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

June 2, 2025

[redacted]
MDT ALF 1, LLC
[redacted]
Suite 100
[redacted]

RE: LEGEND AT SILVER CREEK
425 LAMBS GAP ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33925

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2025, 03/26/2025 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: *LEGEND AT SILVER CREEK* **License #**: *33925* **License Expiration**: *10/04/2025*

Address: *425 LAMBS GAP ROAD, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *MDT ALF 1, LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/14/2023* **Issued By**: *Hampden Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *129* **Waking Staff**: *97*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/26/2025*

Inspection Dates and Department Representative

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

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *108* **Residents Served**: *95*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *24* **Residents Served**: *20*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *95*

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

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

Inspections / Reviews

03/25/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/24/2025*

Inspections / Reviews *(continued)*

04/28/2025 POC Submission

Submitted By: [redacted] - [redacted]
Date Submitted: *06/02/2025*
Reviewer: [redacted]
Follow Up Type: *POC Submission* **Follow Up Date:** *05/05/2025*

04/29/2025 POC Submission

Submitted By: [redacted] - [redacted]
Date Submitted: *06/02/2025*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *06/02/2025*

06/02/2025 Document Submission

Submitted By: [redacted] [redacted]
Date Submitted: *06/02/2025*
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] at approximately 6:15 PM, Staff Person A entered the Secure Dementia Care Unit (SDCU) and witnessed Staff Person B sitting next to Resident [redacted] in the dining room. Resident [redacted] was in a wheelchair and attempting to leave the dining room; however, Staff Person B would not allow Resident [redacted] to leave. Staff Person B blocked Resident [redacted] several times from exiting the dining room by physically placing themselves in front of Resident [redacted]. Staff Person B was also witnessed locking Resident [redacted] wheelchair to prevent the resident from leaving. Resident [redacted] was heard yelling "Why!?" repeatedly and was visibly upset and distressed by the situation. Resident [redacted] repeatedly unlocked the wheels of the wheelchair and attempted to move from the dining room, but Staff Person B repositioned Resident [redacted] and relocked the wheels of the wheelchair. Staff Person A also witnessed Staff Person B jolt Resident [redacted] wheelchair back into position, further frustrating and preventing Resident [redacted] from leaving the area. Staff Person B was observed laughing at Resident [redacted] distress.

Staff Person A immediately reported the incident to Staff Person C. However, the home did not immediately develop and implement a plan of supervision or suspend Staff Person B. Staff Person B continued [redacted] shift, providing unsupervised care for residents until 10:00 PM on [redacted]

Plan of Correction ***Accept [redacted] - 04/28/2025)***

- On 3/14/25, when informed of the incident, the Administrator designee, the Assistant Health Care Director suspended staff member B.
- On 3/17/25, Staff member C was counseled by the Administrator on failure to timely report allegations of abuse. Staff member B was terminated by the Administrator on date 3/19/25.
- By 4/3/25, the administrator educated the department mangers on regulation 2600.15b as well as abuse training, documentation shall be kept. By 5/9/25, the administrator shall educate current staff on regulation 2600.15b and on Mandatory Abuse Reporting Training. All staff abuse training; documentation shall be kept after education 5/9/2025.
- Beginning 4/28/25, the administrator or designee shall review reportable incidents for abuse allegations to ensure adherence to regulation 2600.15b, this audit shall be performed weekly X 4 weeks. Documentation shall be kept.
- To ensure consistent adherence to Regulation 2600.15b, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

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).

16c - Written Incident Report *(continued)*

Description of Violation

On [redacted] Resident [redacted] had a fall resulting in a fracture of the left radius and ulna. However, this incident was not reported to the Department.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 04/28/2025)***

- On 4/23/25, the administrator reported the 2/9/25 incident involving resident [redacted] to the department as a late report per the survey as part of the POC.
- By 5/9/25, the administrator shall review incidents from previous 60 days to ensure adherence to regulation 2600.16c. Any further noted deficient practice shall be reported at time of audit.
- On 4/3/25 the administrator educated department managers on regulation 2600.16c, documentation shall be kept.
- Beginning 4/28/25, the administrator or designee shall audit completed incident reports to ensure compliance with regulation 2600.16c. This audit shall occur at the Clinical Collaboration weekday meeting X 4 weeks.
- To ensure consistent adherence to Regulation 2600.16c, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

