Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 11, 2026

Creek Senior Care LLC
[redacted]

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

Dear Creek Senior Care LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspection on January 21, 2026 and January 22, 2026, 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

February 4, 2026

[redacted]
CREEK SENIOR CARE LLC
[redacted]

RE: THE BRIDGES AT BENT CREEK
2100 BENT CREEK BOULEVARD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33355

Dear [redacted]

[redacted]

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE BRIDGES AT BENT CREEK* **License #:** *33355* **License Expiration:** *09/12/2025*

Address: *2100 BENT CREEK BOULEVARD, MECHANICSBURG, PA 17050*

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

Administrator

Name: [redacted]

Legal Entity

Name: *CREEK SENIOR CARE LLC*

Addres [redacted]

Phone: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *127* **Waking Staff:** *95*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:** *0*

Reason: *Renewal, Complaint, Incident, Monitoring* **Exit Conference Date:** *01/22/2026*

Inspection Dates and Department Representative

01/21/2026 - On-Site: [redacted]

01/22/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served:** *79*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Lilac Trace* **Capacity:** *31* **Residents Served:** *12*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *79*

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

Have Mobility Need: *48* **Have Physical Disability:** *0*

Inspections / Reviews

01/21/2026 - Full

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident #1 and Resident #2 both reside in the Secure Dementia Care Unit. On [redacted]/25 and [redacted]/25, Residents #1 and #2 admitted to Staff Member B they were having sexual intercourse on [redacted]/25 and on [redacted]/25, when found partially clothed in Resident #1's apartment. Then on [redacted]/25 at 5:55 PM, Resident #2 was observed by Staff Member B on Resident #1's bed, and Resident #2 was not wearing [redacted] pants but wearing [redacted] adult brief. Resident #1 was in the room and clothed. The home did report the incident to the Local Area Agency on Aging as suspected abuse. However, the home did not notify the local police department regarding the 12/2/25, 12/3/25 or 12/21/25 incident.

Repeated Violation - 10/29/25, et al

Plan of Correction ***Directed [redacted] - 02/04/2026)***

- The Administrator or designee will report the incidents that occurred on 12/2/25, 12/3/25 and 12/21/25 to the local police department by 3/5/26.
- Education will be provided to all staff, including the Administrator, on regulation 2600.15(a) by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will conduct daily meetings with staff to discuss incidents that occurred the day prior to ensure any allegations of serious abuse are reported to the local police department.
- Documentation of reports made to the local police department, completed staff education and daily meeting minutes will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

15d - Resident Abuse-Notification

2. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On [redacted]/25 at 5:55 PM, Resident #2 was observed by Staff Member B on Resident #1's bed, and Resident #2 was not wearing [redacted] pants but wearing [redacted] adult brief. Resident #1 was in the room and clothed. The home did report the incident to the Local Area Agency on Aging as suspected abuse. However, Resident #1's [redacted] was not notified until approximately 24 hours later, on 12/22/25.

15d - Resident Abuse-Notification *(continued)*

Plan of Correction ***Directed [redacted] 02/04/2026)***

- Education will be provided to all staff, including the Administrator, on regulation 2600.15(d) by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will conduct daily meetings with staff to discuss incidents that occurred the day prior to ensure any allegations of abuse are immediately reported to the resident's designated person.
- Documentation of completed staff education and daily meeting minutes will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

23b - Instrumental Activities of Daily Living Assistance

3. Requirements

2600.
23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan (RASP), dated [redacted]/25, indicated due to cognitive impairment resident may have limited ability to understand or consent to intimate physical contact. Staff are to monitor alcoves, quiet corners, or low-visibility areas where residents might attempt increased physical contact. Ensure doors to private rooms are closed and monitor when the two residents are in the vicinity. Resident #1's RASP, dated [redacted]25, indicated resident has a 1:1 staff to resident ratio in place due to exit seeking behaviors.

