-educate the Maintenance director by 4/30/25 on completing required hot water checks in various locations throughout the building during every regularly scheduled hot water temperature check.
Beginning 4/30/25, the Maintenance Director or designee shall complete daily hot water checks in random locations for one week to ensure the repair resolved the problem and then monthly thereafter. Documentation shall be kept.
(Directed) Daily hot water checks will be completed in least 10 random locations. Documentation will include the measured temperature and the location that was audited- [redacted]
The Executive Director or designee shall review the water temperature logs at the monthly Quality Management Meeting to ensure ongoing compliance
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *04/30/2025*

Not Implemented ([redacted] - 05/05/2025)

100a - Exterior - Free of Hazards

8. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 3/24/25 at 9:51 AM, the egress route from the exterior secured courtyard to the exit was not easily accessible as the pathway consisted of mulch. Approximately 18 residents residing in the secured dementia care unit require a wheelchair or walker for ambulation. Utilizing mobility devices on an uneven surface such as mulch poses a hazardous condition.

Plan of Correction ***Accept ([redacted] - 05/01/2025)***

The Executive Director or designee shall re-educate the Maintenance Director on this regulation, including ensure egress paths and walkways are free of hazards on 4/30/25.

By 5/1/25, The Maintenance Director or designee shall inspect every exterior egress path to ensure there are no hazards. Any needed repairs will be immediately fixed.
Monthly, beginning 5/1/25, The maintenance director will complete monthly audits of all exterior exit routes and walkways to ensure compliance with this regulation. Documentation shall be kept.
The Executive Director will review the initial inspection at the next Quality Management meeting on 5/28/25 and the monthly audits at each meeting thereafter for a period of 90 days.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

103e - Left Overs

9. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

On 3/24/25 at 10:25 AM, in the second-floor activity and craft room, there was an unlabeled and undated bag of meat and cheese cubes and an unlabeled and undated container of left-over food in the mini-refrigerator.

Plan of Correction ***Accept (- 05/05/2025)***

The food was immediately removed and discarded on 3/25/2025 by the Activities Director.

The Dining Director or designee will re-educate all Dietary and Activity Department staff on the requirement of this regulation by 4/30/25. Documentation shall be kept.
Beginning 5/1/25, the Activity Director or designee shall check all activity area refrigerators daily, for 30 days to ensure ongoing compliance with this regulation.
At the end of the 30 days, the Activity Director or designee will complete random weekly checks for 60 more days to ensure ongoing compliance. ***(Directed) weekly checks will include at least four refrigerators weekly.-***
The Executive Director or designee shall review the documentation at the monthly quality management meeting to ensure compliance beginning on 5/28/25.

Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

141a 1-10 Medical Evaluation Information

10. 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. 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

Resident #4's initial medical evaluation, dated did not include information pertaining to body positioning and movement.

Plan of Correction ***Accept (- 05/05/2025)***

On 4/25/25, The Director of Wellness or designee requested a new Documentation of Medical evaluation from resident #4s physician and once received will be reviewed.

By 4/30/25, The Executive Director or Designee shall re-educate all staff members who review incoming DMEs for completion and accuracy as well as the necessary information required by this regulation.
Beginning 5/1/25, The Director of Wellness or designee will review all current DMEs for accuracy and

141a 1-10 Medical Evaluation Information (continued)

completeness. ***(Directed) The review will be completed by 5/20/25 and any medical evaluations identified to be missing required information will be corrected within 5 days-*** [redacted]

Effective 5/1/25, all new and annual DMEs shall be reviewed by 2 parties before they are filed in the resident's record. The second person shall always be the Director of Wellness or Memory Care Director. Both parties shall initial the top left-hand corner of each DME to document review.

At the next Quality Management meeting on 5/28/25 the Executive Director shall review the DME audit to ensure compliance.

Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

142d - Secure Preventative Care

11. Requirements

2600.
142.d. The home shall assist the resident to secure preventative medical, dental, vision and behavioral health care as requested by a physician, physician's assistant or certified registered nurse practitioner.

