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

July 23, 2025

[redacted], REGIONAL DIRECTOR OF OPERATIONS
PARK CREEK MC, LLC
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PARK CREEK PLACE MEMORY CARE* **License #**: *15085* **License Expiration**: *06/14/2025*

Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *PARK CREEK MC, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/21/2025*

Inspection Dates and Department Representative

05/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *24*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *48* **Residents Served**: *24*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

05/21/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/21/2025*

07/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/22/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2025*

Inspections / Reviews *(continued)*

07/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/22/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/28/2025*

07/23/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/22/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

25b - Contract Signatures

1. Requirements

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

Description of Violation

The resident-home contract, dated [redacted] for Resident #1 was not signed by the resident.

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

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

The contract for Resident #1 and Resident #2 have been signed and corrected. The current Resident contracts were audited by the Executive Director, completed on June 25, 2025. The Business Office Manager was trained on 6/26/2025 on this regulation.
The Executive Director will audit contracts quarterly, and report accuracy at the quarterly Quality Assurance Meetings. The next Quality Assurance Meeting is scheduled for July 12, 2025. The Executive Director will oversee the Business Office Manager. The Executive Director will monitor continuously for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Immediate action in conjunction with 25b, an audit was performed of current Resident records which contain a signed acknowledgement of Resident Rights and Complaint procedures by the Executive Director on 5/22/2025. The Executive Director or designee is responsible for contract signing, in the absence of the Executive Director the Business Office Manager may execute the electronic contract to obtain all appropriate signatures per this regulation. The Executive Director will audit quarterly to ensure current Resident Rights and Complaint Procedures are signed in the Resident's record. The results will be presented at the quarterly Quality Assurance Meetings, the next meeting is scheduled for July 12, 2025 for current Directors. The Executive Director will monitor continuously for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

42b - Abuse

3. 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 4/20/25 at approximately 7:00am, Staff Members A, B and C witnessed Resident #1 leaning from their wheelchair [redacted] Resident #3. Resident #1 [redacted] Resident #3's [redacted] Staff report that Resident #3 was awake and just sitting there while this occurred, however, Resident #3's assessment and support plan dated [redacted] indicates that resident has needs related to communication, has difficulty finding the right words, and needs assistance of staff for all ADLs. Resident #1's assessment and support plan indicates that Resident #1 has a moderate need related to judgement and understanding instructions and the support plan indicates that staff are to check on and redirect resident frequently, however a specific time frame for frequent checks is not defined.
Resident #1 [redacted] Resident #3's [redacted] when told to do so by staff. Resident #1 and Resident #3 were separated after the incident and Resident #1 was placed on 15 minute checks.

Plan of Correction ***Accept ([redacted] - 07/08/2025)***

Current staff, as well as all Directors were re-educated regarding regulation 42B; allegations, the types of abuse, and the reporting requirements of the Older Adult Protective Services Act by the Executive Director on 5/23/25. In conjunction, the company abuse policy was re-trained to current staff, completed by 5/23/25. Current Directors will be in attendance at the Quality Assurance on July 11, 2025, led by the Executive Director. To prevent this violation from reoccurring effective 7/8/25 our Memory Care Coordinator will conduct weekly interviews with Residents and staff for four weeks to ensure protection of Resident Rights to establish compliance, then once monthly ongoing. The Health & Wellness Director will oversee the MCC for compliance. The Executive Director will oversee the Health and Wellness Director. Ongoing compliance will be maintained by the Executive Director through training sessions monthly at all staff training meetings continuously.

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

Implemented ([redacted] - 07/23/2025)

63a - First Aid/CPR Training

4. Requirements

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

Description of Violation

On 4/20/25 and 5/2/25, from 3:00p-5:00pm, 24 residents were present in the home. During this time, no staff person was present in the home who is certified in CPR/First Aid.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Immediate action was an audit was conducted by the Health and Wellness Director of current staff's training for first aid and CPR. Those identified as not having first aid and CPR training were scheduled for a class. All trainings were completed by 6/25/2025. The Home certified staff persons with ECSI, Basic Life Support for the Health Care provider, CPR and AED as well as first aid and standard CPR. Upon hiring new staff persons the Business Office Manager will verify current CPR/First Aid upon hire and if not the Business Office Manager will schedule the employee to complete training on CPR/First Aid. The Health and Wellness Director and the Executive Director will ongoing review the schedule weekly to verify there is one staff member certified in first aid and CPR per shift to

63a - First Aid/CPR Training (continued)

meet the needs of our census. The Health and Wellness Director and the Business Office Manager were trained on 5/22/25 on this regulation. The Business Office Manager will maintain ongoing compliance and report results of compliance quarterly at the Quality Assurance Meetings, with all Directors in attendance. The Executive Director will oversee the Business Office Manager for continuous ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Gold Bond Healing Hand Cream, Jergens Ultra Healing Lotion and Colgate Total Whitening Toothpaste with manufacturers' labels indicating "if swallowed, get medical attention and contact poison control center right away," were unlocked, unattended and accessible to Resident #4. Not all the residents of the home, including Resident #4, have been assessed as capable of recognizing and using poisons safely.