However, on [redacted]/25, Resident #1 was unable to be located and was not being monitored by staff. At 5:55 PM, Staff Member B observed Resident #2 in Resident #1's apartment. Resident #2 was not wearing pants but wearing adult briefs and lying on Resident #1's bed. Resident #1 was in the room and clothed. Staff Member G documented that multiple times during the 6:30 AM - 6:30 PM shift on [redacted]/25, Resident #1's 1:1 staff could not be located, and the resident went without supervision multiple times.

Resident #2's RASP, dated [redacted]/25, and Resident #2's RASP addendum, dated [redacted]25, indicated due to cognitive impairment resident may have limited ability to understand or consent to intimate physical contact, and resident needs protection and supervision because participant makes unsafe or inappropriate decisions. Staff are to monitor alcoves, quiet corners, or low-visibility areas where residents might attempt increase physical contact. Ensure doors to private rooms are closed and monitor when the two residents are in the vicinity.

However, on [redacted]5, Resident #2 was unable to be located and was not being monitored by staff. At 5:55 PM, Staff Member B observed Resident #2 in Resident #1's apartment. Resident #2 was not wearing pants but wearing adult briefs and lying on Resident #1's bed. Resident #1 was in the room and clothed.

Plan of Correction ***Directed [redacted] 02/04/2026)***

- Per the home's records, Resident #1 was given a 30-day discharge notice on 12/10/25, and the resident moved out of the home on [redacted]/25.
- Education will be provided to all direct care staff who work in the home's Secure Dementia Care Unit will receive education on the Resident #2's care needs and how to manage these care needs per the resident's support plan by 3/5/26.

23b - Instrumental Activities of Daily Living Assistance (continued)

- Beginning no later than 3/5/26, the Administrator or designee will conduct monthly meetings with direct care staff in the Secure Dementia Care Unit to review the current care needs of the residents who reside in the Secure Dementia Care Unit, address changes in the care needs, and address how the needs are being managed. In addition, any changes in care needs will also be documented in the home's communication log by the Administrator or designee.

- Documentation of staff education and monthly meeting minutes will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

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]9/26 at approximately 5:30 AM, Staff Member C and Staff Member D heard yelling for help in the Secure Dementia Care Unite (SDCU). Upon investigation, Staff Member C and Staff Member D observed Resident #3 standing in the doorway of Resident #4's apartment. Resident #4 had [redacted] hands on [redacted] head. Staff members intervened and escorted Resident #4 from the room. Staff Member E assessed Resident #4 for injures. While being assessed by staff, Resident #4 reported that Resident #3 came into [redacted] room yelling and accusing [redacted] of stealing their friend's property. Then Resident #3 hit Resident #4 on the head with a metal piece from Resident #4's wheelchair. As a result of the incident, Resident #4 sustained a small, red bruise on [redacted] head.

Resident #1 was admitted to the SDCU on [redacted]/25 and diagnosed with mild dementia, memory loss and poor cognitive functioning per [redacted] medical evaluation, dated 1/14/25. Resident #1's preadmission screening to the SDCU, dated [redacted]/25, indicates the needs of the resident cannot be met in the personal care home. Resident #1's support plan, dated 2/17/25, indicates the resident needs protection and supervision because the resident makes unsafe or inappropriate decisions.

Resident #2 was admitted to the SDCU on [redacted]/25 and has poor cognitive functioning per [redacted] medical evaluation, dated 2/17/25. Per Resident #2's preadmission screening, dated [redacted]/25, it is unclear if the resident's needs could be met in the SDCU as yes and no were both checked in response to the statement: the needs of the resident can be met in the personal care home. Resident #2 support plan, dated [redacted]/25, indicates the resident is occasionally disoriented to person, place, time or situation and requires supervision and oversight for safety, and the resident needs protection and supervision because the resident makes unsafe or inappropriate decisions.

