

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 05/23/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>33879</p> <p>Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 35 residents observed (Resident 76).</p> <p>Findings include:</p> <p>Review of facility policy titled Dignity last revised February 2021, revealed, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p> <p>Review of Resident 76's clinical record revealed diagnoses including chronic kidney disease stage 3 (moderately decreased ability of the kidneys to filter toxins from the blood) and osteoarthritis (loss of soft tissue of the joints resulting in stiffness and pain).</p> <p>During observations on May 20, 2024, at approximately 10:49 AM, the door to Resident 76's door was observed to be open. It was observed that Resident 76 was unclothed and the backside of the resident's body was exposed and visible from the hallway.</p> <p>During a resident interview with Resident 76 on May 20, 2024 at approximately 2:04 PM, Resident 76 revealed that she received a bed bath that morning and the staff had spilled the water on the floor; subsequently requiring staff to clean up the water during the bed bath. During the interview Resident 76 reported that she did not realize that her door was left open while unclothed and rolled to her left side. Resident 76 reported that it bothered her that the door was left open exposing her to the hallway; however, did not know it at the time due to not facing the doorway.</p> <p>During an interview on May 23, 2024, at approximately 11:00 AM, Nursing Home Administrator and Director of Nursing revealed they would expect staff to provide care to Resident 76 that did not leave the resident exposed from the hallway.</p> <p>28 Pa. Code 201.29(j) Resident rights</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>33879</p> <p>Based on resident interview, observation, clinical record review, facility document review, and staff interviews it was determined that the facility failed to provide a homelike environment, including a secured lock drawer for personal items, for one of 35 residents reviewed (Resident 88).</p> <p>Findings include:</p> <p>Review of Resident 88's clinical record revealed diagnoses including hypotension (low blood pressure), and schizophreniform disorder (short term mental health disorder that causes symptoms of psychosis such as hallucinations, delusions, and nonsensical/disorganized speech).</p> <p>During a resident interview conducted on May 20, 2024, at approximately 2:10 PM, Resident 88 revealed that the lock on Resident 88's bedside stand drawer did not work and did not lock and secure her personal possessions. Resident 88 stated that the facility was notified approximately one month prior to the interview. During the interview Resident 88 expressed concern about having a drawer that did not lock due to keeping her wallet containing her credit card in the drawer.</p> <p>During the resident interview the lock of Resident 88's drawer was demonstrated to be non-functional.</p> <p>Review of facility maintenance work order submitted by the facility revealed that a work order was submitted on April 29, 2024 for Resident 88's bedside stand, with the concern identified as, side table the lock doesn't work . Review of the work order revealed it included an area to denote who the work order was assigned to, which was documented as, nobody.</p> <p>During a staff interview on May 23, 2024, at approximately 11:00 AM, Nursing Home Administrator revealed that when a work order is completed it should be documented in the work order as completed or closed; however, the work order for Resident 88's bedside table lock, at the time of review, was still open indicating that it was not completed. During the interview, Nursing Home Administrator stated that Resident 88 was provided a new bedside table with an operational lock.</p> <p>28 Pa code 204.5(f) Resident rooms</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to notify the representative of the Office of the State Long-Term Care Ombudsman of resident transfers in writing to include the reason for the transfer or discharge, date of transfer, and location of transfer, for four of ten resident records reviewed for hospitalization s (Residents 7, 13, 35, and 101).</p> <p>Findings include:</p> <p>Review of Resident 7's clinical record revealed a diagnosis including Parkinson's disease (brain disorder that results in uncontrollable muscle movements, stiffness, and difficulty with balance and body coordination) and emphysema (disease of the lungs that results in poor respiratory gas exchange).</p> <p>Review of Resident 7's clinical record revealed that Resident 7 was transferred to the hospital on February 2, 2024 and returned to the facility on [DATE].</p> <p>Review of available information revealed the facility did not provide a notice of transfer to the Office of the State Long-Term Care Ombudsman for Resident 7's February 2, 2024 hospital transfer.</p> <p>During a staff interview on May 23, 2024, at approximately 11:00 AM, Nursing Home Administrator (NHA) confirmed that the facility did not send notice of transfer to the Office of the State Long-Term Care Ombudsman for Resident 7's February 2, 2024 hospital transfer.</p> <p>Review of Resident 13's clinical record documented diagnoses that included hydronephrosis (excess fluid in the kidney causing urine to back up) with ureteral stricture (narrowing of the muscular tube that carries urine from the kidney to the bladder), history of urinary tract infection, and congestive heart failure (the heart doesn't pump blood as it should).