

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

October 5, 2026

[REDACTED]
MDT ALF 1 LLC
[REDACTED]
[REDACTED]

RE: LEGEND AT SILVER CREEK
425 LAMBS GAP ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33925

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/26/2026, 08/27/2026 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: LEGEND AT SILVER CREEK **License #:** 33925 **License Expiration:** 10/04/2026
Address: 425 LAMBS GAP ROAD, MECHANICSBURG, PA 17050
County: CUMBERLAND **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MDT ALF 1 LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 07/14/2023 **Issued By:** Hamden Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 130 **Waking Staff:** 98

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 08/28/2026

Inspection Dates and Department Representative

08/26/2026 - On-Site: [REDACTED]

08/27/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 125 **Residents Served:** 102

Secured Dementia Care Unit

In Home: Yes **Area:** Reflections **Capacity:** 24 **Residents Served:** 21

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 102
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 28 **Have Physical Disability:** 0

Inspections / Reviews

08/26/2026 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/19/2026

Inspections / Reviews (*continued*)

09/17/2026 POC Submission

Submitted By: [REDACTED] -

Date Submitted: 10/02/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/05/2026

10/05/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/02/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's 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

On [REDACTED] at 10:26AM, the home received email notification from Lancaster County Adult Protective Services that a concern was received by their office for caregiver neglect relating to Resident [REDACTED]. A Mandatory Abuse Reporting form (Act 13) was not submitted the local Area Agency on Aging.

Plan of Correction

Accept [REDACTED] - 09/17/2026)

Immediate Action as Result of LIS survey 8/26 & 8/27/26: Late report to the department and AAA submitted on 8/27/26 as a result of concerns regarding resident [REDACTED] caregiver neglect. Documentation shall be kept.

By 9/17/26, the Regional Director of Operations will educate the Resident Director and the Assistant Health Care Director on the requirements housed within 2600.15.a. The Regional Director of Operations will train the Health Care Director by 9/21/2026. Documentation shall be maintained.

By 9/25/2026, the Residence Director or designee will train current staff on the reporting requirements found in 2600.15a. Documentation shall be maintained.

On 10/23/2026, the Residence Director or designee, will review the above trainings for 2600.15a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Proposed Overall Completion Date: 10/09/2026

Licensee's Proposed Overall Completion Date: 09/25/2026

Implemented [REDACTED] - 10/05/2026)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED] at 8:00PM, maggots were discovered by the home in a wound on Resident [REDACTED]'s lower right extremity. The resident was transported to the hospital where the wound was cleaned and the resident discharged with an order for Cephalexin. This incident was not reported to the Department until [REDACTED].

On [REDACTED] at 10:26 AM, the home received email notification from Lancaster County Adult Protective Services that a concern was received by their office for caregiver neglect relating to Resident [REDACTED]. This incident was not reported to the Department.

16c Written Incident Report (continued)

Plan of Correction

Accept () 09/17/2026

By 9/17/26, the Regional Director of Operations will educate the Resident Director and the Assistant Health Care Director on the requirements housed within 2600.16c. The Regional Director of Operations will train the Health Care Director by 9/21/2026. Documentation shall be maintained.

By 9/25/2026, the Residence Director or designee will train current staff on the reporting requirements found in 2600.16c. Documentation shall be maintained.

On 10/23/2026, the Residence Director or designee, will review the above trainings for 2600.16c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/25/2026

Implemented () - 10/05/2026

183e - Storing Medications

3. 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 () at 4:00 PM, the Lantus Solostar insulin pen belonging to Resident () was not labeled with the date of opening. According to the manufacturer's instructions, once a SoloSTAR pen is taken out of cool storage, it can be used for up to 28 days and should be discarded after this time.

On () at 4:00 PM, the () pen belonging to Resident () was not labeled with the date of opening. According to the manufacturer's instructions, once a SoloSTAR pen is taken out of cool storage, it can be used for up to 28 days and should be discarded after this time.

Plan of Correction

Accept () - 09/17/2026

Immediately on 8/26/2026 Lantus Solostar insulin pen belonging to Resident () was correctly restocked with new pen and correctly labeled with new expiration date with manufacturer's instructions of 28 days later by the Health Care Director.

Immediately on 8/26/2026 Lantus Solostar insulin pen belonging to Resident () was restocked with new pen and correctly labeled with new expiration date with manufacturer's instructions of 28 days later by the Health Care Director.

By 9/25/26, the Health Care Director or designee will will train the Medication Technicians and the Medication Management Nurse (LPN) on the requirements of 2600.183.e. Documentation shall be maintained.

