

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  10/15/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46253</p> <p>Based on clinical record review, review of facility investigation, observations and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide adequate supervision to prevent elopement, which resulted in harm, as evidenced by a fall and knee abrasion for one of four resident's reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of Resident 1's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things) and generalized muscle weakness.</p> <p>Review of select facility report detailing an elopement that occurred on October 6, 2024, stated, Resident 1 walked to the front door and asked the receptionist to let him out of the door. The receptionist thought he was a visitor, so she opened the door to let him exit and he left the facility at 3:45 AM. At 4:38 AM, a passerby heard him calling for help and noted him lying in the grass. He assisted him to his feet and brought him into the facility. Resident 1 stated he got confused and thought he was dreaming he was at work and left work to go home.</p> <p>Further review of the facility report revealed a RN (Registered Nurse) Assessment was completed and noted an abrasion to the left knee that required first aide.</p> <p>The physician was made aware and ordered lab work and a urinalysis due to new onset confusion. Psychiatric consult was made and Resident 1 was placed on 15-minute checks and was in agreement to move rooms. Resident 1 was moved to a different building and unit due to elevator monitor being in place on the ground floor.</p> <p>Review of Resident 1's physician orders revealed the following treatment orders:</p> <p>Wound Care: Left Knee, one time a day for Wound Care: Left Knee for 3 Days Cleanse Normal Saline (NS) every dressing change. Pat area dry using sterile gauze. Apply Skin Prep to surrounding intact skin to protect from moisture. Monitor for signs of infection (increased redness, warmth, drainage, swelling), with a start date of October 6, 2024, and discontinued on October 7, 2024.</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
---	-------	-----------

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  10/15/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Wound Care: Left Knee, every evening shift for Wound Care: Left Knee for 3 Days Cleanse Normal Saline (NS) every dressing change. Pat area dry using sterile gauze. Apply Skin Prep to surrounding intact skin to protect from moisture. Monitor for signs of infection, with a start date of October 8, 2024, and completed on October 11, 2024.</p> <p>During an abbreviated survey on October 15, 2024, , the NHA and DON provided information and documentation of a plan of correction put into place after Resident 1's elopement. Review of the facility's plan of correction revealed that an investigation was initiated, interviews were conducted with staff on the unit and the receptionist, and the receptionist was immediately re-educated and disciplinary action was taken. Resident 1 was moved to the building where monitor was in place to prevent elopements. Resident's POA and physician were notified, and new orders were received. Physician review to be conducted for recent medication changes, the residents care plan was updated for elopement risk, and his information was added to the risk of elopement book. An audit was conducted to determine like residents with elopement risk. Residents with exit seeking behaviors were reviewed to confirm that facility procedures are followed.</p> <p>Review of statement provided by Employee 8 (Receptionist) on October 6, 2024, revealed the following, Front desk, I was sitting here, and resident walked up to the counter around 3:45 AM. He startled me by tapping on the glass window saying let me out. So, I did not pay attention that he was a resident. Around 4:38 AM, a good Samaritan was getting off work and heard [Resident 1] screaming for help. He came in to let me know that he fell and helped him off of the ground and back into the facility. Front desk then called up to nursing supervisor around 4:41 AM, they came down to help [Resident 1] get back to his room.</p> <p>Review of document titled Spring Creek Employee Discipline Report dated October 6, 2024, revealed Employee 8 had received written disciplinary action at a level II offense of a violation related to resident safety. The document was signed by Employee 8.</p> <p>Review of document titled Spring Creek Unit Training Form dated October 6, 2024, revealed Resident access in and out of facility, ex LOA policies, visitor's procedures. Supervisor to be notified of as soon as possible as any situation occurs. Maintain all individuals associated with occurrence until interviewed by on duty RN supervisor. The document was signed by Employee 8.</p> <p>Review of document titled Receptionist Competency Checklist dated April 6, 2024, revealed Competency Trained: Door Alarm and Front Door and Independent Resident's with Badges and LOAs, who can come and go, process for signing out and signing in. The competencies were signed off by Employee 8.</p> <p>Review of facility education titled Spring Creek Unit Training Form dated October 7 and 8, 2024, revealed education detailing that process of LOAs including the form that should be used, these education sheets were signed by all nursing staff members.</p> <p>Review of Resident 1's clinical record revealed he was signed off as receiving 15 minute checks on all shifts since the elopement incident.</p> <p>(continued on next page)</p>		

