

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

November 12, 2025

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

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

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/16/2025 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: *06/14/2026*
 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: Total Daily Staff: *50* Waking Staff: *38*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint* Exit Conference Date: *09/16/2025*

Inspection Dates and Department Representative

09/16/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *48* Residents Served: *25*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Entire Building* Capacity: *48* Residents Served: *25*

Hospice
 Current Residents: *4*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *25*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

09/16/2025 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/18/2025*

10/30/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *11/06/2025*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *11/09/2025*

Inspections / Reviews *(continued)*

11/12/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/06/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On [redacted] at 9:30am and 9:45am, the emergency pull cord in room [redacted] and room [redacted] did not work. The home has pagers designed to alert staff in case of an emergency, but these pagers are not functioning, and the computer that receives the signal was turned off.

Plan of Correction

Accept [redacted] - 10/30/2025)

All pull cords and staff pagers were tested by the Plant Operations Director to verify that all were in working order, completed by 10/16/2025. Any pull cords or pagers found not to be in working order were repaired or replaced immediately and reported to the Executive Director, completed by 10/16/2025. All staff pagers were tested and synced to the system by the Plant Operations Director by 10/16/2025. The Executive Director confirmed a full system functionality by conducting a test from each Resident apartment with the Plant Operations Director, completed by 10/16/2025. The Executive Director implemented a "no shutdown" policy on the monitoring computer, completed on 9/17/2025. The Plant Operations Director will perform a weekly full systems check including computer up-time verification, beginning on 10/01/2025 for 3 months, and then bi-weekly thereafter ongoing and continuous. The Executive Director and The Plant Operations Director conducted training with current staff on reporting procedures for system malfunctions, completed on 10/16/2025. The Executive Director will add and discuss Emergency System functionality to the next quarterly Quality Assurance review with current directors present, scheduled 10/27/2025.

Licensee's Proposed Overall Completion Date: 10/16/2025

Implemented [redacted] - 11/12/2025)

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at 9:30am, room [redacted] bathroom had feces smears on the toilet seat, and the uncovered trashcan was not cleaned. There was toilet paper with feces that was inside the uncovered trash can.

Plan of Correction

Accept [redacted] - 10/30/2025)

The affected bathroom was cleaned and disinfected immediately upon discovery by the Plant Operations Director. A new lidded trash can was placed in the bathroom the same day by the housekeeper. Current housekeeping and clinical staff were provided with training by the Executive Director on infection control and sanitation standards 2600.85a on proper cleaning and disinfection techniques, requirements for covered trash receptacles, completed on 10/16/2025. All new employees will receive training upon hire, ongoing and continuous. The Executive Director will review cleaning checklists weekly for completeness and compliance, noncompliance will be addressed immediately, effective 10/01/2025 and ongoing and continuous. The Executive Director will discuss the schedules and compliance of sanitary conditions at the next Quality Assurance review meeting on 10/27/2025.

Licensee's Proposed Overall Completion Date: 10/16/2025

85a Sanitary Conditions (continued)

Implemented [redacted] - 11/12/2025)

85d Trash Receptacles

3. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 9:30am there was a trashcan full, uncovered, unattended trash can in the bathroom inside room [redacted]

Plan of Correction

Accept [redacted] - 10/30/2025)

The uncovered trash can was immediately emptied and replaced by the Plant Operations Director on 09/17/2025 with a covered trash receptacle. Current Resident apartments were checked by the Plant Operations Director to ensure each apartment had a proper covered trash container. Any apartment that did not have a lidded trash can was replaced with a lidded trash can by 09/18/2025. Current staff received training by the Executive Director on this regulation related to lidded trash receptacles and emptying trash cans upon fullness of trash cans and verifying the trash can is lidded after use, completed on 10/16/25. The Plant Operations Director will conducted weekly random apartment checks for one month, completed 10/16/2025, then monthly thereafter to verify that regulation 85d is in compliance. The audit will be reported to the Executive Director if compliance is not being met ongoing and continuous. Results of the audit will be discussed by the Executive Directors with the current directors in attendance at the next quarterly Quality Assurance meeting on 10/27/2025.

Licensee's Proposed Overall Completion Date: 10/16/2025

Implemented [redacted] 11/12/2025)

183e Storing Medications

4. 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 [redacted] with an expiration date of [redacted], was in the medication's cart. According to the manufacturer's instructions expired medications should be removed from the medication's cart.