</p> <p>Review of Resident 13 clinical record documented transfer to the hospital on March 15, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the NHA on May 22, 2024, at 9:55 AM, the NHA indicated that the facility was unable to provide documentation that the Pennsylvania State Ombudsman was notified of Resident 13's transfer to the hospital in March 2024, due to staffing change and the facility couldn't access a particular staff members electronic mail.</p> <p>Review of Resident 35's clinical record revealed diagnoses including atrial fibrillation (irregular heart beat) and hypertension (elevated/high blood pressure).</p> <p>Review of Resident 35's clinical record revealed that Resident 35 was transferred to the hospital on March 15, 2024 and returned to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of available information revealed the facility did not provide a notice of transfer to the Office of the State Long-Term Care Ombudsman for Resident 35's March 15, 2024 hospital transfer.</p> <p>During a staff interview on May 23, 2024, at approximately 11:00 AM, the NHA confirmed that the facility did not send notice of transfer to the Office of the State Long-Term Care Ombudsman for Resident 35's March 15, 2024 hospital transfer.</p> <p>Review of Resident 101's clinical record revealed diagnoses that included chronic respiratory failure (long term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), throat cancer, and aphasia (language disorder that affects a person's ability to communicate).</p> <p>Review of Resident 101's clinical record revealed that they were transferred to the hospital on March 15, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the Nursing Home Administrator (NHA) on May 22, 2024, at 9:45 AM, the NHA indicated that the facility was unable to provide documentation that the Pennsylvania State Ombudsman was notified of Resident 101's transfer to the hospital in March 2024, due to staffing change and the facility couldn't access a particular staff members electronic mail.</p> <p>Electronic communication with the Pennsylvania State Ombudsman on May 22, 2024, at 10:44 AM, revealed that the facility had not provided notice of transfers for March 2024, prior to May 21, 2024, at 5:11 PM.</p> <p>During a final interview with the Nursing Home Administrator on May 22, 2024, at 2:00 PM the surveyor revealed that the Pennsylvania State Ombudsman confirmed the facility had not provided notice of transfers for March 2024, prior to May 21, 2024, at 5:11 PM. The NHA confirmed that he had no other information to offer and that he would expect the reporting to have occurred in a timely manner.</p> <p>28 Pa code 201.18(b)(3) Management</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 39 residents reviewed (Resident 57, 139, and 168).</p> <p>Findings include:</p> <p>Review of Resident 57's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep) and pressure-induced deep tissue damage to the right heel.</p> <p>Review of Resident 57's clinical record revealed that they were admitted to the facility on [DATE], and that they had pressure-induced deep tissue damage to the right heel upon admission.</p> <p>Review of Resident 57's physician orders revealed an order for CPAP (Continuous Positive Airway Pressure - a machine that uses mild air pressure to keep breathing airways open while one sleeps) settings: Auto CPAP 4-20cm H2O at bedtime dated April 10, 2024.</p> <p>Review of Resident 57's April 2024, and May 2024, Medication Administration Record documented the use of the CPAP.</p> <p>Review of Resident 57's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with an ARD (assessment reference date- last day of the assessment period) of February 1, 2024, revealed in Section N. Skin Conditions that their pressure area on their right heel was not coded as being present upon admission.</p> <p>Review of Resident 57's Quarterly MDS with an ARD of May 3, 2024, revealed in Section O. Special Treatments, Procedures and Programs that they were not coded as receiving the CPAP.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on May 23, 2024, at 11:19 AM, the Director of Nursing indicated that both of Resident 57's aforementioned MDS's had been modified and confirmed that she would expect MDS to be completed accurately.</p> <p>Review of Resident 139's clinical record documented diagnoses that included sleep apnea (sleep disorder in which breathing repeatedly stops and starts) and chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe).</p> <p>Review of Resident 139's physician orders included CPAP (continuous positive airway pressure-a machine that uses mild air pressure to keep breathing airways open while you sleep)/BIPAP (bilevel positive airway pressure- a non-invasive ventilation devise that helps people breath by suppling pressurize air into their lungs through a mask) settings: 16 cm water 14 breath/min every night shift with start date January 9, 2024, at 11:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 139's February 2024, and April 2024 Medication Administration Record documented use of CPAP/BiPAP.</p> <p>Review of Resident 139's March 1, 2024, and April 16, 2024, quarterly MDS failed to document use of non-invasive mechanical ventilator.