Description of Violation

Resident #3's assessment and support plan, dated [redacted]*, indicates the resident needs total physical assistance in scheduling and tracking appointments as well as arranging for transportation and appointments. It also indicates the resident needs prompting and cueing for overall health care coordination such as tracking different doctors appointments and medications. On* [redacted]*, resident #3's physician recommended the resident follow up with a wound care specialist provider and for the home to arrange for resident #3 to resume care with the wound clinic for treatment* [redacted] *The home did not arrange for the resident to return to the wound clinic until* [redacted] *2024.*

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

On or by 4/30/25, the Bridges at Bent Creek shall review and amend their process for scheduling and tracking appointments as well as arranging for transportation and appointments, as needed. It shall include their process for assisting with a resident's need for prompting and cueing for overall health care coordination such as tracking different doctor's appointments and medications.

On 4/30/25 the Executive Director or designee shall train all staff on the Community's policy and procedure and any changes to the Policy and Procedure to ensure compliance with this regulation.

Effective 4/27/25 all residents being admitted or readmitted to the community will be assessed at the discharging location to ensure that the needs of resident can be met or coordinated by the community.

The home will request all physician orders prior to admission or readmission to ensure that all supplemental services are schedule or in place before the resident physically arrives at the community.

Beginning 5/26/25, The Director of Wellness will hold individual weekly meetings with active supplemental Health Care Providers to discuss continuity of care and address any clinical changes to create and foster a more collaborative relationship. Any recommendations shall be immediately implemented.

Documentation of all training and audits shall be kept.

142d - Secure Preventative Care (continued)

(Directed)

In addition to the above plan of correction:

- *Beginning no later than 5/1/25, the home will request all physician orders prior to admission or readmission to ensure that all supplemental services are scheduled or in place before the resident physically arrives at the community.*
- *An audit will be completed on all other resident physician summaries to ensure recommended follow-ups have been scheduled and/or attended. Audit will be completed by 5/31/25 by the Administrator or designee.*

Directed Completion Date: *05/31/2025*

144c1 - Smoking Area Guidelines

12. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 3/27/25, at 8:55 AM, residents #13 and #14 were smoking on the front porch of the home. The home does not permit smoking on the property.

Plan of Correction ***Accept ([redacted] - 04/30/2025)***

On 3/27/2025, The Executive Director spoke with the two identified residents to remind them of the non-smoking on the premises policy.

The Executive Director or designee shall re-educate all staff on the campus non-smoking policy and ask them to intervene if they witness a resident smoking on the premises on 4/30/25.

The receptionist on duty will monitor the activity of the residents who smoke to ensure they are maintaining compliance with the home's policy when they exit through the main entrance.

The Executive Director will ask the resident council to remind residents of the smoking policy at their next resident council meeting on 5/7/25.

Any resident who repeatedly violates the smoking policy will be issued a 30 day notice of discharge from the community.

Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/07/2025*

182b - Prescription Medication

13. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

182b - Prescription Medication *(continued)*

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted] resident #3's hospital discharge instructions and prescriber's orders for [redacted] included the following: [redacted].

On multiple occasions after resident #3's return to the home on [redacted] staff member G, who is not certified in medication administration, cleaned and dressed resident #3's [redacted] Staff member G indicated that [redacted] did not know how to complete this wound care for resident #3.

Multiple staff interviews indicated that over the-counter medicated creams were applied to resident #3 by resident care aides who were not qualified to administer medications and, over-the-counter medicated creams were available to all resident care aides in resident #3's bathroom so they could apply if needed.

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

Effective 4/8/25, Only a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies shall administer medications.

The Director of Wellness or designee shall re-educate all staff who administer medications on this regulation and that under no circumstances shall they give a medication to a non-medication administration trained staff person to administer or apply the medication in their place. Documentation of this training shall be kept.
On 3/26/25, the Home's Medication Administration trainer shall observe one full medication pass for each staff member who administers medication, including LPNs and RNs, to ensure compliance with this regulation. Observations shall be kept.
Beginning 5/1/25, The home Medication Administration trainer shall observe a monthly medication pass at random to ensure ongoing compliance.
Documentation of all training and audits shall be kept.

