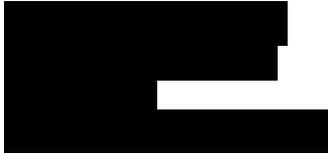




Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 2, 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 September 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,

A handwritten signature in cursive script that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

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*
 Address: [REDACTED]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 134 Waking Staff: 101

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *09/18/2025*

Inspection Dates and Department Representative

09/17/2025 - On-Site: [REDACTED]
 09/18/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 130 Residents Served: 93

Secured Dementia Care Unit

In Home: Yes Area: *Lillac Trace* Capacity: 31 Residents Served: 18

Hospice

Current Residents: 14

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 93
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 41 Have Physical Disability: 0

Inspections / Reviews

09/17/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type:

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 9/17/25, the home's license revocation notice, dated 5/9/25, was not posted in a conspicuous and public place in the home.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

- *The Administrator or designee will post the license revocation notice in a conspicuous and public place in the home by 10/10/25.*
- *Beginning 10/10/25 the Administrator or designee will check the home weekly to ensure all required documentation including the current license and violation report are posted in a conspicuous and public place in the personal care home.*

Directed Completion Date: 10/10/2025

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The certificate of operation for the home's boiler expired on 8/25/25.

Plan of Correction

Directed [REDACTED] - 09/25/2025)

- *The Administrator will have the boiler inspected and a new certificate of operation for the home's boiler by 10/10/25.*
- *The Administrator will be responsible for creating a tracking system to ensure that the boiler certificate will be procured prior to its expiration date. This system and tracking mechanism will be reviewed quarterly to ensure that scheduled maintenance and inspections can occur timely.*

Directed Completion Date: 10/10/2025

65f - Training Topics

3. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
6. Safe management techniques.

Description of Violation

Staff Member A did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and safe management techniques during training year 2024.

Staff Member B did not receive training in instruction on meeting the needs of the residents as described in the

65f - Training Topics (continued)

preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Plan of Correction**Directed** [REDACTED] **- 09/26/2025)**

- Staff Member A and B will receive training in in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and safe management techniques by 10/10/25. Documentation of the training will be kept and made available to the Department upon request.

-The administrator will review all current staff training records to ensure all staff persons have completed the required training in accordance with regulation 2600.65f during the current training year.

-The administrator will review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65f.

Directed Completion Date: 10/10/2025

65g - Annual Training Content**4. 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.

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff Member 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 and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 2024.

Staff Member B did not receive training in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 2024.

Plan of Correction**Directed** [REDACTED] **- 09/26/2025)**

- Staff Member A and B will receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, and Older Adult Protective Services Act by 10/10/25, documentation of this training will be kept and made available to the Department upon request.

-The Administrator or designated staff person will review all current staff training records to ensure all staff persons have completed the required training in accordance with regulation 2600.65g during current training year.

-The Administrator or designated staff person will review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65g.

Directed Completion Date: 10/10/2025

81b - Resident Personal Equipment**5. Requirements**

2600.

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

81b - Resident Personal Equipment (*continued*)**Description of Violation**

The home uses a call bell system in which residents are given pendants to wear and activate if they need staff assistance. If a pendant is activated, it sends a signal to pagers worn by staff who are on duty. On 9/18/25 at 3:31 PM, resident 7's pendant was activated, however, the pager worn by staff C did not receive a signal of the activation. A second pendant was provided to the resident and both pendants were tested separately. At this time, neither pager for staff C or D received a signal that the pendants had been activated.

On 9/17/25, resident 4's bed had a bedside mobility device attached. The device was not covered and had an opening within the device measuring approximately 12" x 8," creating a potential entrapment hazard.

On 9/17/25, resident 5's bed had a bedside mobility device attached. The device was not covered and had an opening within the device measuring approximately 6.25" x 9," creating a potential entrapment hazard.

