STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395074	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Rehabilitation and Nursing Center	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48484 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of 10 residents reviewed (Resident 2). Findings include: Review of facility policy, titled Administering Medications last revised December 2012, read, in part, Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. Review of Resident 2's clinical record revealed diagnoses that included pancreatitis (inflammation of the pancreas that can cause swelling, pain, and changes in how an organ or tissues work), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and hypertension (high blood pressure). Review of Resident 2's physician orders revealed an order for Creon Oral Capsule (a medication that contains digestive enzymes to aid in the breakdown of food), give four capsules by mouth three times a day with meals. The administration times for the medication were noted as 7:30 AM, 11:30 AM, and 5:30 PM daily, consistent with the mealtimes on the nursing unit. Review of Resident 2's care plan revealed a focus area Nutritional Care Plan: at risk for malnutrition related to chronic disease and increased metabolic needs, with a start date of March 13, 2025, with an intervention for administer medications and obtain labs as ordered, with a start date of March 13, 2025. Observation on the South 1 Nursing Unit on March 20, 2025, at 9:30 AM, revealed Resident 2's call light was on above his room. (continued on next page)

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 03/21/2025
NAME OF PROVIDER OR SUPPLIER: Spring Creek Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1205 South 28th Street, Harrisburg, PA 17111	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 2 on March 20, 2025, between 9:33 AM and 9:44 AM, he revealed that he had stomach issues, and he required a medication called Creon with meals. He further revealed he had his call light on because he still hasn't received the medication, despite that it should have been served with his breakfast meal around 7:30 AM. He stated that he was requesting to have his medication, as well as a lactose free milk to have the medication with some cereal. During an interview with Employee 1 (Registered Nurse Unit Manager) on March 20, 2025, at 9:46 AM, the surveyor revealed the concern with Resident 2 not receiving his Creon with his breakfast meal, and that his call bell had been on for an extended period. Employee 1 revealed the Creon should have been given with his breakfast meal. Observation of the call light system at the nurse's station on March 20, 2025, at 9:46 AM, revealed Resident 2's call light had been on for 24 minutes. The surveyor and Employee 1 went to find Employee 2 (Licensed Practical Nurse) who was found on a different part of the unit passing medications. Employee 1 then went to answer Resident 2's call bell. During an interview with Employee 2 on March 20, 2025, at 9:47 AM, she revealed she had a late start passing medications that morning, because there was a resident on the unit that was having behaviors, and she needed to spend time calming him down. Follow-up interview with Employee 2 on March 20, 2025, at 10:07 AM, revealed she had just administered Resident 2's Creon and made sure he had some milk and cereal while he consumed the medication. She further revealed she was late passing medications as she was overseeing 22 residents, many of which need blood sugar checks in addition to morning medications, and reiterated that she spent extra time calming the resident with behaviors. She stated that she also helped a dependent resident get dressed to go out for a funeral, and that the nurse aide staff was too busy that morning passing meal trays and doing their rounds to help with other tasks. Follow-up interview with Employee 1 on March 20, 2025, at 10:13 AM, revealed she would have helped assist Employee 2 with her duties since she was behind, or call to another unit for assistance, but she got caught up on a phone call with a resident's family member for an extended period of time. She further revealed that there was typically another Registered Nurse Unit Manager assigned to the unit during day shift, but that she was on vacation. Review of Resident 2's clinical record revealed his meal completion for breakfast on March 19, 2025, was documented as 75-100% of the meal eaten at 9:00 AM. Review of Resident 2's Administration History Report noted that on March 19, 2025, he did not receive his Creon medication that should have been served with breakfast until 10:37 AM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on March 20, 2025, at 3:25 PM, she revealed that medications should be given timely and per physician order, call bells should be answered timely, and she would expect that staff not report that they are too busy to pass medications on time or answer call bells timely, due to other basic care needs on the unit. She revealed that staff is aware that they could call for assistance from nursing staff on other units, and that Employee 1 should have called Employee 6 (Registered Nurse Unit Manager) for help. She further revealed the incident of the late medication and the long call bell wait time would not have occurred if they were staffed with the other unit manager that was on vacation; however, they had not designated a staff member to replace her that week. Follow-up email correspondence with the DON on March 20, 2025, at 4:21 PM, revealed she was unable to provide information as to why Resident 2 received his Creon late on March 19, 2025. 28 Pa. Code 201.18(b)(1) Management 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services