Dove Deodorant and Medline Remedy Anti-Fungal Powder with manufacturers' labels indicating "if swallowed, get medical attention and contact poison control center right away," were unlocked, unattended and accessible to Resident #5. Not all the residents of the home, including Resident #5, have been assessed as capable of recognizing and using poisons safely.

Repeat Violation Date: 3/5/25

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Gold Bond Healing Cream, Jergens, Ultra Healing Lotion , Colgate Total Whitening Toothpaste, Dove Deodorant, and Medline Remedy Anti-Fungal Powder was removed at the time of survey by the Resident Care Coordinator and placed in the designated locked area. Locking poisonous materials was re-educated to current staff , with importance on this ; is a repeat violation from 3/5/25. The companies Safe Haven Policy was re-educated to current staff , completed on 6/26/25. Weekly audits were conducted by the Executive Director beginning May 22, 2025 for four weeks, which included daily manager rounds, reporting any discrepancies regarding poisonous materials immediately to the Executive Director. Weekly Manager rounds will be completed by The Director of Plant Operations ongoing.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #6 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 07/07/2025)***

The regulation 101j7, to have an operable lamp or access to a source of light that can be turned on/off at bedside was reviewed by the Executive Director with current staff on 5/22/25 . All staff in-services regarding the requirement of the regulation was completed on 6/17/25. The Plant Operations Director has included in the room safety audits the regulation to have an operable lamp or access to a source of light that can be turned on/off at bedside. Current staff were trained to immediately report if there is not an operable light source, training was completed on 6/26/25. The regulation was included in the quarterly Quality Assurance meetings, the next scheduled meeting is July 12, 2025 for all Directors to attend. The Executive Director will monitor ongoing and continuous compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented (- 07/23/2025)

101r - Bedroom - shades/drapes/window covering

7. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The window in the bedroom belonging to Resident #7 has blinds that are broken and in disrepair.

Plan of Correction ***Accept (- 07/07/2025)***

Immediate action was the Director of Maintenance installed a new blind on 5/21/2025. The Director of Maintenance conducted an internal inspection of all Resident bedrooms, new blinds were installed where needed on 5/22/2025 . The regulation 101r was trained by the Executive Director, completed trainings on 6/26/25, to have window coverings clean, in good repair, and to provide privacy and cover the entire window when drawn was reviewed by the Executive Director to all staff. All staff were re-educated to report to the Plant Operations Director, of a need to replace a window covering. The Plant Operations Director conducted a weekly audit for 4 weeks beginning on 5/22/25 to maintain compliance with this regulation. All staff in-services were regarding the requirement of this regulation was completed on 6/26/25. The Plant Operations Director has included in the room safety audits regulation 101r. The Plant Operations Director will immediately report any discrepancies to the Executive Director. The regulation was included in the quarterly Quality Assurance meetings, the next scheduled meeting is July 12, 2025 with all current Directors in attendance. The Executive Director will monitor compliance ongoing and continuous.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented (- 07/23/2025)

103e - Left Overs

8. Requirements

2600.

103e - Left Overs *(continued)*

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.

Description of Violation

On 5/21/25 at 10:20am, an unsealed bag of lima beans was found unlabeled/undated in the main kitchen freezer and a container of dry pasta was found unlabeled/undated in the dry goods storage area.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Immediate action was the Dining Director discarded the lima beans and the container of dry pasta. The Dining Director completed on audit of the kitchen of all food items were labelled and dated on 5/21/25. The Executive Director trained the cooks of this regulation, completed on 6/26/2025. The Dining Director completed weekly audits of the kitchen for this regulation starting 5/22/2025 for four weeks to establish compliance, the results were reviewed by the Executive Director. The Dining Director will oversee the cooks ongoing and the Executive Director will oversee the Dining Director ongoing and continuous for compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

144c1 - Smoking Area Guidelines

9. 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

The home's designated smoking area located at a picnic table outside the back of the home does not have a receptacle or fire proof container to properly dispose of cigarette butts.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Immediate action was the Plant Operations Director ordered a fire proof receptacle for this requirement. The receptacle was put in place immediately upon delivery on May 28, 2025. The Plant Operations Director conducted weekly audits for four weeks beginning on May 28, 2025 to maintain the receptacle remained in place, the Executive Director reviewed the results of the audits. Current staff were trained on this regulation by the Executive Director, completed 6/26/25. The Director of Maintenance incorporated this corrective action into the monthly Safety Meeting. The Director of Maintenance will report results at the quarterly Quality Assurance Meetings, the next Quality Assurance Meeting is July 12, 2025, for Directors to attend. The Executive Director will oversee the the Director of Maintenance continuously for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

183e - Storing Medications

10. Requirements

2600.