(Directed)
In addition to the above plan of correction:

- *The Director of Wellness or designee shall re-educate all staff who administer medications on this regulation and that under no circumstances shall they give a medication to a non-medication administration trained staff person to administer or apply the medication in their place. Education to be completed no later than 5/28/25. Documentation of this training shall be kept.*
- *All staff who are not certified to administer medications will receive education by the Administrator or designee on the requirements for administering medications and treatments including topical ointments and wound dressings. Education will be completed by 5/28/25.*
- *Beginning 5/28/25, the Administrator or designee will interview at least 3 non-medication administration trained staff per week to ensure only certified staff are administering medications and treatments.*
- *Beginning 5/1/25, the home Medication Administration trainer shall observe a monthly medication pass for*

182b - Prescription Medication (continued)

at least two staff to ensure ongoing compliance.

- *Documentation of interviews and observations will be kept by the home and available for review by the Department.*

Directed Completion Date: *05/28/2025*

183b - Meds and Syringes Locked

14. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/24/25 at 9:40 AM, multiple medication bottles, ointments, eye drops, powders, and pill packets for residents were observed unlocked, unattended, and accessible in the medication area alcove off the dining room in the following locations: the trashcan of two medication carts, and one medication cart was left unlocked entirely. The following are examples of medications observed unlocked and unattended in these areas:

- *Resident #1's amlodipine, aspirin, atorvastatin, citalopram, memantine, senna-doc, vitamin B-12, and Vitamin D-3.*
- *Resident #5's hydrocellular foam dressing, nystatin powder, and refresh tears.*
- *Resident #6's diclofenac sodium gel.*
- *Resident #15's triamcinolone cream and nystatin powder.*

On 3/24/25 at 10:16 AM, a bottle of Tylenol 650mg tablets and Vicks VapoRub was unlocked, unattended, and accessible in the unlocked second-floor housekeeping closet.

On 3/26/25 at 10:06 AM, an unlocked, unattended, and accessible bottle of Nystatin Kaylesta Pow 100000 Powder and a tube of McKesson Thera Calazinc Body Shield belonging to resident #16 were located above the toilet in the shared bathroom. Neither resident residing in the shared room, are assessed to self-administer medications.

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

The identified medication was immediately removed and secured by staff on 3/24/2025 and 3/26/2025.

The Director of Wellness or designee will re-educate all staff on 4/8/25 on properly securing medication at all times, including medication kept in resident rooms.
The Director of Wellness, Memory Care director and designees will inspect every resident room, common areas and office by 5/5/25 to ensure there is no medication left unlocked, unattended and accessible to residents.
Documentation of the room checks shall be kept.
Beginning 5/5/25, The Director of Wellness, Memory Care Director or designee shall complete a weekly random audit of the community for 30 days to check for any unsecured medication and monthly thereafter for 60 days.
Documentation shall be kept.
The findings of the audits will be review by the Executive Director at the Monthly Quality Management meeting beginning 5/28/25.
Documentation of all training and audits shall be kept.

183b - Meds and Syringes Locked (continued)

(Directed)

In addition to the above plan of correction:

- *All staff in the home will receive education on storing medications as required per a resident's ability to self-administer medications. Education will be completed by 5/28/25 by the Administrator or designee.*
- *Residents will receive education on storing medications properly per their assessed ability to self-administer medications. Education will be completed by 5/28/25 by the Administrator or designee.*
- *Beginning 5/5/25, the Director of Wellness, Memory Care Director or designee shall complete at least one weekly audit of the community to include at least 5 resident bedrooms, all medication administration areas and at least 3 housekeeping/supply closets for 30 days to check for any unsecured medication and monthly thereafter for 60 days. Documentation shall be kept.*

Directed Completion Date: *05/28/2025*

183f - Discontinued Medications

15. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 3/24/25 at 9:40 AM, the following medications were observed in the unlocked trash cans attached to medication carts 1 and 2:

- *Resident #1's amlodipine, aspirin, atorvastatin, citalopram, memantine, senna-doc, vitamin B-12, and Vitamin D-3.*
- *Resident #5's refresh tears.*
- *Resident #17's diclofenac sodium gel.*

This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

Effective 3/24/2025, all medication shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations.

