Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 8, 2025

Creek Senior Care LLC

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 inspection on June 17, 2025, of the above facility, that is operating pending an appeal, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Licensing Inspection Summary were found.

Correction of these violations in accordance with the specified plan of correction is required. Failure to correct these violations may result in further licensing enforcement action.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

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:

Legal Entity

Name: *CREEK SENIOR CARE LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/03/2001* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *131* **Waking Staff**: *98*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *06/23/2025*

Inspection Dates and Department Representative

06/17/2025 - On-Site:
06/18/2025 - On-Site:
06/23/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *98*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lilac Trace* **Capacity**: *31* **Residents Served**: *21*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *98*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

06/17/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *Exception*

17 - Record Confidentiality

1. Requirements

2600.
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 6/17/25 at approximately 9:45 AM, a laptop showing the profile and medical information including diagnoses for resident #1 was unlocked, unattended, and accessible on top of the med cart in the SDCU.

Repeated Violation - 3/24/2025, et al

Plan of Correction ***Directed - 07/02/2025)***

- *All staff persons will be educated on the confidentially of resident records and the procedures for maintaining resident records in a secure location. Education to be completed by 7/14/25 by the Administrator.*
- *The Administrator will review the policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records. Updates to the policy and procedures will be completed, as necessary, and all staff persons will be educated on the updated policy by 7/14/25.*
- *A designated staff person on each shift will audit the home daily to ensure all resident records are confidential, kept safe and locked beginning 7/14/25.*
- *The Administrator will audit the home weekly to ensure all resident records are confidential, kept safe and locked beginning 7/14/25.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/14/2025*

42b - Abuse

2. 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 #2 was admitted to the home on /25 from UPMC following a partial left foot amputation and a left plantar distal wound with discharge instructions to change wound dressings daily. From 3/31/25-4/15/25, the resident attended weekly podiatry appointments during which time, the podiatrist ordered daily wound care and indicated the progression of wounds as follows:

- *On 3/31/25, the podiatrist noted that a right heel bulla had ruptured with measurements of 4.5cm x 4.5cm. The resident "is going to have require dressing change to this area a swell as heel protection at all times otherwise this is going to progress into a full-thickness ulceration." The left foot ulceration measured 8cm x 4.5 cm in total which had a necrotic odor. The podiatrist documented that there was no excuse for getting pressure wounds on the opposite foot and to ensure wound care and overall care is intact or the resident would have to be removed from the facility.*
- *On 4/8/25, the podiatrist indicated the right heel wound was full thickness ulceration measuring 5.5 x 4.5cm. The left foot ulceration measured 7.5cm x 4.5cm.*

42b - Abuse (continued)

- *On 4/15/25, the podiatrist indicated "the right heal wound is full thickness ulceration and larger than one week ago. Now measuring 7cm x 4cm." "The left foot ulceration measured 7.5cm x 4.5 cm in total" and had a "necrotic odor". The left foot ulceration was noted to have extension to bone seen in the 1st and 2nd metatarsals. The podiatrist indicated the "wound care for the left foot is not degrading. This wound needs to be changed daily and it is getting maybe a change once or twice a week....It is likely a matter of time before he becomes systemically ill". It was in the podiatrists' opinion that the resident required skilled nursing care or rehospitalization.*

Daily wound care was provided by ██████ Health agency (HHA) from 3/26/25 – 4/1/25. After 4/1/25, the resident only received wound care on 4/4/25, 4/7/25, 4/9/25, 4/11/25, and 4/17/25.

On 4/21/25, resident #3 pushed resident #4, resulting in residents #3, #4, and #5 falling to the floor. Resident #4 sustained a skin tear on ██ left wrist. Resident #5 complained of shoulder pain and was taken to the emergency room, where ██ was ordered Tylenol for pain.

Repeated Violation - 3/24/2025, et al

Plan of Correction ***Directed ██ - 07/07/2025)***

- *The Administrator or designee will assess all residents in the home by 7/18/25 to check for skin integrity issues. The home will hold a meeting by 7/23/25 with all necessary personnel to develop a plan of care to provide routine treatment and care for any resident observed to have a pressure ulcer or open area. The team will hold monthly meetings to review progress of the residents open areas/wounds and develop additional treatment options to implement to assist with the healing of the residents' identified areas.*
- *Education will be provided to all staff on proper wound care treatment and prevention by the Administrator or designee by 7/18/25. Education will also include how to complete proper skin assessments as necessary, repositioning needs and*
  who to notify if any areas of concern are identified for prompt treatment and follow-up.
- *Beginning 7/23/25, the Administrator or designee will hold individual weekly meetings with active supplemental Health*
  Care Providers to discuss continuity of care and address any clinical changes including measurements of open areas to determine if treatment is being provided effectively. Discussion will also include reviewing additional medical consultations including podiatry and wound care specialist's summaries.
- *The Administrator or designee will complete an assessment for resident #3's needs in the areas of behavioral concerns by 7/18/25 to determine if additional supervisor or supports are needed.*