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  10/15/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of email correspondence provided revealed an email from the Assistant Director of Nursing to Unit Managers that read, in part, Unit Managers, please review all of your residents for change in condition and possible elopement risks. Any resident that has had a recent change in condition needs to be reviewed for a possible elopement risk. Please complete an elopement risk form. Notify myself of the audit results so corrective action can be taken to ensure resident safety.</p> <p>Review of select facility audit documentation titled Exit Seeking revealed risk forms had been completed for all units.</p> <p>Interview with Employee 3 (Receptionist) on October 15, 2024, at 1:19 PM, revealed the ability for resident LOA is determined by therapy and the doctor. If a resident is determined to go LOA, there needs to be a form completed by the unit and a copy is given to the receptionist. She has paper documentation of which residents are allowed to go out, and they are signed out in a book. Independent LOA residents carry a badge and sign themselves in and out at the reception desk. Visitors are required to sign in and out on a kiosk, and the front door remains locked at all times.</p> <p>Interview with Nursing Home Administrator (NHA) and the Director of Nursing (DON), on October 15, 2024, at 2:18 PM, revealed the precautions they put in place to prevent an incident from occurring again was re-education and disciplinary action for Employee 8. The NHA further revealed Employee 8 was a per-diem employee and the facility currently has a full-time receptionist hired for all three shifts.</p> <p>During a follow-up interview with the NHA and DON on October 15, 2024, at approximately 2:30 PM, the surveyor revealed the concern with the lack of proper supervision to prevent accidents that occurred on October 6, 2024. No further information was provided.</p> <p>During the abbreviated survey, the facility's audits and education were reviewed. Resident 1's clinical record was reviewed and revealed updated precautions. Observations were made of residents and the visitor sign-in/out process. Staff were interviewed about the LOA and visitor sign-in and out process and there were no concerns identified.</p> <p>28 Pa. Code 201.4(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3) Nursing Services.</p>		

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  10/15/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, facility provided documentation review, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to properly secure controlled medications which resulted in missing controlled medications prescribed to Resident 6.</p> <p>Findings include:</p> <p>Review of facility policy titled Controlled Substances, with a revised date of September 2022, revealed [in part] Only authorized licensed nursing and/or pharmacy personnel have access to . controlled substances maintained on premises and controlled substances are separately locked in permanently affixed compartments.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), and narcolepsy (a chronic neurological disorder that impairs the ability to regulate sleep-wake cycles).</p> <p>Review of Resident 5's progress notes revealed a note dated October 8, 2024, at 2:20 PM that indicated Called to unit for resident having Ativan [a controlled medication used to treat anxiety] found in room. Resident was AOX3 (alert and oriented to person, time, and place), PERRLA (pupils equal, round, reactive to light, and accommodate or the ability to see things near and far) and in NAD [no acute distress]. No c/o [complaints of] pain or discomfort. Resident in no respiratory distress. Resident noted to be drowsy, and does have a narcolepsy diagnosis. Resident denies taking the Ativan, and said someone else did it. He did not know how the pills (18) in the clear plastic container sitting on his nightstand got in his room. Room searched w/ resident present and another Ativan pill found in the glove box on his bedside table. No other pills found. Empty pill pack found in residents bathroom garbage can torn into 4 pieces. No pills found in garbage can. Total found 19. Provider notified and ordered neuro checks [which assess an individual's neurological functions, motor and sensory response, and level of consciousness and allows medical specialists to determine whether a patient ' s neurological functions are working and reacting correctly] q [every] 2 hours for 24 hours and to notify immediately if any change in mental status. Administrator notified.</p> <p>Review of Resident 5's progress notes revealed a note dated October 8, 2024, at 4:46 PM, that indicated Resident refused to go to the hospital. Resident was talked to by two EMT's [Emergency Medical Technician] and charge nurse, and still declined to go to the ED [emergency department].</p> <p>Review of Resident 5's progress notes revealed a note dated October 8, 2024, at 8:15 PM, that indicated No decreased respirations as resident engaging in conversations with Writer with his eyes closed. Continues with frequent neurological assessments. Self-propels in wheelchair on unit. Room search and shower search was conducted by writer, and no evidence of nonprescribed medications. Plan of care ongoing.</p> <p>(continued on next page)</p>		