On 4/8/25, all staff who administer medication shall be re-educated on the proper destruction of medication including documentation. Documentation of this training shall be kept.

The Director of Wellness will create and implement a destruction log to be used for all medication beginning 5/1/25.

The Executive Director or Director of Wellness, shall participate in medication destruction once per week for 30 days and once per month for 60 more days to measure compliance with this regulation.

Compliance with this medication destruction procedure will be reviewed at the monthly Quality Management meeting beginning 5/28/25.

Documentation of all training and audits shall be kept.

(Directed)

183f - Discontinued Medications (continued)

In addition to the above plan of correction:

- *The Administrator will review the home's current Medication Management Medication Storage and Disposal Policy and revise, as necessary, to include procedures on how to properly destroy medications according to the Department of Environmental Protection and Federal and State regulations. The policies and procedures will be reviewed and/or updated by 5/20/25. Education on the updated policies and procedures will be provided to all staff who administer medications by 5/28/25.*
- *Beginning no later than 5/28/25, the Executive Director or Director of Wellness, shall participate in medication destruction once per week for 30 days and once per month for 60 more days to measure compliance with this regulation.*

Directed Completion Date: *05/28/2025*

185a - Implement Storage Procedures

16. 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

The home's Medication Management Medication Storage and Disposal Policy, effective 7/2021, indicates that the destruction of non-controlled medications shall be completed by the Executive Director, Director of Wellness, or [redacted] Designee who is qualified to administer medications. Documentation of the destruction performed per state regulations and records retained for a period of two years.

On 3/27/25, at 2:25 PM, staff member B was observed removing 6, 5mg escitalopram pills from resident #18's weekly pillow packs, then placed the pills in the drug buster in the home's nurses' station on the first floor. Staff member B did not record the medication destruction on a log and is not qualified to administer medications.

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

Effective 3/24/2025, all medication shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations and documented per the Community's Storage and disposal policy.

Beginning 3/27/2025, Medication shall only be destroyed by the Executive Director, Director of Wellness, or [redacted] Designee who is qualified to administer medications.
On 4/8/25 all staff who administer medication were re-educated on proper documentation, so they are following the regulation and the Community's Policy and procedure
The Director of Wellness will implement a log to be used for documenting the destruction of all medication beginning 5/1/25.
The Executive Director or Director of Wellness shall participate in medication destruction once per week for 30 days and once per month for 60 days to measure compliance with this regulation.
Compliance with the medication destruction policy and procedure will be reviewed at the monthly Quality Management meeting beginning 5/28/25.
Documentation of all training and audits shall be kept.

(Directed)

185a - Implement Storage Procedures (continued)

In addition to the above plan of correction:

- *The Administrator will review the home's current Medication Management Medication Storage and Disposal Policy and revise, as necessary, to include procedures on how to properly destroy medications according to the Department of Environmental Protection and Federal and State regulations. The policies and procedures will be reviewed and/or updated by 5/20/25. Education on the updated policies and procedures will be provided to all staff who administer medications by 5/28/25.*
- *Beginning no later than 5/28/25, the Executive Director or Director of Wellness, shall participate in medication destruction once per week for 30 days and once per month for 60 more days to measure compliance with this regulation.*

Directed Completion Date: *05/28/2025*

187b - Date/Time of Medication Admin.

17. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On [redacted], resident #3 was discharged from the hospital with [redacted] prescribed [redacted] 1 tablet by mouth every 12 hours for 6 days. Documentation on Resident #3's [redacted] 2025 MARs indicate the medication was administered twice daily for 7 ½ days, totaling 15 doses. However, on 3/31/25, resident #3's pharmacy confirmed only 12 tablets (doses) [redacted] were dispensed.

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The Executive Director or designee re-educated all staff who administer medication on the Community's process for recording the administration of medication on 4/8/25.