Directed Completion Date: *07/23/2025*

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's staffing during overnight hours is insufficient to meet the needs of the residents as specified in the residents' assessments and support plans and according to staff interviews. The home has a current census of 98 residents with 21 residents in the Secured Dementia Care Unit (SDCU). There are 33 residents in the home who have mobility needs,

60a - Staff/Support Plan (continued)

and at least 3 residents who require a 2-person transfer assist. On 4/24/25, from 11:00 PM to 7:00 AM, there were 5 staff members present in the home. A fire drill was completed at 5:24 AM and the home was unable to have all residents in the home evacuate within the maximum safe evacuation time specified by the fire safety expert of 15 minutes, with 5 staff participating in the fire drill.

Plan of Correction ***Directed [redacted] - 07/02/2025)***

- *The Administrator or designee will assess the needs of all residents in the home to ensure the home is providing the appropriate staffing levels based on the needs identified in the resident's assessment and support plans. This will be completed no later than 7/18/25.*
- *Education will be provided to all staff members, including administrative staff, on providing staffing to meet the needs of the residents as specified in the resident's assessment and support plan. Education will be completed by 7/14/25.*
- *Beginning no later than 7/14/25, the Administrator or designee will provide staffing levels based on the current needs of the residents in the home.*
- *The Administrator will review the home's current policies and procedures on fire safety and evacuation. Updates will be made, as necessary and all staff will receive education on the home's fire evacuation processes by 7/14/25.*
- *The home will complete a fire drill during the overnight hours by 7/18/25.*

Directed Completion Date: *07/18/2025*

84 - Heat Sources

4. Requirements

2600.
84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 6/18/25 at 2:46 PM, the temperature of the round warming tray in the SDCU kitchenette was 133.0 degrees Fahrenheit. There were no protective guards in place to prevent residents from coming in contact with the trays.

Plan of Correction ***Directed [redacted] 07/02/2025)***

- *All staff persons will be educated on 2600.84 by the Administrator or designee by 7/14/25.*
- *A protective guard will be installed by the home by 7/18/25. While the home is waiting for the installation of the protective guard, the home will ensure warming trays and dishes are not accessible to residents during each meal beginning no later than 7/14/25.*
- *Beginning no later than 7/14/25, the Administrator will complete random audits at least one time per week during mealtimes to ensure heat sources during mealtimes are not accessible to residents without a protective guard in place.*
- *Documentation of staff education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/18/2025*

132d - Evacuation

5. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The fire drill held on 4/24/25 at 5:24 AM had an evacuation time of 21 minutes and 36 seconds. The maximum safe evacuation time specified in writing within the past year by a fire safety expert is 15 minutes.

Plan of Correction ***Directed [redacted] - 07/02/2025)***

- *The Administrator will review the home's current policies and procedures on fire safety and evacuation. Updates will be made, as necessary and all staff will receive education on the home's fire evacuation processes by 7/14/25.*
- *Fire drills will continue to be conducted monthly under the direction of the Maintenance Director or designee to*
  ensure resident evacuations are under the maximum safe evacuation time.
- *Beginning no later than 7/14/25, the Administrator will observe the home's fire drills for the next 3 months. If a fire drill evacuation time exceeds the maximum time specified by a fire safety expert, a second fire drill will be completed. The Administrator will keep records of the observations completed.*
- *Beginning no later than 7/14/25, an audit of the fire drill documentation will be reviewed monthly by the Administrator after each drill to ensure the fire drill process did not exceed the specified time by the fire safety expert. If a fire drill evacuation time exceeds the time specified by the fire safety expert, the home will review the fire drill within five days to discuss any obstacles that may have caused the delay in evacuation and a second fire drill will be completed.*
- *Documentation of completed staff education, completed audits and meeting minutes will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/14/2025*

141a 1-10 Medical Evaluation Information

6. 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.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

Resident #2's initial medical evaluation, dated [redacted]/25, did not include information pertaining to body positioning and movement. The resident requires assistance with turning and positioning in bed or chair and had a "wound on foot" at the time of the medical evaluation.