</p> <p>Further review of Resident 139's clinical record on May 23, 2024, at 11:50 AM modifications to the March 1st and April 16th, 2024, MDSs were completed on May 22, 2024, to include documentation for use of a non-invasive mechanical ventilator.</p> <p>Electronic communication with the Director of Nursing on May 23, 2024, at 2:32 PM revealed the MDS should've been coded accurately to include use of non-invasive mechanical ventilator.</p> <p>Review of Resident 168's clinical record revealed diagnoses that included: end stage renal disease (a condition where the kidneys reach advanced state of loss of function), hyperkalemia (high potassium levels in the blood), and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time)</p> <p>During an interview with Resident 168 on May 20, 2024, at 11:33 AM, he revealed he has been on dialysis (a blood purifying treatment given when kidney function is not optimum) for three years.</p> <p>Review of Resident 168's physician orders revealed he has an order for hemodialysis (a machine that filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately), with a start date of December 26, 2023.</p> <p>Review of Resident 168's Quarterly MDS with ARD of April 29, 2024, under Section O- Special Treatments, Procedures, and Programs, subsection O0110 J1. Dialysis, Resident 168 was marked No indicating he does not receive dialysis services.</p> <p>During an interview with the DON on May 23, 2024, at 11:50 AM, she revealed his aforementioned MDS was marked in error that he was not receiving dialysis, and she would expect Resident 168's MDS assessment to be completed accurately.</p> <p>28 Pa. Code 211.5(f) Medical records.</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</p> <p>Based on facility policy review, observations, clinical record reviews, and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan to address the resident's medical, physical, mental, and psychosocial needs for two of 39 records reviewed (Residents 57 and 185).</p> <p>Findings include:</p> <p>Review of facility policy titled Care Plans, Comprehensive Person-Centered, with a last review date of March 20, 2024, revealed [in part] 2. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS{Minimum Data Set-an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs}assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and e. reflects currently recognized standards of practice for problem areas and conditions; and 12. The interdisciplinary team reviews and updates the care plan c. when the resident has been readmitted to the facility from a hospital stay.</p> <p>Observation of Resident 57's room on May 20, 2024, at 11:41 AM, revealed the presence of a [NAME] remote pacemaker check device on their nightstand.</p> <p>Review of Resident 57's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) and the presence of a pacemaker.</p> <p>Further review of Resident 57's clinical record revealed that they were admitted to the facility on [DATE], and had hospital stays with subsequent readmissions to the facility on [DATE], and April 9, 2024.</p> <p>Review of Resident 57's current physician orders revealed orders for Eliquis (a blood thinner medication) 2.5 milligrams by mouth two times a day dated April 9, 2024; a remote pacemaker check on July 10, 2024, dated May 9, 2024; and an in-office pacemaker check on January 16, 2025, dated May 1, 2024.</p> <p>Review of Resident 57's current care plan failed to reveal the presence of their pacemaker or their use of an anticoagulant medication as well as all appropriate safety precautions for both.</p> <p>Review of Resident 57's care plan history failed to reveal the presence of their pacemaker or their use of an anticoagulant medication as well as all appropriate safety precautions for both since their original admission to the facility on [DATE].</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 22, 2024, at 1:27 PM, the DON indicated that anticoagulant use and precautions should be included in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Email communication received from the DON on May 22, 2024, at 6:00 PM, revealed Resident 57's care plan was revised to include the pacemaker and anticoagulant use as well as appropriate safety precautions.</p> <p>During an interview on May 20, 2024, at 11:08 AM with Resident 185, she revealed she was receiving an intravenous (IV) antibiotic for an infection. An observation was made of a midline IV catheter (a long flexible tube inserted into a large vein in the upper arm) in Resident 185's upper right arm.</p> <p>Review of Resident 185's clinical record revealed diagnoses that included bacteremia (bacteria in the blood) and sepsis (when the body's response to an infection causes injury to its own tissues and organs).</p> <p>Review of Resident 185's physician orders revealed an order dated April 29, 2024, for ceftriaxone sodium (antibiotic) two grams intravenously one time a day.</p> <p>Review of Resident 185's comprehensive plan of care revealed Resident 185 did not have a care plan focus area developed that addressed the IV catheter.</p> <p>Email communication received on May 23, 2024, from the DON, revealed Resident 185's care plan had been updated to include a focus area for the IV catheter. The DON stated the facility expected that care plans be completed accurately.</p> <p>28 Pa. Code 211.12(d)(2)(3)(5) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>37817</p> <p>Based on review of facility policies, observations, record reviews, and staff interviews it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for four of 39 residents reviewed (Residents 13, 57, 139, and 605).