On 4/17/25 and 4/18/25, An EMAR to cart audit was completed by the Director of Wellness and/or designee to check for discrepancies between the documentation of medication administered with the actual medication on hand. Any discrepancies will be investigated, corrected and addressed with the staff person responsible.
Beginning 5/5/25, The Director of Wellness or designee shall complete a Medication to EMAR Audit once per week for 30 days and then monthly ending on 9/1/25 to monitor for ongoing compliance. ***(Directed) The Director of Wellness or designee shall complete a Medication to EMAR Audit for at least 10 residents-[redacted]***
The Executive Director will review the weekly audits beginning 5/28/25 and then monthly during the Quality Management meeting, thereafter, and address as needed.

Licensee's Proposed Overall Completion Date: *05/28/2025*

187c - Refusal of Medication

18. 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.

187c - Refusal of Medication *(continued)*

Description of Violation

On 1/4/25 at 7:30 PM, resident #3 refused to have [redacted] The home did not report the refusal to the resident's prescriber.

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

All staff who administer medication will be retrained on documentation and reporting refusals by the Director of Wellness or designee on 4/8/25.

The Wellness Director will audit the EMAR by 5/5/25 to identify residents who refused medication in the previous week and report as required to establish a baseline for ongoing compliance.
Director of Wellness or designee shall review the EMAR every morning for 30 days and then weekly for 60 more days, for medication refusal or other medication errors and verify they were reported or need to be reported to the prescriber as required. ***(Directed) Beginning no later than 5/20/25, the Director of Wellness or designee shall review at least 10 resident's EMAR every morning-***[redacted]
The Executive Director shall review every medication refusal report to track and trend and discuss at the monthly Quality Management meeting for interventions that can be implemented to reduce refusals beginning on 5/28/25.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #3 was prescribed Levothyroxine 112mcg, take daily on an empty stomach. However, this medication was not administered on 10/15/24 at 6AM, as it was not available in the home.

On [redacted], resident #3 was discharged back to home from the hospital with discharge instructions and prescriber's orders for wound care to include the following:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

187d - Follow Prescriber's Orders (continued)

Multiple staff interviews indicated that the home does not provide wound care and did not provide the prescribed would care to resident #3 as the services are not offered by the home to include staff member [redacted] the homes Director or Wellness and Staff member [redacted] the homes Executive Director/Administrator.

Resident #4 was prescribed the following medications and treatments that were not administered to the resident in accordance with the prescriber's orders on the following dates and times:

- *Epsom Salt- soak bilateral feet daily for 20 minutes, not completed on 3/9/25, at 8:00AM.*
- *Eucerin Original Lotion- apply topically to bilateral feet twice daily for dry skin, not completed on 3/9/25, at 8:00AM.*
- *Lidocaine 4% patch- apply topically to lower back every morning and remove every evening, not completed on the morning of 2/16/25 as the medication was not available in the facility.*
- *Omega 3 Fish Oil 1200 MG-take 2 capsules by mouth daily for supplement; this medication was not administered on 2/10/25, at 8:00AM, as the medication was not available at the facility.*

Plan of Correction ***Directed ([redacted] - 04/30/2025)***

The Items that were identified during the inspection that could be corrected were

The Executive Director or designee shall re-educate the appropriate clinical staff and Staff who administer medication on the Community's process for timely reordering of medications so they are available at all times.
On 4/17/25 and 4/18/25, A med cart audit was completed by the Director of Wellness and/or designee to ensure that all meds are available as indicated on the resident's EMAR. Any discrepancies will be corrected immediately.
Beginning 5/5/25, The Director of Wellness or designee shall complete a Medication to EMAR Audit once per week for 30 days and then monthly ending on 9/1/25.
The Executive Director will review the weekly audits beginning 5/5/25 and then monthly during the Quality Management meeting beginning on 5/28/25, thereafter.
Documentation of all training and audits shall be kept.