Repeated Violation - 3/24/2025, et al

Plan of Correction

Licensee's Proposed Overall Completion Date

142d - Secure Preventative Care

7. 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 #6's assessment and support plan, dated [redacted]/25, indicates the resident needs some physical assistance in locating a health care provider for a specified need, scheduling and tracking appointments as well as arranging for transportation to appointments. On 4/3/25, staff documented an open area to resident #6's right lower extremity and informed the resident's home health agency nurse. The home did not secure wound care until the first skilled nursing visit which was not provided until 5/15/25. The wound growth was documented on 5/22/25 to have increased in size from 0.2cm to 0.4cm and a new open area on the coccyx was discovered 6/9/2025 which was documented as a stage 2 wound.

Repeated Violation - 3/24/25, et al.

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

- *The Administrator or designee will assess all residents in the home by 7/18/25 to check for skin integrity issues. The home will hold a meeting by 7/23/25 with all necessary personnel to develop a plan of care to provide routine treatment and care for any resident observed to have a pressure ulcer or open area. The team will hold monthly meetings to review progress of the residents open areas/wounds and develop additional treatment options to implement to assist with the healing of the residents identified areas.*
- *Education will be provided to all staff on proper wound care treatment and prevention by the Administrator or designee by 7/18/25. Education will also include how to complete proper skin assessments as necessary, repositioning needs and*
  who to notify if any areas of concern are identified for prompt treatment and follow-up.
- *Beginning 7/23/25, the Administrator or designee will hold individual weekly meetings with active supplemental Health*
  Care Providers to discuss continuity of care and address any clinical changes including measurements of open areas to determine if treatment is being provided effectively. Discussion will also include reviewing additional medical consultations including podiatry and wound care specialists summaries.

142d - Secure Preventative Care *(continued)*

Directed Completion Date: *07/23/2025*

183e - Storing Medications

8. Requirements

2600.
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 6/23/25 at 2:05 PM, the multidose packaging for resident #6 containing a single dose of Diltiazem had a slit in the top of the pack where discontinued medications Eliquis and Ferrous Sulfate had been removed by the pharmacy. The pack was not re-sealed and the medications were being stored open to the air.

Plan of Correction ***Directed █ - 07/02/2025)***

- *The medications in the medication pack will be destroyed by the Administrator or designee by 7/14/25.*
- *The Administrator or designee will complete an audit of all medication carts in the home by 7/14/25 to ensure medications are stored properly.*
- *Education will be given to all staff who administer medications on 2600.183(e) by 7/14/25.*
- *Beginning no later than 7/14/25, the Administrator or designee will complete weekly audits on the home's medication carts.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/14/2025*

184a - Resident's Meds Labeled

9. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #7's Polyethylene Glycol did not include the current instructions for administration. The pharmacy label included instructions to dissolve 17gm in 4-8 oz fluid and take by mouth two times a day. The current physician's order included instructions to mix 17gm with 8 ounces liquid and drink by mouth once daily as needed.

Plan of Correction ***Directed █ - 07/02/2025)***

- *The Administrator or designee will contact pharmacy by 7/14/25 to obtain the correct pharmacy label. A change of order sticker may be placed on the medication until the corrected label is received.*
- *Education will be provided to all staff who administer medications on 2600.184(a) and comparing physician's orders to the pharmacy labels by 7/14/25.*
- *An audit will be completed on all other resident medications and physician's orders by 7/18/25 by the Administrator or designee.*
- *Beginning 7/14/25, the Administrator or designee will complete weekly audits on at least 25% of resident*

184a - Resident's Meds Labeled (continued)

physician orders and medication labels.

- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/18/2025*

185a - Implement Storage Procedures

10. 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

On 6/18/25, the Controlled Substance Record for resident #8's Morphine Sulfate 20 MG indicated 16 syringes were remaining; however, only 15 syringes were available in the home.

Plan of Correction ***Directed ██ - 07/02/2025)***

- *The Administrator or designee will complete an investigation resident #8's medication by 7/14/25.*
- *The Administrator or designee will review the home's policies and procedures regarding the administration and documentation of narcotic medications, updates will be made as necessary. Education will be provided to all staff who administer narcotic medications by 7/14/25.*
- *Beginning no later than 7/14/25, the Administrator or designee will audit all resident Controlled Substance Records and current available doses at least once weekly.*
- *Documentation of education and completed audits will be kept in the home and available for review by the Department.*

Directed Completion Date: *07/14/2025*

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident #6 was prescribed Cerave moisturizing lotion apply topically to bilateral arms and legs daily. The medication was not administered to the resident on 4/23/25 because the medication was not available in the home.

