

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2024
NAME OF PROVIDER OR SUPPLIER  Spring Creek Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1205 South 28th Street Harrisburg, PA 17111	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>33879</p> <p>Based on clinical record, facility document review, and staff interview, it was determined that the facility failed to notify a resident representative of an accident that resulted in an emergency transfer immediately for one of three residents reviewed for falls (Resident 3).</p> <p>Findings include:</p> <p>Review of facility policy, titled Change in Resident's Condition or Status, last revised February 2021, revealed the facility policy was, [The facility will] promptly [notify] the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .</p> <p>Review of Resident 3's clinical record on February 20, 2024, at approximately 10:00 AM, revealed diagnoses that included Alzheimer's dementia (irreversible, progressive degenerative disease of the brain that leads to decreased contact with reality and decreased ability to perform activities of daily living) and chronic kidney disease stage 3 (decreased ability of the kidneys to filter toxins from the blood).</p> <p>Review of Resident 3's Quarterly Minimum Data Set (MDS - standardized assessment tool utilized to identify a residents physical, emotional, and psychosocial needs) with an assessment reference date of January 25, 2024, revealed that section C - Cognitive Patterns, Brief Interview for Mental Status (15 question assessment tool utilized to quickly gauge a residents cognitive ability) revealed that Resident 3 scored 00 of 15, indicating severe cognitive deficit.</p> <p>Review of a facility incident report dated February 10, 2024, revealed that on February 10, 2024, Resident 3 suffered an unwitnessed fall at approximately 11:00 PM. Further review of the incident report revealed that during an assessment after the fall, Resident 3 had pain and could not bear weight (stand) on her right leg.</p> <p>According to the incident report, the physician was notified on February 10, 2024, at 11:15 PM, at which time the physician provided an order for Resident 3 to be transported to the hospital via emergency ambulance transport for evaluation and treatment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 3's interdisciplinary progress notes revealed that on February 10, 2024, at 11:33 PM, Employee 1 (Registered Nurse [RN]) documented a note which stated, This RN responded to call from staff with a fall. Upon arrival resident alert. Resident [3] on the floor in front of the bed [sic], not resident's room. Resident [3] wanders at baseline. Resident [3] laying in semi fetal position on her left side. With assistance resident able to extend both her lower extremities with varying degrees of discomfort noted. Returning to fetal position when left be. No open areas or bruising noted. Attempted to stand resident with severe pain noted. Resident then lifted manually to a W/C [wheelchair] with assist of three staff members. Once sitting in W/C noted that residents' right knee bend compared to left knee bend considerably shorter to waist area. On palpation no acute deficit noted as well as no significant pain induced. Pulses to bilateral feet faintly equally palpable. No overt edema noted, resident able to wiggle toes. PERRLA. Resident was last visualized by unit staff minutes before wandering the hallways on the unit, which is her baseline. Mood returned to baseline once placed in W/C. C/o of right leg discomfort with inability to obtain comfortable position. Resident sta[t]es she does feel better in W/C vs laying on the floor. Tylenol administered. Neuro checks started. MD provider phoned updated with current VS and suspicion of possible fracture, from unwitnessed fall. Order noted to send resident to ER for evaluation and treatment. Family to be phoned and updated after EMS transports resident by unit LPN.</p> <p>Review of facility's incident report revealed that the facility staff documented that Resident 3's Responsible Party was not notified until the following morning, February 11, 2024, at 7:31 AM.</p> <p>Review of Resident 3's interdisciplinary progress notes revealed that after the aforementioned progress note entered on February 10, 2024, at 11:33 PM, there was no documented note until February 11, 2024, at 8:07 AM, which was entered by Employee 2 (Licensed Practical Nurse). The note indicated that Resident 3 had suffered a fracture of the right femoral bone which required surgical intervention.</p> <p>During a staff interview on February 20, 2024, at approximately 1:00 PM, Director of Nursing (DON) revealed it was the facility's expectation that staff notify family and/or a Resident's Representative in a timely manner. During the interview, the DON revealed that approximately eight hours between Resident 3's fall and 7:30 AM the following morning, was not considered timely.</p> <p>28 Pa code 201.18 (b)(1) Management</p> <p>28 Pa code 211.12 (d)(1)(5) Nursing services</p>		