(Directed)

- *The Items that were identified during the inspection that could be corrected were corrected by 4/29/25.*
- *The Executive Director or designee shall re-educate the appropriate clinical staff and Staff who administer medication on the Community's process for timely reordering of medications so they are available at all times. The education will be completed by 5/28/25.*
- *Beginning 5/5/25, The Director of Wellness or designee shall complete a Medication to EMAR Audit for at least 15 residents once per week for 30 days and then monthly ending on 9/1/25. The audit will also include checking if a medication or treatment was administered per the physician's order.*
- *Education will be provided to all staff who administer medications and treatments on providing the medications per the prescribers order. If a medication or treatment was not provided, documentation on the residents medication record should include why the medication or treatment was not administered. This education will be completed by 5/28/25 by the Administrator or designee.*
- *Beginning no later than 5/28/25, if a resident receives physician's orders for treatment of an open area or wound, the Administrator or designee will consult with the physician to provide clarification on the home's ability to administer the medications and/or treatments. Documentation of the physician's response will be kept by the home and available for review by the Department.*

187d - Follow Prescriber's Orders (continued)

Directed Completion Date: *05/28/2025*

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

The home did not notify resident #4's prescriber(s) of the following medication and treatment errors:

- *Epsom Salt soaks to bilateral feet daily for 20 minutes was not provided on 3/9/25, at 8:00AM.*
- *Eucerin Original Lotion was not applied topically to bilateral feet for dry skin on 3/9/25, at 8:00 AM.*
- *Levothyroxine 137 MCG tablet was not administered on 3/16/25 and 2/13/25, at 6:00 AM.*
- *Lidocaine 4% patch was not applied in the morning on 2/16/25.*
- *Omega 3 Fish Oil 1200mg was not administered on 2/10/25, at 8:00 AM.*

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The identified medication errors were reported to the physician on 4/25/25 by the Director of Wellness as a late report to establish initial compliance with this regulation.

All staff who administer medication will be retrained on identifying and reporting medication errors by the Director of Wellness or designee on 4/8/25.
The Director of Wellness or designee shall review the EMAR every morning for 30 days and then weekly for 60 more days, for missed medications or other medication errors and verify they were reported or need to be reported as required. ***(Directed) Beginning no later than 5/28/25, the Director of Wellness or designee will review at least 10 resident's EMAR's each morning for 30 days, then weekly for 60 more days-[redacted]***
The Executive Director shall review every medication error report to track and trend for immediate interventions and ongoing training and development opportunities.
Documentation of all training and audits shall be kept.

Licensee's Proposed Overall Completion Date: *05/28/2025*

190a - Completion Medication Course

21. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff member B has not completed the annual medication administration training requirements since initially certified on 11/2/23 and administered the following medications to resident #2 and resident #3:

190a - Completion Medication Course (continued)

- *Breo Ellipta 100-25 MCG, Calcium 600 MG-Vit D3, cetirizine 10mg, Diclofenac Sodium 1% Gel, Duloxetine HCL DR 60Mg Cap, and Eliquis 5mg on [redacted] to Resident #2.*
- *Morphine 100mg/5ml oral solution to Resident #3 on [redacted]*

Staff member H has not completed the annual medication administration training requirements since initially certified on 11/2/23 and administered the following medications to resident #3:

- *Buspirone 10mg at 4PM, Furosemide 20mg, Magnesium oxide 400mg, and Metformin 500mg at 5PM, Triad Wound dressing paste at 7:30PM, Acetaminophen 650mg at 8PM, and Melatonin 3mg and Simvastatin 20mg at [redacted] to Resident #3 from [redacted]*

Staff Member I was initially certified in medication administration on 10/20/22. Staff Member I has not completed a MAR review or medication administration observation per the annual practicum requirements since 1/24/2023. Staff Member I administered the following medications to resident #3:

- *Allopurinol 100mg, Buspirone 10mg, Jardiance 10mg, Magnesium oxide 400mg, Metformin 500mg, Sodium Chloride 2gm, Triad wound dressing paste, and vitamin D3 at [redacted] amox-clav 875-125mg at [redacted] Furosemide 20mg at [redacted] and Tramadol 50mg at [redacted]*

Staff Member J has not been qualified to administer medications, as their initial medication administration training online summary report does not indicate that 4 practicum observations were completed to finalize the course requirements. Staff Member J administered the following medications to resident #3:

- *Buspirone 10mg at [redacted], Furosemide 20mg and Magnesium oxide 400mg at [redacted], Triad wound dressing paste at [redacted] Acetaminophen 650mg at [redacted] and Melatonin 3mg at [redacted] on [redacted] and Amox-clav 875-125mg at [redacted] on [redacted]*

Staff Member K did not complete the Department-approved medication administration course as Staff Member K completed the Modified Medication Administration Training Course on 11/12/2024. Staff Member K administered the following medications to resident #3:

- *Levothyroxine 112mcg at [redacted] on [redacted]*

Plan of Correction ***Accept ([redacted] - 05/05/2025)***

The identified staff members retrained to administer medications by the Community's Medication Administrator trainer on 4/8/25.