183e - Storing Medications *(continued)*

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/21/25, the following medication cards were observed to have a punctured/taped blister foil with the medication still present in the spot.

- *Resident #8's Alprazolam 0.25mg tab*
- *Resident #9's Lorazepam 0.5mg tab*

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

The immediate action on 5/21/25 was Resident #8s and Resident #9s medications were destroyed by the Health and Wellness Director per company policy. The Medication Technicians were trained by the Health and Wellness Director, completed 6/26/25. The Medication Technicians will immediately notify the Health and Wellness Director, the Health and Wellness Director will immediately notify pharmacy to refill due to damaged blister card. Ongoing compliance is monitored monthly by the Health and Wellness Director and reported at the quarterly Quality Assurance meetings, the next scheduled Quality Assurance Meeting is July 12, 2025. Weekly audits of the blister cards will be included in the weekly audits of the two medication carts. The Health and Wellness Director will oversee the Medication Technicians for ongoing compliance. The Executive Director will oversee the Health and Wellness Director ongoing for continuous compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

184b - Labeling OTC/CAM

11. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 5/21/24, a bottle of Bayer Low Dose Aspirin was found in the south medication cart of the home, the bottle was not labeled with a resident name.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

The immediate action on 5/21/25 the bottle of Bayer Low Dose Aspirin was labelled with the Residents name by the Resident Care Coordinator. On 5/22/25 The Health and Wellness Director trained current Medication Technicians on the company policy and regulation. During weekly cart audits the Medication Technician will maintain all OTC/CAM are properly labelled with the Resident's name. The Health and Wellness Director performed weekly audits beginning 5/25/25 for 4 weeks to establish compliance. The Health and Wellness Director will oversee the Medication Technicians . Ongoing compliance is monitored monthly by the Health and Wellness Director and reported at the quarterly Quality Assurance meetings, the next scheduled Quality Assurance Meeting is July12, 2025 with Directors. The Executive Director will oversee the Health and Wellness Director for continuous and ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)

185a - Implement Storage Procedures

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #10 is prescribed Morphine Sulfate. Two separate prescriptions were dispensed to the home on 3/20/25 containing ten prefilled syringes each. Only ten vials were signed in as received on the narcotics record however all twenty pre-filled syringes of Morphine Sulfate were present in the narcotics lock box.

Plan of Correction ***Accept (- 07/07/2025)***

Immediate action was a narcotic log was created and the ten vials of morphine sulfate were signed in by the Resident Care Coordinator. The Medication Technicians were re-educated on maintaining accurate narcotic records by the Health and Wellness Director ,completed on 5/23/25. The Health and Wellness Director conducted weekly audits effective 5/23/25 for four weeks establishing compliance. Any discrepancies will immediately reported to the Executive Director. Weekly audits of the narcotic logs are included in the audits of the medication carts. The Health and Wellness Director will oversee the Medication Technicians for ongoing compliance. The Executive Director will oversee the Health and Wellness director ongoing and continuous.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented (- 07/23/2025)

191 - Resident Right to Refuse

13. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #2, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 07/07/2025)***

The Executive Director immediately provided training to the Health and Wellness Director on this regulation.The Health and Wellness Director and the Resident Care Coordinator provided training to current Residents in Memory Care of their right to refuse medications, completed on 6/24/25. The Medication Technicians were trained on this regulation and the Resident's right to refuse medications, completed on 6/24/25. The Health and Wellness Director will oversee the Medication Technicians for ongoing education monthly at our staff meetings. The Executive Director will oversee the Health and Wellness Director ongoing and continuous.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented (- 07/23/2025)

231e - No Objection Statement

14. Requirements

231e - No Objection Statement *(continued)*

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 07/07/2025)***

Immediate action in conjunction with the audit of all Resident's contracts, an audit of the signed no objection statement was verified. The latter was completed by 6/25/2025 by the Executive Director. The Executive Director, Business Office Manager, or designee will obtain the signing of the no objection statement at the time of the contract signing. The Executive Director trained the Business Office manager on this regulation. The Executive Director will audit this requirement monthly and will report findings at the quarterly Quality Assurance Meetings, the next scheduled meeting is July 12, 2025, with Directors. The Executive Director will monitor ongoing for continued compliance.

Licensee's Proposed Overall Completion Date: *06/26/2025*

Implemented ([redacted] - 07/23/2025)