Plan of Correction**Directed** [REDACTED] **- 09/26/2025)**

- The call bell system will be tested to ensure proper functioning by 10/10/25. Staff will be notified to alert the Administrator if they notice that the pendants are not functioning properly.
- The Administrator will monitor the call bell system on a weekly basis to ensure that is functioning properly, any issues noted will be followed up immediately and corrected by professional staff.
- Resident 4 and 5's bedside mobility devices were covered immediately. Staff will receive education by 10/10/25 regarding the safe use of bedside mobility devices and identifying when any risks/hazards are present.
- On a weekly basis the Administrator or designee will inspect and review a sample of bedside mobility devices to ensure they are compliant and do not pose any safety hazards.

Directed Completion Date: 10/10/2025

85a - Sanitary Conditions

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/17/25 at 10:03 AM, feces was present on the garbage can lid in resident room 149.

Repeated Violation - 8/27/24

Plan of Correction**Directed** [REDACTED] **S - 09/26/2025)**

- The feces was immediately cleaned up by staff on the date of the inspection and the trash can and lid were disinfected
- All direct care staff will receive training by 10/10/25 in identifying sanitary issues and properly cleaning/disinfecting them
- The Administrator or designee will conduct weekly room checks in order to ensure that rooms are clean and sanitary.

Directed Completion Date: 10/10/2025

91 - Telephone Numbers

7. Requirements

2600.

91 - Telephone Numbers (continued)

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in bedrooms 245 or 255.

Plan of Correction

Directed [REDACTED] - 09/26/2025)

- The Administrator or designee will post the telephone numbers to the nearest hospital and fire department in rooms 245 and 255 by 10/10/25.
- All staff persons will be educated that emergency telephone numbers including the nearest hospital and fire department be posted on or by each telephone. Documentation of education shall be kept.

Directed Completion Date: 10/10/2025

103d - Storing Food Off Floor**8. Requirements**

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 9/17/25 at 9:55 AM, there were 7 oranges stored on the floor in the walk-in refrigerator.

Plan of Correction

Directed [REDACTED] - 09/26/2025)

- Dietary staff immediately discarded the 7 oranges that were stored on the floor of the walk-in refrigerator
- All dietary staff will received education in proper food storage by 10/10/25
- Beginning 10/10/25 the Administrator or designee will conduct weekly audits of refrigerators/freezers and other food storage areas to ensure that food is stored in a sanitary way in accordance with this regulation.

Directed Completion Date: 10/10/2025

103i - Outdated Food**9. Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 9/17/25 at 9:56 AM there was an open, undated container of sour cream with cling wrap over the top covered by a cracked lid in the walk-in refrigerator.

Plan of Correction

Directed [REDACTED] - 09/26/2025)

- Dietary staff immediately discarded container of sour cream in the walk-in refrigerator
- All dietary staff will received education in proper food storage by 10/10/25
- Beginning 10/10/25 the Administrator or designee will conduct weekly audits of refrigerators/freezers and other food storage areas to ensure that food is stored in a sanitary way in accordance with this regulation.

Directed Completion Date: 10/10/2025

124 - Notice to Fire Department**10. Requirements**

124 - Notice to Fire Department (continued)

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home last notified the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency by letter dated 5/2/21.

Plan of Correction**Directed [REDACTED] - 09/26/2025)**

- The Administrator will notify the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency in writing by 10/10/25, documentation of this will be kept.
 -The Administrator will implement a reminder system for annual regulatory requirements to ensure this notification is made in accordance with this regulation.

Directed Completion Date: 10/10/2025

127a - Portable Space Heaters**11. Requirements**

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 9/17/25 at 11:03 AM, a portable space heater was present in the bathroom of resident room 118, next to the toilet.

Plan of Correction**Directed [REDACTED] - 09/26/2025)**

-Staff removed and discarded the portable space heater on the date of the inspection
 -All staff persons will be educated on the acceptable methods of maintaining the required temperatures in the home including the prohibition of space heaters by 10/10/25, documentation of this training will be kept.
 -Beginning on 10/10/25 the Administrator or designated staff person will check the home at least weekly to ensure no portable space heaters are in the home.