The Director of Wellness will audit the training records for all staff who administer medications to ensure they are up to date and in compliance on 4/6/25. Any required training or observations were completed on 3/26/25.
From this audit, The Director of Wellness will create and maintain a file of medication training and observation due dates for all staff who administer medications.
The Executive Director will review the newly created tracking file by 5/5/25 and then monthly at the Quality Management meeting beginning 5/28/25.
Documentation of all training and audits shall be kept.

190a - Completion Medication Course *(continued)*

Licensee's Proposed Overall Completion Date: *05/28/2025*

225c - Additional Assessment

22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's initial assessment, dated [redacted], indicates the resident is independent with eating and ambulation and requires prompting and cueing for toileting, turning and positioning in bed/chair and personal hygiene. As of [redacted] resident #3 required physical assistance from at least 2 staff members for all activities of daily living to include eating, ambulation, toileting, turning and positioning in bed/chair and personal hygiene. However, the resident's assessment was never updated.

Resident #3's initial assessment, dated [redacted], also indicates that the resident has no dietary need. However, resident #3 also has a prescribed diet which was reassessed multiple times following the admission to the home which included soft diet with ground meat and diabetic desserts, encourage hydration and protein in diet, Glucerna once daily at breakfast, high protein ice cream once daily at dinner, aspiration precautions, level 7 diet- easy to chew solids, fluid restriction of 1800 upon discharge, weigh patient daily and record, Ensure high protein oral liquid drink twice daily, and requires intermittent assistance and supervision from another person at meal times. However, the resident's assessment was never updated.

Resident #3 has experienced multiple open areas during [redacted] time residing at the home. Areas of need were not assessed for care/treatment or prevention of open areas and wounds. On 3/24/25, staff member [redacted] the home's Director of Wellness, and staff member [redacted] the home's Executive Director/Administrator, reported to Agents of the Department that Resident #3's needs relating to [redacted] wound care were not assessed.

Plan of Correction ***Directed ([redacted] - 05/01/2025)***

The identified resident's Assessment could not be updated as the resident is no longer residing at the community.

The Executive Director will re-educate all staff who complete resident assessments on the Community/s policies and procedures and state regulations regarding the accuracy and completeness of the resident needs on 4/30/25.
The Director of Wellness or designee shall audit all resident assessments to ensure that all resident needs, physician orders and other requirements have been captured and addressed.
Starting5/1/25 all new and annual assessments shall be reviewed and initialed by 2 parties before they are signed and executed for a period of 90 days to ensure ongoing compliance with this regulation.
The Executive Director will review the assessment audits at the monthly quality management meeting beginning 5/28/25.
Documentation or training and audits shall be kept.

(Directed)

225c - Additional Assessment (continued)

In addition to the above plan of correction:

- *The Director of Wellness or designee shall audit all resident assessments to ensure that all resident needs, physician orders and other requirements have been captured and addressed. The initial audit will be completed by 5/28/25.*
- *The Executive Director will re-educate all staff who complete resident assessments on updating a resident's assessment if the condition of the resident significantly changes prior to the annual assessment. Education to be completed by 5/15/25.*
- *Beginning no later than 5/28/25, the Administrator or designee will audit at least 10 resident records monthly to ensure the resident's assessment has been updated with any changes in need by reviewing physician's orders, medical summaries, staff documentation and interview for change in physical or mental status, etc.*

Directed Completion Date: *05/28/2025*

233c - Key-Locking Devices

23. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 3/24/25, the directions for operating the home's locking mechanism are not conspicuously posted near the following doors to the Secure Dementia Care Unit (SDCU) and the courtyards off the SDCU:

- *The code posted near the egress door leading from the SDCU to the personal care side of the home read, 7050; however, staff member C reports the code is 17050 and confirmed the "1", was not visible but hidden behind the picture frame housing the code.*

Plan of Correction ***Accept ([redacted] - 05/01/2025)***

Directions for the operations of the magnetic locking systems where placed at all entrance and exits from the Lilac Trace neighborhood and courtyards by the Maintenance Director on 3/24/2025.