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  10/15/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 5's physician services progress notes revealed a note by psychiatric services on October 10, 2024, at 7:52 PM, with recommendations for medication changes.</p> <p>Review of Resident 5's physician services progress notes also revealed a note by their primary physician services dated October 10, 2024, at 8:45 PM, that indicated [in part] Resident 5 was seen due to increased behaviors. Per nursing, pt took another resident's Ativan off nursing cart. He was found to have medication at bedside and 11 pills were missing. Per nursing, pt was monitored closely and his own narcotics were held. No adverse reactions noted. Pt seen sitting in room. He adamantly denies taking medication off nursing cart. He is alert and orient x 3. He denies CP [chest pain], SOB [shortness of breath]. The note further indicated that approval was given for the psychiatry recommended medication changes.</p> <p>Review of Resident 5's clinical record progress notes from October 8, 2024, through October 15, 2024, failed to reveal that Resident 5 had experienced any negative outcome from the possible ingestion of the 11 missing Ativan tablets.</p> <p>Review of a facility provided document titled Neurological Record revealed that Resident 5's neuro checks were completed every two hours beginning on October 8, 2024, at 2:00 PM and ending on October 10, 2024, at 6:00 AM, with no changes noted in their neurological status.</p> <p>Review of facility provided documentation revealed a statement from Employee 5 (Licensed Practical Nurse) dated October 8, 2024, that indicated around 8:00 AM that date a pharmacy driver delivered Resident 6's Ativan 1 mg (milligram) tablets in the quantity of 30. Employee 5 indicated another nurse had originally signed for this medication but Resident 6 had now moved to another nursing unit. Employee 5 further checked the card and ensured it matched the narcotic count sheet with it for 30 tablets. Employee 5 then signed for the medication and placed the card in the lock box of their medication cart until Employee 4 was available for direct hand off. Employee 5 indicated that she gave the medication card to Employee 4 at 12:00 PM.</p> <p>Review of facility provided documentation revealed a statement from Employee 4 (Licensed Practical Nurse) dated October 8, 2024, that indicated a coworker gave her Resident 6's medication card at 12:00 PM. Employee 4 indicated that she became distracted when a resident asked for water and ice. Employee 4 indicated that she placed the medication card containing the lorazepam in the narcotic logbook and when she came back the card was gone. Employee 4 indicated that they started a search and located the medication in a resident's room.</p> <p>Review of facility provided documentation revealed a statement from Employee 10 (Nurse Aide) dated October 8, 2024, that indicated they observed Resident 5 in their wheelchair going down the hall. Employee 10 indicated that when they arrived at the nurse's desk, they overheard the nurse's discussing a blister pack of Ativan was missing. Employee 10 indicated that they went to Resident 5's room and found a small clear container of pills, they removed them from the room, and gave them to the unit manager. Employee 10 said that they went back to the room to see if they could find the blister pack and that when they went into the bathroom, they saw that there were a bunch of unused paper towels in the trash can and when they looked underneath them the blister pack was there and that she gave this to the unit manager. Employee 10's statement further indicated that she assisted the Assistant Director of Nursing and another RN search the room again and that was when another tablet was found in a box of gloves sitting on the bedside stand.</p> <p>(continued on next page)</p>		