Directed Completion Date: 10/10/2025

132g - Fire Drills Days/Times**12. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home's last three sleeping-hour fire drills were conducted at approximately the same time: on Thursday 7/17/25 at 5:35 AM; on Thursday 4/24/25 at 5:24 AM; and on 12/17/24 at 5:25 AM.

Plan of Correction**Directed [REDACTED] - 09/26/2025)**

-The Administrator will conduct the next sleeping hours fire drill In January 2026 at a time other than 5:30 AM to ensure that residents and staff are able to safely evacuate all residents in the approved amount of time
 -The Administrator will be responsible for documenting and alternating times for all fire drills including overnight drills. Reviews of these drills will take place on a quarterly basis to ensure drills are not being conducted at the

132g - Fire Drills Days/Times (continued)

same times.

Directed Completion Date: 10/10/2025

183b - Meds and Syringes Locked**13. 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 9/17/25 at 10:48 AM, a bottle of TheraBreath oral rinse, Touchless Care Zinc oxide protectant spray, tube of Petroleum, and Medline Remedy Z-guard paste protectant were unlocked, unattended, and accessible in resident 10's bedroom. Resident 10 is not assessed to self-administer own medications.

Repeated Violation - 6/17/25, 3/24/25

Plan of Correction

Directed - 09/26/2025

-The medications that were unlocked, unattended and accessible in resident 10's room were immediately secured by staff stored in a locked cabinet.

-By 10/10/25, all staff persons will be educated on the required locked storage of medications. Documentation of the training will be kept.

-Beginning 10/10/25 a designated staff person will check the home daily on each shift to ensure all medications and controlled substances are kept in an area or container that is locked.

Directed Completion Date: 10/10/2025

183e - Storing Medications**14. 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

Resident 7 is prescribed Albuterol HFA 90 MCG, inhale 2 puffs by mouth every 4 hours as needed for wheezing. The inhaler that was given to resident 7 to use on 9/18/25 at approximately 3:30 PM expired 5/31/23.

Plan of Correction

Directed - 09/26/2025

- Resident 7's Albuterol inhaler was immediately discarded on the date of the inspection. The physician was notified by staff and a new inhaler was ordered for the resident.

-By 10/10/25, all staff who administer medications will receive training to include checking medications expiration date before administering the medication.

-A designated staff person will check all medications weekly to ensure no medications are expired this process will begin no later than 10/10/25.

Directed Completion Date: 10/10/2025

185a - Implement Storage Procedures

15. 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

A comparison of blood sugar readings stored in resident 8's glucometer was made against those recorded on medication administration records (MARs). On 9/15 at 11:50 AM there is a reading of 67 and at 11:48 AM a reading of 65 which are not documented on the MAR. In addition, on 9/13/25 at 11:30 AM, a reading of 168 is documented on the MAR, however the meter has a reading of 169 for this date and time.

A comparison of blood sugar readings stored in resident 9's glucometer was made against those recorded on his MARs. On 9/14/25 at 9:21 AM a reading of 243 is stored in meter, however 273 is documented on the MAR.

Repeated Violation - 8/27/24

Plan of Correction

Directed - 09/26/2025)

-All staff will receive education on the importance of documenting residents blood sugars accurately on the MAR by 10/10/25.
-Beginning 10/10/25, the Administrator or designee will audit blood glucose monitors and MAR's to ensure that there are no discrepancies. Any issues identified during these audits will be investigated immediately and followed up on.

Directed Completion Date: 10/10/2025

190a - Completion Medication Course**16. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member E did not have an initial medication administration training certification present in the staff file. Staff Member E administered Lorazepam 0.5 MG tablet, take 1/2 tablet by mouth, to resident 11 on 9/16/25 at 8:00 AM and 9/7/25 at 8:00 PM and 8:00 AM.