On 12/2/25 at 9:00 PM, Resident #1 and Resident #2 were not provided supervision and oversight as Resident #2 was in Resident #1's apartment with [redacted] pants off and on Resident #1's bed. Staff observed Resident #1 near the bed, zipping up [redacted] pants. Resident #1 and Resident #2 stated to Staff Member B that they had sex, which was reported to Staff Member A and Staff Member H. Staff Member A reported the incident to the Department via an incident

42b - Abuse (continued)

reporting form that Residents #1 and Resident #2 were being monitored every 30 minutes for the remainder of the night. However, Staff Member A and Staff Member F (who was onsite until midnight [redacted]/25) did not inform staff to complete monitoring checks every 30 minutes, but to do this "frequently".

On 12/2/25, both Resident #1 and Resident #2's assessment and support plans (RASPS) were updated to indicate due to cognitive impairment resident may have limited ability to understand or consent to intimate physical contact. Staff are to monitor alcoves, quiet corners, or low-visibility areas where residents might attempt to increase physical contact. Ensure doors to private rooms are closed and monitor when the two residents are in the vicinity.

On 12/3/25 at 10:10 AM and 10:15 AM, Staff Member A and Staff Member G assessed Resident #1 and Resident #2's cognitive impairment via the VAMC SLUMS examination; Resident #1 scored a 14, dementia present and Resident #2 scored a 5, significant dementia present.

On [redacted]25 at 4:00 PM, Resident #1 and Resident #2 were not provided supervision and oversight as Resident #2 was again in Resident #1's apartment not wearing pants or their adult brief. Resident #1 and Resident #2 stated to staff they were engaging in sexual activity, and this was reported to Staff Member A. Staff Member A reported to the Department via an incident reporting form that one-on-one, staff-to-resident ratio, supervision was put in place for the residents. However, 1:1 supervision was only put in place for Resident #2 as [redacted] was reportedly identified as the initiator of the incident.

On 12/9/25 at 2:45 AM, Resident #1 was without supervision and monitoring as [redacted] was found in between the two front doors of the main entrance to the building, which is outside of the SDCU. The resident unscrewed the window of [redacted] bedroom with a flashlight and climbed out the window. Resident #1 started receiving 1:1 supervision due to this incident, and Resident #2 stopped receiving the 1:1 supervision at this time without being reassessed by the home.

On [redacted]/25, a search of the SDCU was conducted by multiple staff as Resident #1's 1:1 staff could not locate Resident #1. At 5:55 PM, Resident #2 was located in Resident #1's apartment not wearing pants but wearing an adult brief. Resident #1 was in the room and clothed. Staff Member G reported that Resident #1's 1:1 staff was "nowhere to be found multiple times" during the 6:30 AM - 6:30 PM shift on 12/21/25. Per staff interviews, staff did not step in and provide 1:1 staffing for Resident #1 when the outside agency 1:1 staff was not located or performing supervision for Resident #1.

Staff Member A reported via an incident report that one-to-one supervision remains in place for residents, one-to-one instructed to monitor residents during shift, and staff to monitor one-to-one for resident during shift, following the 12/21/25 incident. However, one-to-one supervision and staffing was not provided to both Resident #1 and Resident #2 but was only provided to one of the residents until 12/29/25.

Repeated Violation - 8/25/25, et al, 6/17/25, et al and 3/24/25, et al

Plan of Correction ***Directed ([redacted] - 02/04/2026)***

- Per the home's records, Resident #1 was given a 30-day discharge notice on [redacted]/25, and the resident moved out of the home on [redacted]/25.

42b - Abuse (continued)

- The Administrator or designee will complete an assessment for Resident #3's needs in the areas of behavioral concerns by 3/5/26, in order to determine if additional supervisor or supports are needed.
- Education will be provided to all direct care staff who work in the home's Secure Dementia Care Unit on the current care needs of the residents who reside in the Secure Dementia Care Unit, how to manage these care needs and any time private duty or supplemental care providers are not available, direct care staff must ensure care needs are met, including when supervision must be provided. This education is to be provided by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will conduct monthly meetings with direct care staff in the Secure Dementia Care Unit to review the current care needs of the residents who reside in the Secure Dementia Care Unit, address changes in the care needs, and address how the needs are being managed. In addition, any changes in care needs will also be documented in the home's communication log by the Administrator or designee.
- Documentation of completed assessments, staff education and monthly meeting minutes will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

103g - Storing Food

5. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 1/21/26, there were three plastic food storage containers in the walk-in refrigerator that were not sealed. One of the containers has watermelon, dated 1/20; one has crab salad, dated 1/19; one has cantaloupe, dated 1/20.