24 - Personal Hygiene

3. Requirements

2600.
24. Personal Hygiene - A home shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

Description of Violation

Resident [redacted] assessment and support plan (RASP), dated [redacted], indicates the resident is to have physical assistance with showers 2 times a week, and the home will provide physical assistance with showers 2 times a week. However, the resident did not have the required number of showers during the following weeks:

- *During the week of [redacted] through [redacted] the resident only received one shower.*
- *During the week of [redacted] through [redacted] the resident only received one shower.*
- *During the week of [redacted] through [redacted] the resident only received one shower.*
- *During the week of [redacted] through [redacted], the resident received no showers.*

Plan of Correction ***Accept [redacted] 04/28/2025)***

- Unable to correct missed showers for resident [redacted] during the weeks of 12/8/24-12/14/24, 12/22/24-12/28/24, 1/12/25-1/18/25 and 12/29/24-1/4/25.
- By 5/9/25 administrator and/or Healthcare Director shall educate care staff on regulation 2600.24, use of the support plans, care delivery worksheet and reporting changes/refusal of care to the nurse and/or Healthcare Director. Documentation shall be kept.
- Beginning 4/28/25, the Healthcare Director shall interview/observe 5 residents weekly to inquire if care/showers were completed as noted on the resident's support plan. This audit shall continue X 4 weeks. Documentation shall be kept.
- To ensure consistent adherence to Regulation 2600.24, compliance monitoring will be conducted during the

24 - Personal Hygiene (continued)

QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

42b - Abuse

4. 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

On [redacted] at approximately 6:15 PM, Staff Person A entered the Secure Dementia Care Unit (SDCU) and witnessed Staff Person B sitting next to Resident [redacted] in the dining room. Resident [redacted] was in a wheelchair and attempting to leave the dining room; however, Staff Person B would not allow Resident [redacted] to leave. Staff Person B blocked Resident [redacted] several times from exiting the dining room by physically placing themselves in front of Resident [redacted]. Staff Person B was also witnessed locking Resident [redacted] wheelchair to prevent the resident from leaving. Resident [redacted] was heard yelling "Why!?" repeatedly and was visibly upset and distressed by the situation. Resident [redacted] repeatedly unlocked the wheels of the wheelchair and attempted to move from the dining room, but Staff Person B repositioned Resident [redacted] and relocked the wheels of the wheelchair. Staff Person A also witnessed Staff Person B jolt Resident [redacted] wheelchair back into position, further frustrating and preventing Resident [redacted] from leaving the area. Staff Person B was observed laughing at Resident # [redacted] distress.

Repeated Violation - [redacted]

Plan of Correction ***Accept[redacted] 04/28/2025)***

- On 3/14/25, the administrator designee, Assistant Health Care Director suspended staff member B. On 3/17/25, Staff member C was counseled by the Administrator on failure to timely report allegations of abuse. Staff member B was terminated by the Administrator on 3/19/25.
- By 4/3/25, the administrator educated the department mangers on regulation 2600.42.b as well as Abuse training. Documentation shall be kept.
- By 5/9/25, the administrator shall educate current staff on regulation 2600. 42.b. Documentation will be kept.
- By 5/9/25, the administrator shall educate current staff and department mangers on Mandatory Abuse Reporting Training. Documentation will be kept.
- Beginning 4/28/25, the administrator or designee shall interview/observe 5 memory care residents weekly to ensure safety of residents. This auditing shall occur 1 x weekly X 4 weeks. Documentation shall be kept.
- To ensure consistent adherence to Regulation 2600.42b, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] 06/02/2025)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person B was hired on [redacted] and has completed [redacted] 40th work hour. However, Staff Person B did not receive training on the following topics:

1. Resident rights

2. Emergency medical plan

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)

4. Reporting of reportable incidents and conditions

Repeated Violation [redacted] et al

Plan of Correction ***Accept [redacted] 04/28/2025)***

-On 3/19/25, the administrator designee, the Assistant Health Care Director terminated staff member B and unable to provide training to staff member B on the following topics:

-Resident rights

-Emergency medical plan

-Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act

-Reporting of reportable incidents and conditions

-By 5/9/25, the Customer Service Associate shall audit current associate files for required trainings included in regulation 2600.65b. Any further deficient findings shall be corrected; the administrator or designee shall train any associates in need of further trainings prior to the next working shift.