Resident #7 was prescribed Losartan Potassium take one tablet by mouth every evening. This medication was not administered to the resident on 5/16/25 because the medication was not available in the home.

Resident #9 is prescribed Buspirone 10mg-take 1 tablet by mouth three times daily which is scheduled for 7:00 AM, 12:00 PM and 5:00 PM. On 5/23/25, the resident received the 5:00 PM dose at 2:30 PM, resulting in two doses being administered in only 2.5 hours.

Resident #10 was prescribed Atorvastatin 10mg and Doxcyclin 100mg. Resident #10 was not administered these medications on 5/13/25 at 8:00 PM as the medication was still present in the resident's bedroom on 5/14/25 at 8:00 AM.

187d - Follow Prescriber's Orders (continued)

Repeated Violation - 3/24/2025, et al

Plan of Correction ***Directed [redacted] - 07/02/2025)***

- *The Administrator or designee will provide education to the appropriate clinical staff and staff who administer medication on the home's policy and procedures for reordering medications so they are available as prescribed, medication administration requirements to administer medications in the medication administration area or near the medication cart and observing a resident ingest his/her medications, and ensuring medications are given at the scheduled times. Education will be completed by 7/14/25.*
- *Beginning no later than 7/14/25, the Administrator or designee will complete weekly medication cart audits to ensure medications are available in the home as prescribed.*
- *Beginning no later than 7/14/25, the Administrator or designee will complete an audit of at least 25% of the residents medication administration records to ensure medications are administered timely and as prescribed by the physician.*

Directed Completion Date: *07/14/2025*

225c - Additional Assessment

12. 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 #6's current assessment, dated [redacted]/25, indicated the resident is independent in turning and positioning in bed/chair, and needs some physical assistance to make and keep appointments and managing health care. However, resident #6 had an open area as of 4/3/25 on the right lower extremity and on 6/9/25, resident was observed to have a stage 2 pressure sore on coccyx area. Resident #6 was refusing the need for turning and positioning as well as refusing recommended medical treatments. The resident's assessment was not updated to reflect these changes and needs relating to pressure injuries and wound care were not assessed.

Repeated Violation - 3/24/2025, et al

Plan of Correction ***Directed [redacted] - 07/03/2025)***

- *The Administrator will assess Resident #6's current medical status and needs and complete updates, as necessary by 7/14/25.*
- *The administrator or designated staff person will review all current and newly completed resident assessments for accuracy and completion including positioning and medical care needs for open areas and medical conditions by 7/18/25. If the review of resident assessments reveals that a resident's needs cannot be met by the home, the home will assist the resident to relocate to a home that can meet the resident's needs.*
- *All staff persons involved with the assessment process will be educated on the requirement that each*

225c - Additional Assessment (continued)

resident shall have an additional assessment completed if the condition of the resident significantly changes prior to the annual assessment. Education to be completed by 7/14/25.

- *Beginning no later than 7/18/25, the Administrator or designee will review a 25% sample size of resident assessments each month to ensure the residents needs are accurate and current.*
- *Documentation of completed audit and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/18/2025*

227g -Support Plan Signatures

13. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2's support plan, completed on [redacted]/25, was not signed by the assessor or the resident.

Resident #11's support plan, completed on [redacted]/25, was not signed by the assessor.

Plan of Correction ***Directed [redacted] - 07/03/2025)***

- *The administrator or designee will review all current and newly completed support plans to ensure completion including signatures of those involved in the development of the plan by 7/18/25.*
- *All staff persons involved with the completion of support plans will be educated on the proper completion of support plans including the required signature of persons involved with the development of support plans by 7/14/25.*
- *Beginning 7/14/25, all residents will be provided with the opportunity to participate in the development of their support plan. All persons participating in the development of the support plan will be provided with the opportunity to sign the support plan. If the resident or designated person refuses or is unable to sign the support plan, the staff person completing the document will indicate the reason for not signing, the date, time and staff persons initials.*
- *The Administrator will audit a 25% sample of resident support plans each month beginning 7/14/25 to ensure the opportunity to sign have ben provided to all participants and signatures are present and dated, if applicable.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: *07/18/2025*