Beginning 9/14/26, the Health Care Director or designee will audit 5 residents using pens, eye drops, or inhalers

183e - Storing Medications (continued)

daily for 2 weeks then weekly for 2 weeks to ensure that any medication that should have have an open date, has one and is labeled correctly and disposed of in the appropriate amount of time. Documentation shall be maintained.

On 10/23/2026, the Residence Director or designee, will review the above findings for 2600.183e during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/17/2026

Implemented () - 10/05/2026

184a - Resident's Meds Labeled**4. Requirements**

2600.

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

1. The resident's name.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for Resident [REDACTED] did not include the prescribed dosage and instructions for administration nor the name and title of the prescriber.

The pharmacy label for Resident [REDACTED] did not include the name and title of the prescriber.

The pharmacy label for a [REDACTED] present in the medication cart did not include the resident's name, the prescribed dosage and instructions for administration, nor the name and title of the prescriber.

Repeated Violation [REDACTED], et al

Plan of Correction

Accept () - 09/17/2026

Immediately on 8/26/2026 the pharmacy label for resident [REDACTED] autologous serum tears was correctly labeled to include the prescribed dosage and instructions for administration and the name and title of the prescriber by the Health Care Director.

Immediately on 8/26/2026 the pharmacy label for resident [REDACTED] Latus Solostar insulin pen was correctly labeled to include the name and title of the prescriber by the Health Care Director.

Immediately on 8/26/2026 the pharmacy label for Novolog Flexpen was correctly labeled to include resident's name, the prescribed dosage and instructions for administration, Novolog Flexpen was also correctly labeled with the name and title of the prescriber by the Health Care Director.

By 9/23/26, the Regional Health Care Director or designee will training the Health Care Director and Assistant Health Care Director on the requirements of 2600.184a. Documentation shall be maintained.

By 9/30/2026, the Health Care Director or designee will train all licensed staff and med techs on the requirements

184a Resident's Meds Labeled (continued)

within 2600.184a. Documentation shall be maintained.

By 9/23/2026, the Health Care Director or designee will audit current medications labels for the resident's name, the prescribed dosage and instructions for administration, the name and title of the prescriber. Any label found to be missing these items will be corrected at the time of audit. Documentation shall be maintained.

Starting 9/21/2026, the Health Care Director or designee will review any new medication label weekly for 4 weeks to ensure it meets 2600.184a. Documentation shall be maintained.

On 10/23/2026, the Residence Director or designee, will review the above findings for 2600.184a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented [REDACTED] - 10/05/2026)

187a - Medication Record**5. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [REDACTED] was prescribed wound care to the [REDACTED] to cleanse right lower leg wound with wound cleanser, pat dry with sterile gauze, apply oil emulsion dressing, over with bordered gauze dressing, change twice weekly and as needed for soilage. This wound care was completed by the home on [REDACTED]. This treatment was not included on resident's June 2026 Medication Administration Record.

Resident [REDACTED] was prescribed wound care to the [REDACTED] to cleanse lesion on left upper arm with wound wash, pat dry, cover with dry dressing twice weekly and as needed for soilage or dislodgement effective [REDACTED] and cover with sterile gauze, apply oil emulsion dressing, cover with bordered gauze dressing, and discontinue when healed effective [REDACTED]. This wound care was completed by the home on [REDACTED] and [REDACTED]. This treatment was not included on resident's June 2026 Medication Administration Record.

187a - Medication Record (continued)

Plan of Correction

Accept (████ - 09/17/2026)

Immediately the wound care orders were added to the MAR so that proper documentation could be met.

By 9/23/26, the Regional Health Care Director or designee will training the Health Care Director and Assistant Health Care Director on the requirements of 2600.187a. Documentation shall be maintained.

By 9/30/2026, the Health Care Director or designee will train all licensed staff and med techs on the requirements within 2600.187a. Documentation shall be maintained.

By 9/23/2026, the Health Care Director or designee will review current treatments and ensure they are on the current MARs. Documentation shall be maintained.

On 10/23/2026, the Residence Director or designee, will review the above findings for 2600.187a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented (████ 10/05/2026)

187b - Date/Time of Medication Admin.

6. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident █████ was prescribed █████ instill 1 drop into both eyes four times a day. Resident █████'s June 2026 medication administration record included the initials of staff members as administering serum tears on █████ at 5:00 PM and 8:00 PM, █████ at 8:00 AM, 12:00 PM, 5:00 PM, and 8:00 PM, and █████ 5:00 PM; however, the medication was not available in the home between █████.