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] 10/30/2025)

The expired medication was immediately removed from the medication cart and the unexpired medication is available for the Resident. A full audit of current Resident's medications in the medication cart or overflow storage was completed by the Heath and Wellness Director to ensure no other expired medications are present. Any expired medications found will be discarded per state guidelines and the medication will be reordered per the medication order. The results of the audit was reviewed by the Executive Director on 10/16/2025. Current Medication Technicians were trained by the Health & Wellness Director on removing expired medications and reordering

183e - Storing Medications (continued)

medications timely for medication administration as ordered , completed 10/16/2025. A weekly medication cart audit will be conducted by the Health and Wellness Director or designee to verify that there are no expired medications stored in the medication cart, the audit is weekly for 30 days, then monthly thereafter or until established. Any discrepancies will be reported immediately to the Executive Director, audit for 30 days completed 10/17/2025, monthly audits effective ongoing and continuous. The results of the audit will be discussed at the Quarterly Quality Assurance meeting on 10/27/2025.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented (████) - 11/12/2025)

184a - Resident's Meds Labeled

5. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident █████ is prescribed █████ unit; apply topically under the bilateral breasts every 8 hours as needed. The pharmacy label does not match the order on the MAR. A change of directions sticker was not place on the medication.

Resident █████ is prescribed █████; take two tablets by mouth every twelve hours. The pharmacy label does not match the order on the MAR. A change of directions sticker was not place on the medication.

Plan of Correction

Accept (████) - 10/30/2025)

The order for the medication was reviewed and clarified by the Health and Wellness Director, a change of direction sticker was placed on the medication card immediately. The MAR was reviewed to verify the MAR and the medication label matched. Current Medication Technicians received training by the Health and Wellness Director on the Medication Administration Records (MARS) / Medication Observation Record (MOR) Policy on verifying the medication record matches the medication label and also the use of change of direction stickers when a medication changes, completed 10/16/2025. An audit of medication changes for 30 days was established 10/17/2025, as compliance was established. Periodic checks will be conducted by the Health and Wellness Director ongoing and continuous. The Executive Director will be notified upon completion of the audit and will review, the Health and Wellness Director or designee will complete the audit.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented (████) - 11/12/2025)

185a - Implement Storage Procedures

6. 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 █████, resident █████ is prescribed █████ tab for █████. The medication administration record indicates the medication was given from May 7 thru May 15. The home does not have a narcotic sheet showing administration, the count and the initial who administered the medication. The medication is not in the home and there is no documentation of destroying the medication.

185a - Implement Storage Procedures (continued)

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] 10/30/2025)

The Health and Wellness Director conducted an audit of the narcotic sheets of the current Residents on narcotics to verify compliance, completed on 10/17/2025. The company policy was re-trained to all Medication Technicians by the Health and Wellness Director, completed 10/17/2025. A full audit of current Residents that are administered narcotics and their narcotic sheets were reviewed weekly as part of the weekly cart audit by the Health and Wellness Director, completed 10/17/2025. An unannounced audit will be conducted monthly in addition to the weekly cart audits ongoing and continuous for compliance.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] 11/12/2025)

231c - Preadmission Screening

7. Requirements

2600.

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

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident [REDACTED] written cognitive preadmission screening was completed on [REDACTED]

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] 10/30/2025)

An audit of current Residents preadmission screenings were conducted and completed on 10/16/2025 to verify that all current written cognitive preadmission screenings have accurate dates, completed within 72 hours prior to admission. The Health and Wellness Director received training on this regulation completed 10/16/2025. 72 hours prior to admission the Executive Director will verify for accuracy the correct timeframe is established ongoing and continuous.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] - 11/12/2025)

234a - Admission Support Plan

8. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial support plan was completed on [REDACTED]

234a - Admission Support Plan (continued)**Plan of Correction****Accept** [REDACTED] - 10/30/2025)

An audit of the current Residents admission support plans were conducted and completed on 10/16/2025 to verify that all current support plans are completed within 72 hours prior to Resident's admission. The Health and Wellness Director received training on this regulation completed 10/16/25. within 72 hours prior to the admission the Executive Director will verify for accuracy the correct timeframe is established ongoing and continuous.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] - 11/12/2025)