- On 4/3/25, the administrator educated the Customer Service Associate on the requirements in regulation 2600.65b. Documentation shall be kept.

- Beginning 4/21/25 the administrator or designee shall audit new hire training records prior to filing. This audit shall occur weekly X 4 weeks.

- To ensure consistent adherence to Regulation 2600.65b, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation occurred on [redacted]. However, the resident's prior evaluation occurred

141b1 Annual Medical Evaluation (continued)

on 8/25/23.

Plan of Correction ***Accept ([redacted] - 04/28/2025)***

The former Healthcare Director failed to obtain the current medical evaluation for resident [redacted] in a timely manner; unable to correct.

By 4/22/25, the Healthcare Director or designee shall audit current resident files and create a tickler to track completion dates. Any further noncompliant DMEs shall be noted as found during POC audit.

On 4/3/25 the administrator educated the Healthcare Director on regulation 2600.141b1. Documentation shall be kept.

Beginning 4/28/25, the administrator and Healthcare Director shall review the DME tickler file weekly to ensure upcoming DMEs are completed timely. Completed DMEs shall be reviewed by the Healthcare Director prior to filing to ensure completion date is in compliance X 4 weeks.

To ensure consistent adherence to Regulation 2600.141b1, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

187a - Medication Record

7. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [redacted] medication administration record (MAR) is missing the diagnosis or purpose for the following medications:

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

Repeated Violation [redacted] and [redacted] et al

Plan of Correction ***Accept ([redacted] - 04/28/2025)***

On 4/21/25, the MAR for resident [redacted] and [redacted] were corrected to reflect the diagnosis by the HCD.

By 5/2/25, the Healthcare Director or designee shall audit current MARs for compliance with regulation 2600.187a. MARs found not in compliance will be corrected at time of audit.

By 4/3/25, the Administrator educated the Healthcare Director on regulation 2600.187a, documentation shall be kept.

By 5/2/25, the Healthcare Director shall educate associates who administer medications on regulation 2600.187a, documentation shall be kept.

Beginning 4/28/25, the Healthcare Director or designee shall audit new orders on MARs weekly X 4 weeks for compliance with regulation 2600.187a.

To ensure consistent adherence to Regulation 2600. 187a, compliance monitoring will be conducted during the

187a - Medication Record (continued)

QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident [redacted] was prescribed [redacted] with orders to take twice a day. However, the resident did not receive the medication from [redacted] through [redacted], due to the medication being discontinued in error on [redacted] and not be restarted until [redacted]

Resident [redacted] is prescribed [redacted] conc with orders to take 0.5ml (1mg) by mouth three times daily as needed. On [redacted] at 2:01 PM, Staff Person D administered 2.0ml to the resident.

Repeated Violation - [redacted] et al, [redacted] and [redacted], et al

Plan of Correction ***Accept [redacted] - 04/28/2025)***

-As a result of survey, as part of POC a late report was made on 4/23/25 by the administrator for resident [redacted] due to a medication error. The resident no longer resides at the facility.
- As a result of survey, as part of POC a late report was made on 4/23/25 by the administrator for resident [redacted] due to a medication error. On 4/23/24, the Healthcare Director notified the physician, no new orders received.
-On 4/23/24, the Healthcare Director counseled staff person D regarding resident [redacted] medication error.
-By 5/2/25, the Healthcare Director shall educate associates who administer medications on regulation 2600.187d. Documentation shall be kept.
-Beginning 4/28/25, the Healthcare Director shall audit incoming orders and MARs weekly X 4 weeks.
- To ensure consistent adherence to Regulation 2600.187.d, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

202 - Prohibitions

9. Requirements

2600.
202. The following procedures are prohibited:
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

