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

June 10, 2026

[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 04/09/2026 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: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/09/2026*

Inspection Dates and Department Representative

04/09/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Home* **Capacity**: *48* **Residents Served**: *38*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *38*

Have Physical Disability: *0*

Inspections / Reviews

04/09/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/16/2026*

06/04/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/10/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/14/2026*

Inspections / Reviews *(continued)*

06/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/10/2026*

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

63a - First Aid/CPR Training

1. 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 3/22/26, from 3:00 P.M. to 7:00 A.M., 36 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

On 3/30/26, from 7:00 A.M. to 12:00 A.M. and 12:00 A.M. to 7:00 A.M., 36 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

On 4/4/26, from 11:00 P.M. to 7:00 A.M., 36 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

Repeat Violation 5/21/25

Plan of Correction ***Directed ([redacted] - 06/04/2026)***

• An Audit has been conducted by Business Office manager identifying staff needed to fulfill regulation and SLC requirements .
• Executive Director or designee will have required documentation completed by 5/15/2026 bringing staff fully compliant with regulatory requirements by 5/30/2026.
• New hire Medication Technician staff will be required to have CPR/First Aid training before working on the floor. Audits will be completed for the next three months to ensure compliance by Business Office Manager or designee .
• The Executive Director will discuss the results of the audits at the quarterly Quality Assurance review with current directors present .

Directed Plan of Correction ([redacted] 6/4/26):
In addition to the steps submitted in the Plan of Correction, the administrator will implement the following steps immediately:
1. The administrator or scheduler will review the daily staff schedule to ensure at least one staff per 50 residents are present and certified in FA/CPR, for the next four weeks, then monthly thereafter for the next six months.
2. Documentation of the scheduling review will be maintained for the Departments review.
Proposed Overall Completion Date: 06/12/2026

Directed Completion Date: *06/12/2026*

Implemented ([redacted] - 06/10/2026)

65g - Annual Training Content

2. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.

65g - Annual Training Content *(continued)*

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations during training year January 1, 2025 to December 31, 2025.

Staff Person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations during training year January 1, 2025 to December 31, 2025.

Plan of Correction ***Directed ([redacted] - 06/04/2026)***

• Audits have been conducted by the Business Office manager identifying items needed to fulfill regulation
• Business Office Manager or designee will have required documentation completed by 5/29/2026 bringing staff fully compliant with regulation
• . Business Office Manager or designee will review monthly audits beginning 6/1/2026 of annual training modules to ensure proper training modules are completed timely for the next two months. Results of the audits will be reviewed upon completion by the Executive Director
• The Executive Director will discuss the results of the audits at the next quarterly Quality Assurance review with current directors present .
Directed Plan of Correction ([redacted] 6/4/26):
In addition to the steps submitted in the Plan of Correction, the administrator will implement the following additional steps immediately:
1. Staff A and B will complete training in Fire Safety within the next 15 days.
2. Documentation of the fire safety training will be maintained for the Departments review.

Proposed Overall Completion Date: 06/12/2026

Directed Completion Date: *06/19/2026*

Implemented ([redacted] - 06/10/2026)

88a - Surfaces

3. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/9/26 at 9:35 A.M. in the South Side Activity Room the carpet is fraying causing a tripping hazard.

On 4/9/26 at 9:49 A.M. in the North Side Sitting Room the carpet is fraying causing a tripping hazard.

88a Surfaces *(continued)*

Plan of Correction ***Directed ([redacted] - 06/04/2026)***

A walkthrough inspection of current carpets will conducted by the Plant Operations Director or designee to verify that the carpets are in good repair. The results of the inspection will be reviewed by the Executive director .5/12/26
Carpets will be placed on a routine maintenance scheduled and be inspected for damaged areas by maintenance director or designee.
The Executive Director or designee will monitor weekly times 4 weeks and monthly times 2 months.
Quotes are currently being obtained by the Executive Director to repair damaged areas identified during the survey .
The results of the inspections will be discussed during the quarterly Quality Assurance review by the executive Director with current Directors in attendance .

Directed Plan of Correction ([redacted] 6/4/26):
In addition to the steps submitted in the Plan of Correction, the administrator will implement the following steps starting immediately:
1. The frayed carpet identified during the inspection will be repaired within the next 10 days.
2. A photo of the repaired carpet will be made available for the Departments review.

Proposed Overall Completion Date: 06/12/2026

Directed Completion Date: *06/12/2026*

Implemented ([redacted] - 06/10/2026)

141a 1-10 Medical Evaluation Information

4. 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.

Description of Violation

Resident # 1's medical evaluation dated [redacted] does not include the determination that Resident # 1's needs can be met in the personal care home.

Repeat Violation: 9/22/25

Plan of Correction ***Directed ([redacted] - 06/04/2026)***

• An audit will be conducted by the Health & Wellness Director or Designee for current resident to verify medical evaluation is documented to include the determination that the resident needs can be met in the personal care home by 5/29/26.

141a 1-10 Medical Evaluation Information (continued)

• The Executive Director or Designee will review all medical evaluations prior to admission & annual DME's weekly for 4 weeks and monthly for two months

• The Executive Director will discuss the results of the audit during the next quarterly Quality Assurance review . Current Directors will be present .

Directed Plan of Correction ([redacted] 6/4/26):

In addition to the steps submitted in the Plan of Correction, the administrator will implement the following steps, starting immediately:

1. Resident #1's medical evaluation will be reviewed to determine if the home can meet the needs of the home.

2. A copy of the corrected medical evaluation will be made available for the Departments review.

3. The Executive Director will review all newly admitted residents' medical evaluation within 30 days of admission for the next six months.

Proposed Overall Completion Date: 06/12/2026

Directed Completion Date: *06/12/2026*

Implemented ([redacted] - 06/10/2026)