The Executive Director will re-educate the Memory Care staff and Maintenance staff on the importance of posting the current code to operate the key pads in public and conspicuous place to ensure ongoing compliance with this regulation.
Beginning 5/1/25, The Maintenance Director will complete a weekly check, for thirty days, of all door code signs to ensure they are present, visible, then monthly thereafter until 9/1/25.
The Executive Director will review the door code checks at the monthly Quality Management meeting to ensure ongoing compliance with this regulation.
Documentation of all training beginning on 5/28/25 and audits shall be kept.

233c - Key-Locking Devices (continued)

Licensee's Proposed Overall Completion Date: *05/28/2025*

234b - Support Plan Needs Elements

24. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #4's initial support plan, dated [redacted], indicates the resident has a need for ambulation. The resident's support plan, dated [redacted] does not include resident #4's use of a rollator which was observed during the inspection on 3/24/25.

Plan of Correction ***Directed ([redacted] - 05/01/2025)***

The identified residents support plan was updated to include their use of a rollator by the Director of Wellness on 3/27/2025.

By 4/30/25, The Executive Director will re-educate all staff who complete resident support plans on the Community/s policies and procedures and state regulations regarding the specific details on how their needs are being met.
The Director of Wellness or designee shall audit all current resident Support Plans to ensure that staff understand how the resident's needs are being met, who is responsible and whether any equipment they use is documented.
Starting 5/5/25 all new and annual Support Plans shall be reviewed and initialed by 2 parties before they are signed and executed for a period of 90 days to ensure ongoing compliance with this regulation.
The Executive Director will review the Support Plan audits at the monthly quality management meeting beginning on 5/28/25.
Documentation of all training and audits shall be kept.

(Directed)
In addition to the above plan of correction:

- *The Director of Wellness or designee shall audit all resident support plans to ensure that the support provided to each resident is identified. The initial audit will be completed by 5/31/25.*
- *The Executive Director will re-educate all staff who complete resident support plans on updating a resident's support plan if the condition of the resident significantly changes prior to the annual assessment. Education to be completed by 5/25/25.*
- *Beginning no later than 5/31/25, the Administrator or designee will audit at least 10 resident records monthly to ensure the resident's supports plans have been updated with any changes in need by reviewing physician's orders, medical summaries, staff documentation and interview for change in physical or mental status, etc.*

Directed Completion Date: *05/31/2025*

252 - Record Content

25. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident #3 passed away in the home. On 3/24/25, Resident #3's record did not include [redacted] death certificate.

Resident #19 passed away in the home [redacted]. On 3/24/25, resident #19's record did not include [redacted] death certificate.

Plan of Correction ***Directed ([redacted] - 05/01/2025)***

The Executive Director secured copies of the identified death certificates on 3/27/25.
Effective 4/28/25, The Executive Director, Wellness Director or designee will request a copy of the death certificate from family, funeral directors, coroners and other related parties immediately after a resident passes away to ensure ongoing compliance with this regulation.
Beginning 4/28/25 and monthly thereafter, The Executive Director will review files for any resident who passes away prior to the file being archived on a monthly basis to ensure the community has obtained a death certificate at the monthly Quality Management meeting beginning on 5/28/25.
Documentation of all training and audits shall be kept.

(Directed)
In addition to the above plan of correction:

- *Education will be provided to staff responsible for obtaining a copy of a resident's death certificate by 5/28/25.*
- *An audit of all records for residents who have passed away since 5/1/24 will be completed by the Administrator or designee to ensure a death certificate has been obtained and placed in the resident's record. Audit will be completed by 5/28/25.*

Directed Completion Date: *05/28/2025*