Plan of Correction ***Directed [redacted]- 02/04/2026)***

- The containers for the watermelon, crab salad and cantaloupe will be sealed by the Administrator or designee by 2/7/26.
- Education will be provided to all staff who are involved with food storage on regulation 2600.103(g) by 3/5/26.
- An initial audit of all stored food will be completed by 3/5/26 by the Administrator or designee to ensure compliance.
- Beginning no later than 3/5/26, the Administrator or designee will complete weekly audits of the home's food storage to ensure compliance.
- Documentation of completed staff education and completed audits will be kept by the home and available for review by the Department.

103g - Storing Food *(continued)*

Directed Completion Date: *03/05/2026*

181c - Self-administration Assessment

6. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #5 self-administers medications to include Equate-brand Antibiotic Ointment; however, Resident #5 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Directed [redacted] 02/04/2026)***

- Resident #5's Equate-brand Antibiotic Ointment will be removed by 2/7/26 by the Administrator or designee.
- Resident #5 and Resident #5's designated person will be educated on regulation 2600.181(c) by 3/5/26.
- Education will be provided to all staff who go into resident rooms on regulation 2600.181(c) by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will conduct monthly audits of Resident #5's room to ensure compliance.
- Documentation of completed education provided to the resident and the resident's designated person, completed staff education and completed monthly audits will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

183b - Meds and Syringes Locked

7. Requirements

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

Description of Violation

On 1/22/26 at 11:09 AM, the T1 medication cart was unlocked, unattended, and accessible in the hub outside of the dining room.

Repeated Violation - 10/29/25, et al, 9/17/25, et al, 7/29/25 and 3/24/25, et al

Plan of Correction ***Directed [redacted] 02/04/2026)***

- The T1 medication cart was immediately locked by staff.
- Education will be provided to all staff who administer medications on regulation 2600.183(b) by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will do weekly walkthroughs to review the medication carts in the home to ensure compliance.
- Documentation of completed education and completed weekly walkthroughs will be kept and available for review

183b - Meds and Syringes Locked (continued)

by the Department.

Directed Completion Date: *03/05/2026*

184a - Resident's Meds Labeled

8. 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

On 1/10/26, the directions for Resident #2's prescribed Lantus Solostar 100 units changed from 18 units in the morning to 20 units in the morning. However, the directions on the pharmacy label stated inject 18 units and did not include a direction of change sticker.

Repeated Violation - 6/17/25, et al

Plan of Correction ***Directed ([redacted] 02/04/2026)***

- The Administrator or designee will contact the pharmacy by 3/5/26 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 3/5/26.
- An initial audit will be completed on all other resident medications and physician's orders by 3/5/36 by the Administrator or designee.
- Beginning no later than 3/5/26, the Administrator or designee will complete weekly audits on at least 25% or resident physician orders and medication labels.
- Documentation of completed education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

227h - Support Plan Refuse Sign

9. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1 did not sign [redacted] support plan, dated [redacted]/25. The home did not make a notation regarding the resident's inability or refusal to sign.

Plan of Correction ***Directed ([redacted] - 02/04/2026)***

- The Administrator or designee will update Resident #1's support plan to reflect either the resident's inability or refusal to sign by 3/5/26.
- Education will be provided to all staff that complete support plans on 2600.227(h) by 3/5/26.
- An initial audit will be completed on all current support plans by 3/5/36 by the Administrator or designee to ensure compliance.

227h - Support Plan Refuse Sign (continued)

- Beginning no later than 3/5/26, the Administrator or designee will complete quarterly audits on all current support plans.

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

Directed Completion Date: *03/05/2026*

231b - Medical Evaluation

10. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25; However, the initial medical evaluation, dated [redacted]25, does not include a diagnosis of dementia.