Plan of Correction

Directed - 09/26/2025)

-The Administrator immediately removed staff member E from the schedule as a staff who administers resident medications
-Staff Member E will receive the initial medication administration training by 10/10/25.
- The administrator will review all staff person training records to ensure all staff persons administering medications are qualified to administer medications and the documentation is present.
-The administrator will review all medication administration training records as part of the quality management review to ensure all staff persons continue to meet the qualifications to administer medications.

Directed Completion Date: 10/10/2025

225a - Assessment 15 Days**17. Requirements**

225a - Assessment 15 Days (*continued*)

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 10 was admitted to the home on [REDACTED]/25; however, the resident's assessment was not completed until [REDACTED]/25.

Repeated Violation - 8/25/25, 1/7/25

Plan of Correction

Directed [REDACTED] - 09/26/2025)

- By 10/10/25, all staff persons completing assessments will be educated on the timelines that they need to be completed by.

-The Administrator or designee will review/audit all new resident assessments on a monthly basis to ensure that they are being completed in a timely manner in accordance with this regulation.

Directed Completion Date: 10/10/2025

225c - Additional Assessment

18. 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 has a bedside mobility device, however, the resident's support plan, dated [REDACTED]/25, does not include:

- *the specific need for the device*
- *the intended use and risks of the device*
- *the ability of the resident to safely use the device*
- *identification of the specific device to be used and whether a cover is necessary to meet FDA guidelines*

Resident 7's assessment dated [REDACTED]/25, does not include the need for a mechanical soft diet which was ordered on 8/1/25.

Repeated Violation - 8/25/25, 6/17/25, 3/24/25

Plan of Correction

Directed [REDACTED] 09/26/2025)

-The Administrator updated Resident 6's assessment to include the information that was missing regarding the use of bedside mobility device.

-The Administrator updated resident 7's assessment to include the mechanical soft diet which was ordered for the resident on 8/1/25.

-By 10/10/25 the Administrator or designee will audit all resident assessments to verify that they are accurate and up to date.

-All staff who are responsible to complete resident assessments will be educated on the need to ensure that they are updated after any significant care need is identified.

Directed Completion Date: 10/10/2025

227a - Support Plan 30 Days

19. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 10 was admitted on [REDACTED] 25; however, the resident's initial support plan was not completed until [REDACTED] /25.

Plan of Correction**Directed [REDACTED] - 09/26/2025)**

- By 10/10/25, all staff persons completing resident support plans will be educated on the timelines that they need to be completed by.

-The Administrator or designee will review/audit all new resident support plans on a monthly basis to ensure that they are being completed in a timely manner in accordance with this regulation.

Directed Completion Date: 10/10/2025

231c - Preadmission Screening**20. 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 11 was admitted to the Secured Dementia Care Unit (SDCU) on [REDACTED] /25. However, the resident's written cognitive preadmission screening was completed on 6/2/25.

Repeated Violation - 1/7/25

Plan of Correction**Directed [REDACTED] 09/26/2025)**

- By 10/10/25, all staff persons completing cognitive preadmissions screenings will be educated on the timelines that they need to be completed by.

-The Administrator or designee will review/audit all new resident cognitive preadmission screenings on a monthly basis to ensure that they are being completed in a timely manner in accordance with this regulation.

Directed Completion Date: 10/10/2025

251b - Record Entries Legible**21. Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction tape was used on resident 12's support plan signed [REDACTED] /25.

Plan of Correction**Directed [REDACTED] - 10/06/2025)**

- The Administrator or designee will provide a training to all staff responsible for making entries into the record by 10/20/25. The purpose of this training will be to educate staff on making permanent entries into the record that are legible, dated and signed by the person making the entry.

-The Administrator or designee will review a sample of records on a bi-weekly basis to ensure that entries into the

251b - Record Entries Legible (continued)

records are permanent, legible, and signed and dated by the staff person making the entry.

Directed Completion Date: 10/20/2025