</p> <p>Findings include:</p> <p>Review of facility policy CPAP (continuous positive airway pressure machine that uses mild air pressure to keep breathing airways open while you sleep)/BiPAP (bilevel positive airway pressure- a non-invasive ventilation device that helps people breathe by supplying pressurized air into their lungs through a mask) Support, revised March 2015, read, in part, mask and tubing are to be cleaned daily by placing in warm soapy water for five minutes, rinse with warm water and allowed to air dry between uses.</p> <p>Review of facility policy Administering Medications Through a Small Volume Nebulizer, revised October 2010, read, in part, store equipment in a plastic bag with the resident's name and date.</p> <p>Review of Resident 13's clinical record documented diagnoses that included congestive heart failure (the heart doesn't pump blood as it should).</p> <p>Resident 13's physician orders included Ipratropium-Albuterol Inhalation Solution (medications used to prevent bronchospasm in patients with asthma) 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally two times a day for Wheezing, start date March 21, 2024, scheduled to be administered at 9:00 AM and 9:00 PM.</p> <p>During an interview with Resident 13 on May 20, 2024, at 11:10 AM it was stated she wears the nebulizer mask in the morning and at night. It was also revealed that she requires staff must assist her to utilize the mask.</p> <p>Observations on May 20, 2024, at 11:10 AM, and May 21, 2024, at 1:29 PM the nebulizer mask was on top of the nightstand and not covered.</p> <p>Review of Resident 13's medication administration record (documentation of medication administered) documented the Albuterol was administered as ordered May 19th at 9:00 PM, May 20th at 9:00 PM and May 21st at 9:00 AM and 9:00 PM.</p> <p>During an interview with the Director of Nursing (DON) on May 23, 2024, at 1:30 PM it was revealed that Resident 13's nebulizer mask should be stored in a plastic bag.</p> <p>Review of Resident 57's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep) and cerebral infarction (stroke damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 57's physician orders revealed an order for CPAP settings: Auto CPAP 4-20cm H2O at bedtime dated April 10, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 57 on May 20, 2024, at 10:59 AM, revealed their CPAP mask was hanging off their nightstand and was not bagged.</p> <p>Observation of Resident 57 on May 21, 2024, at 10:21 AM, revealed their CPAP mask was lying on their nightstand and was not bagged.</p> <p>During a follow-up interview with NHA and DON on May 22, 2024, at 2:06 PM, the DON confirmed that Resident 57's CPAP mask should be bagged when not in use.</p> <p>Review of Resident 139's clinical record documented diagnoses that included sleep apnea (sleep disorder in which breathing repeatedly stops and starts), and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe).</p> <p>Review of Resident 139's physician orders included CPAP/BIPAP settings: 16 cm water 14 breath/min every night shift with start date January 9, 2024, at 11:00 PM.</p> <p>Observation in Resident 139's room on May 20, 2024, at 9:48 AM the BiPAP mask was on top of a plastic bag on nightstand which was positioned behind the resident. Per Resident 139 the mask should be in the bag. It was also revealed that she needs help taking the BiPAP mask on and off and storing it.</p> <p>Employee 5, Licensed Practical Nurse, entered and exited Resident 139's room on May 20, 2024, at 9:54 AM. Additional observations in Resident 139's room on May 20th at 10:02 AM and 2:14 PM, and May 21st at 1:19 PM the BiPAP mask remained on top of the plastic bag on the nightstand.</p> <p>Electronic mail communication with the DON on May 22, 2024, at 11:00 AM it was revealed that Resident 139's BiPAP mask should be covered when stored.</p> <p>Review of Resident 605's clinical record revealed diagnoses that included: acute respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide) and muscle weakness.</p> <p>Observation in Resident 605's room on May 20, 2024, at 11:07 AM, revealed she was out of her room at the time and her oxygen mask was laying out on her bed.</p> <p>Observation in Resident 605's room on May 20, 2024, at 12:46 PM, revealed staff had been in the room to take her tube feeding supplies down, and the mask was still lying out on her bed.</p> <p>Observation in Resident 605's room on May 21, 2024, at 11:17 AM, revealed her mask was laying on the floor beside her oxygen tank.</p> <p>During an interview with Resident 605 on May 21, 2024, at 11:18 AM, she revealed she wears oxygen at night.</p> <p>Review of Resident 605's physician orders revealed an order for oxygen as needed with a start date of May 12, 2024.</p> <p>During an interview with the DON on May 23, 2024, at 11:10 AM, she revealed she would expect Resident 605's oxygen mask to be cleaned and bagged when not in use.</p> <p>(continued on next page)</p>		

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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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.12(d)(1)(2) Nursing Services