202 - Prohibitions *(continued)*

Description of Violation

On [redacted], at approximately 6:15PM, Staff Person A entered the Secure Dementia Care Unit (SDCU) and witnessed Staff Person B sitting next to Resident [redacted] in the dining room. Resident [redacted] was in a wheelchair and attempting to leave the dining room; however, Staff Person B would not allow Resident [redacted] to leave. Staff Person B blocked Resident [redacted] several times from exiting the dining room by physically placing themselves in front of Resident [redacted] Staff Person B was also witnessed locking Resident [redacted] wheelchair to prevent the resident from leaving. Resident [redacted] repeatedly unlocked the wheels of the wheelchair and attempted to move from the dining room, but Staff Person B repositioned Resident [redacted] and relocked the wheels of the wheelchair. Staff Person A also witnessed Staff Person B jolt Resident [redacted] wheelchair back into position, further frustrating and preventing Resident [redacted] from leaving the area.

On [redacted], at 4:19PM, Staff Person E administered a pro re nata (PRN) dose of [redacted] Conc to Resident [redacted] The reason for PRN administration was documented as "behavior" on the resident's medication administration record (MAR).

On [redacted], at 12:16PM, Staff Person F administered a PRN dose of [redacted] Conc to Resident [redacted] The reason for PRN administration was documented as "behavior" on the resident's MAR.

On [redacted] at 8:01AM, Staff Person F administered a PRN dose of [redacted] Conc to Resident [redacted] The reason for PRN administration was documented as "behavior" on the resident's MAR.

Plan of Correction ***Accept [redacted] 04/29/2025)***

-On 3/14/25, staff person B was suspended pending investigation by the administrator designee, Assistant Health Care Director. Staff person B was terminated on 3/19/25 by the Administrator.
-By 5/2/25, the Healthcare Director will counsel staff person E for administering medications for "behavior" and educate staff person E on regulation 2600.202 and de-escalation techniques. Documentation shall be kept.
-By 5/12/25, the Healthcare Director will counsel staff person F (who is PT and will not be on shift again until 5/10 & 5/11/25) for administering medications for "behavior" and educated staff person F on regulation 2600.202 and de-escalation techniques. Documentation shall be kept.
-By 5/2/25, the Healthcare Director shall educate associates who administer medications on regulation 2600.202 and de-escalation techniques. Documentation shall be kept.
- Beginning 4/28/25, the Healthcare Director or designee to audit MARs for symptom documentation with administration of PRN medications. Audit to be performed weekly x 4 weeks.
- Beginning 4/28/25, the Administrator/designee will interview at least 10% of residents in the secured dementia unit weekly to ensure residents do not feel neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment, or disciplined in any way, as indicated by Regulation 2600.42(b). Interviews to be performed weekly x 4 weeks, or ongoing if necessary.
- Residents are regularly informed of their rights (upon admission and during resident council). They are and will continue to be encouraged to report if someone is allegedly mistreating or neglecting them promptly.
-To ensure consistent adherence to Regulation 2600.202, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

202 - Prohibitions (continued)

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On [redacted] Resident [redacted] sustained a hip fracture and now utilizes a wheelchair for mobility and ambulation. However, Resident [redacted] current assessment, dated [redacted] does not include the resident's mobility and ambulation changes, including the resident requiring assistance with transferring to and from the wheelchair.

Plan of Correction ***Accept [redacted] - 04/28/2025)***

- On 4/23/25 resident [redacted] was assessed by the Healthcare Director and a change in status assessment and support plan was updated to reflect resident's current needs.
- By 5/2/25, the Healthcare Director shall audit current resident assessments and support plans for accuracy. Assessments and support plans to be updated as needed at time of audit.
- By 4/3/25, the administrator shall educate the Healthcare Director on regulation 2600.225c. Documentation shall be kept.
- Beginning 4/28/25, the Healthcare Director shall review the 24-hour report daily on workdays for reported changes in resident status; assessments/support plans to be updated as needed X 4 Weeks.
- Beginning 4/28/25, the Healthcare Director shall Educate Care staff to document changes on 24-hour report daily.
- To ensure consistent adherence to Regulation 2600.225c, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 5/28/25, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 06/02/2025)