Plan of Correction

Accept (████ - 09/17/2026)

Immediately the med techs who initialed for the medication while it was unavailable were retrained on the 5 rights. Med techs were warned that further incidents of this nature would result in corrective action and being removed from passing medications.

By 9/30/26, the Health Care Director or designee will train current licensed staff and med techs on the requirements found in 2600.187b. Documentation shall be maintained.

By 9/25/2026, the Health Care Director or designee will do a MAR to Cart audit to ensure all medications are available. Any that are found to be unavailable will be addressed with the pharmacy immediately with documentation maintained.

Starting 9/28/2026, the med techs will audit 5 resident MAR's against what is available in the cart per shift daily for 2 weeks. Documentation shall be maintained. The Health Care Director will review the med tech audits daily.

187b - Date/Time of Medication Admin. (continued)

On 10/23/2026, the Residence Director or designee, will review the above findings for 2600.187b during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented [REDACTED] 10/05/2026)

187d - Follow Prescriber's Orders

7. Requirements

2600.

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

Description of Violation

Resident [REDACTED] was ordered wound care for [REDACTED] to cleanse with wound cleanser, pat dry, cover with oil emulsion gauze, apply dry dressing twice weekly and as needed for soilage or dislodgement effective [REDACTED]. However, visit and wound care was only completed on [REDACTED] until the wound was inactivated on [REDACTED].

Resident [REDACTED] was ordered wound care for [REDACTED] to cleanse wound with gentle wound wash, apply skin prep to periwound, cover with bordered foam dressing change 3 times per week and PRN for soilage, may discontinue once healed effective [REDACTED]. However, visit and wound care was only completed on [REDACTED] until the wound was inactivated on [REDACTED].

Resident [REDACTED] was ordered wound care for [REDACTED] to cleanse right lower leg distal skin tear with gentle wound wash or normal saline, pat dry, apply skin prep to periwound area, cover with bordered foam or bordered gauze dressing change dressing 3 times weekly and PRN for soilage, may discontinue wound care when healed effective [REDACTED]. However, visit and wound care was only completed on [REDACTED] until the wound was inactivated on [REDACTED].

Resident [REDACTED] was ordered wound care for [REDACTED] to use clean technique to cleanse wound with wound cleanser or normal saline pat dry, apply skin prep periwound, cover with bordered foam gauze 3 times a week and PRN if dressing becomes soiled or dislodged using clean/aseptic technique, may DC wound care when wound closed or healed effective [REDACTED]. However, visit and wound care was only completed on [REDACTED] until the wound was inactivated on [REDACTED].

Resident [REDACTED] was ordered wound care for [REDACTED] to cleanse lesion on left upper arm with wound wash, pat dry, cover with dry dressing twice weekly and as needed for soilage or dislodgement effective 5/4/2026. However, visit and wound care was only completed on [REDACTED] until the wound was inactivated on 5/19/2026.

Resident [REDACTED] was prescribed [REDACTED] – 1 tablet by mouth on Monday Tuesday Wednesday Thursday Friday Saturday. The resident was not administered this medication on [REDACTED] and [REDACTED] 5:00AM because the medication was not available in the home.

Resident [REDACTED] was prescribed Serum tears instill 1 drop in both eyes four times a day. The resident was not

187d Follow Prescriber's Orders (continued)

administered this medication from [REDACTED] 8:00PM through [REDACTED] at 12:00PM because the medication was not available in the home.

Resident [REDACTED] was prescribed [REDACTED] take one tablet by mouth nightly. The resident was not administered this medication on [REDACTED] at 8:00PM because the medication was not available in the home.

Plan of Correction**Accept [REDACTED] - 09/17/2026)**

By 9/23/26, the Regional Health Care Director or designee will train the Health Care Director and Assistant Health Care Director and licensed staff on 2600.187d and doing wound care rounds and assessments with any 3rd party providers. Documentation shall be maintained.

Starting 9/21/2026, the Health Care Director or designee will do wound rounds with all 3rd party providers. Resident wounds will be assessed weekly by the Health Care Director or designee.

By 9/25/2026, the Health Care Director or designee will do a MAR to Cart audit to ensure all medications are available. Any that are found to be unavailable will be addressed with the pharmacy immediately with documentation maintained.

Starting 9/28/2026, the med techs will audit 5 resident MAR's against what is available in the cart per shift daily for 2 weeks. Documentation shall be maintained. The Health Care Director will review the med tech audits daily.

On 10/23/2026, the Residence Director or designee, will review the above findings for 2600.187d during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented [REDACTED] - 10/05/2026)