Plan of Correction ***Directed [redacted] 02/04/2026)***

- The Administrator or designee will add documentation to Resident #2's record, identifying the violation and date violation was cited. This will be completed by 3/5/26.

- Education will be provided to all staff who review initial medical evaluations for residents in the Secure Dementia Care Unit on regulation 2600.231(b).

- An initial audit will be completed all initial medical evaluations for residents in the Secure Dementia Care Unit by 3/5/36 by the Administrator or designee. Documentation will be added to any residents' records where the initial medical evaluation found to be out of compliance, identifying the violation and date violation was cited. This will be completed by 3/5/26.

- Beginning no later than 3/5/26, the Administrator or designee will review initial medical evaluations for new admissions to the Secure Dementia Care Unit at least 72 hours prior to the new admission's move-in date.

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

Directed Completion Date: *03/05/2026*

231c - Preadmission Screening

11. 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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However. Resident #1

231c - Preadmission Screening (continued)

's written cognitive preadmission screening indicates that the needs of the resident cannot be met in the personal care home.

Resident #2's cognitive preadmission screening, dated 2/17/25, does not include a diagnosis of dementia or Alzheimer's disease.

Repeated Violation - 9/17/25, et al and 1/7/25

Plan of Correction ***Directed [redacted]- 02/04/2026)***

- The Administrator or designee will add documentation to Residents #1 and #2's records, identifying the violation and date violation was cited. This will be completed by 3/5/26.
- Education will be provided to all staff who complete preadmission screenings for residents in the Secure Dementia Care Unit on regulation 2600.231(b).
- An initial audit will be completed preadmission screenings for residents in the Secure Dementia Care Unit by 3/5/36 by the Administrator or designee. Documentation will be added to any residents' records where the initial medical evaluation found to be out of compliance, identifying the violation and date violation was cited. This will be completed by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will review completed preadmission screenings for new admissions to the Secure Dementia Care Unit within 72 hours prior to the new admission's move-in date.
- Documentation of completed education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

234a - Admission Support Plan

12. 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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/25. However, the resident's initial support plan was completed on 2/17/25.

Repeated Violation - 1/7/25

Plan of Correction ***Directed [redacted]- 02/04/2026)***

- The Administrator or designee will add documentation to Resident #1's record, identifying the violation and date violation was cited. This will be completed by 3/5/26.

234a - Admission Support Plan (continued)

- Education will be provided to all staff who complete support plans for residents in the Secure Dementia Care Unit on regulation 2600.234(a).
- An initial audit will be completed all initial support plans for residents in the Secure Dementia Care Unit by [redacted] by the Administrator or designee. Documentation will be added to any residents' records where the initial medical evaluation found to be out of compliance, identifying the violation and date violation was cited. This will be completed by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will review initial support plans for new admissions to the Secure Dementia Care Unit within 72 hours of a new admission's move-in date.
- Documentation of completed education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: *03/05/2026*

234b - Support Plan Needs Elements

13. Requirements

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

Description of Violation

Per documentation of a physician's office visit on [redacted]/25, Resident #2 has a diagnosis of unspecified dementia. However, Resident #2's current support plan, dated [redacted]/25 and addendum, dated [redacted]/25, did not include this diagnosis.

Repeated Violation - 3/24/25, et al

Plan of Correction ***Directed [redacted] - 02/04/2026)***

- The Administrator or designee will update Resident #2's current support plan to include a diagnosis of unspecified dementia by 3/5/26.
- Education will be provided to all staff who complete support plans for residents in the Secure Dementia Care Unit on regulation 2600.234(b).
- The Administrator or designee will complete an initial audit, comparing all current medical evaluations to all current support plans for residents in the Secure Dementia Care Unit to ensure all current support plans include all diagnoses. This will be completed by 3/5/26.
- Beginning no later than 3/5/26, the Administrator or designee will complete quarterly audits on all current support plans for residents in the Secure Dementia Care Unit.
- Documentation of completed education and completed audits will be kept by the home and available for review by the Department.

234b - Support Plan Needs Elements (continued)

Directed Completion Date: *03/05/2026*