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  10/15/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility provided documentation revealed that the Nursing Home Administrator (NHA) had called a meeting of the facility Quality Assurance Performance Improvement Committee on October 8, 2024, to review and resolve this incident. This documentation indicated the following plan of correction:</p> <ol style="list-style-type: none"> <li>1) the police were notified, and that Resident 5 was interviewed, but continued to deny involvement;</li> <li>2) Resident 5's legal guardian was also notified and spoke with Resident 5 but was unable to obtain any additional information;</li> <li>3) additional searches were performed of all common areas on the unit and no additional pills were located;</li> <li>4) due to being unable to locate the additional eleven missing pills, other residents that are independently mobile on the unit had their vital signs completed and were monitored for changes in condition;</li> <li>5) Employee 4 was immediately educated, and disciplinary action rendered;</li> <li>6) counts were completed for controlled medications for every medication cart in the facility and all controlled substances were accounted for with no discrepancies noted;</li> <li>7) education on the facility Controlled Substances policy was immediately initiated with the licensed nurses and would continue every shift until all licensed nurses were educated;</li> <li>8) an audit of all medication carts with controlled substances in the facility will be completed daily for one week to ensure no discrepancies arise; and</li> <li>9) the medical Director was made aware of the Ativan issue and the plan to address the concern.</li> </ol> <p>This facility provided documentation indicated that the above plan and findings were reviewed at another Quality Assurance Performance Improvement Committee on October 9, 2024.</p> <p>During a staff interview with the Director of Nursing (DON) on October 15, 2024, at approximately 12:45 PM, she indicated that the police had come to the facility to investigate and provided their business card but said that they could not take any action as there was no evidence that Resident 5 stole the medication. She indicated that Resident 5 nor any of the other residents being monitored had experienced any noted changes in condition. She also confirmed that they could not prove that Resident 5 stole the medication, nor that Resident 5 had ingested the eleven missing tablets. The DON also shared that Employee 10 (Nurse Aide) was a regular staff member on that unit and very familiar with the residents and when they heard the package was missing and noticed Resident 5 was acting out of character they went in Resident 5's room and found the pills immediately bringing them to the nurse.</p> <p>Review of facility audits on October 15, 2024, revealed that the audits were completed daily on each medication cart from October 8-14, 2024, with no discrepancies noted.</p> <p>(continued on next page)</p>		

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  10/15/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of education sign-in sheets on October 15, 2024, revealed that a total of 65 nurses had received education.</p> <p>During a staff interview with Employee 6 (Licensed Practical Nurse) on October 15, 2024, at 1:20 PM, Employee 6 indicated that when medications are delivered to the unit, the carrier will present the medications to a nurse who would complete a count of the medications and verifies this with the delivery receipt and then signs for the delivery. The nurse is then responsible to put the controlled medications into the lock box and place the reconciliation sheet into the controlled medication logbook. Employee 6 indicated that all non-controlled medication gets placed into the other drawers of the medication cart.</p> <p>During a staff interview with Employee 5 (Licensed Practical Nurse) on October 15, 2024, at 1:26 PM, Employee 5 indicated that when medications are delivered to the unit, the medication nurse checks the actual medications being received against the packing slip to make sure they match and if accurate they sign for the medication receipt. Employee 5 then indicated that uncontrolled medications go into the regular drawers of the cart and that controlled medications go into the narcotic lock box.</p> <p>During a staff interview with Employee 7 (Licensed Practical Nurse) on October 15, 2024, at 1:29 PM, Employee 7 indicated that when medications are delivered to the unit, the nurse checks the paperwork to reconcile the medication counts are correct. Employee 7 indicated that once the counts are completed and noted to be correct medications are then placed in the drawers of the medication cart with controlled medications going into the lock box. Employee 7 indicated that this would be the same process that would be followed if a resident were to transfer from one unit to another.</p> <p>During a final staff interview with the NHA and DON, on October 15, 2024, at approximately 1:45 PM, the DON confirmed that all licensed staff had received the education on the facility Controlled Substances policy. The NHA and DON both confirmed Employee 4 failed to store the medication properly which resulted in the theft of the medication card. They further confirmed they were unable to locate the additional 11 Ativan tablets, they were unable to prove that Resident 5 had stolen the medication card, and they were unable to prove that Resident 5 had ingested the 11 missing Ativan tablets.</p> <p>During the abbreviated survey, the facility's audits and education were reviewed. Observations were made of medication storage and medication carts and nursing staff were interviewed regarding the controlled substances policy. There were no concerns identified.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(2) Nursing services.</p>		