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>33879</p> <p>Based on clinical record review, resident interviews, observations, resident group interviews, facility policy review and staff interviews, it was determined that the facility failed to provide adequate staffing levels to provide a timely response to call bell requests for six of eight units (Main 1, Main 2, South 1, South 2, South 3, and South 4).</p> <p>Findings include:</p> <p>Review of facility policy titled, Answering the Call Light, last revised September 2022, revealed the policy's purpose stated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.</p> <p>Review of a subsection of the policy titled, Steps in the Procedure, it stated, 1. Answer the resident call system immediately .</p> <p>During an interview with Resident 558 on May 20, 2024, at 9:40 AM, they indicated that the facility needs more help and that they often have to wait between 45 minutes and an hour for their call bell to be answered.</p> <p>During an interview on May 20, 2024 at 11:16 AM, Resident 185 indicated sometimes it takes 1 hour and 25 minutes for staff to answer her call bell.</p> <p>During an interview with Resident 557 on May 20, 2024, at 12:01 PM, they indicated that they have experienced long call bell wait times sometimes up to an hour.</p> <p>During an interview with Resident 304 on May 20, 2024, at 1:26 PM, they indicated that they often wait a long time for their call bell to be answered.</p> <p>Review of Resident 231's clinical record revealed diagnoses including chronic kidney disease stage 3 (moderately decreased ability of the kidneys to filter toxins from the blood) and contracture of the right shoulder and right hand (tightening of the muscles, tendons and other tissues that causes joints to have decreased range of motion and movement).</p> <p>During observations on May 20, 2024, Resident 231's call bell was observed to be turned on at 11:39 AM. It was observed that staff did not answer Resident 231's call bell until 12:19 PM, which was a total of 40 minutes that Resident 231 waited for staff assistance.</p> <p>During a staff interview on May 21, 2024, at approximately 1:30 PM, Director of Nursing revealed that the facility would expect staff to answer call bells in a timely manner and that 40 minutes was not considered timely.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a Resident group meeting on May 21, 2024, from 1:30 PM to 2:10 PM, with Residents 17, 50, 79, 142, and 211, Resident 17 indicated that they had to wait two hours to get a shower after putting on their call bell and asking for one. Resident 79 indicated that staff typically respond timely, but sometimes they have to wait longer than expected because they might be helping other people.</p> <p>Review of Resident Council meeting minutes for February 24, 2024, revealed that residents voiced that they felt the facility needed more staff.</p> <p>Review of Resident Council meeting minutes for March 28, 2024, revealed that residents voiced staffing concerns.</p> <p>Review of Resident Council meeting minutes for April 25, 2024, revealed that residents voiced concerns that staff were being taken from S4 and sent to assist other floors.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>49123</p> <p>Based on surveyor observations, facility policy, and staff interview, it was determined that the facility failed to discard expired medications for one of eight medication carts (S2) observed and failed to place opened dates on medications in two of eight medication carts (M3 and S2) observed.</p> <p>Findings Include:</p> <p>Review of facility policy titled, Storage of Medications, with a revision date of August 2020, read in part, medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. General Guidance, 8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. Expiration Dating (Beyond-Use Dating), 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.</p> <p>Observation of the M3 medication cart on May 21, 2024, at 10:09 AM, revealed one open Humalog Kwik pen with no open date.</p> <p>Observation of the S2 medication cart on May 22, 2023, at 10:00 AM, with Employee 6 and Employee 7, revealed one open Humalog Kwik pen with no open date, one open Lantus Solostar pen with no open date, one open Levemir multidose vial with no open date, one open Lantus multidose vial with no open date, one open Bupivacain 25% multidose vial with no open date, and one open Humalog multidose vial with no open date.</p> <p>Further observation of the S2 medication cart revealed one open Lantus Solostar pen with an open date of March 26, 2024, one open Insulin Glargine -yfgn multidose vial with an open date of April 10, 2024, and one open Fiasp multidose vial with an open date of April 16, 2024.</p> <p>During a staff interview on May 22, 2024, at 10:00 AM, with Employee 6, it was revealed multidose vials and medication pens should be dated when opened.</p> <p>During a staff interview on May 22, 2024, at 1:43 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the surveyor notified the NHA and DON of the aforementioned observations. The DON stated that it is the facility's expectation that multidose vials and pens be dated when opened and expired medications be removed from medication carts and disposed of.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817</p> <p>Based on observations and resident and staff interviews, it was determined that the facility failed to ensure the menus were followed and a substitution was provided for a dessert not available at one of one meals observed.</p> <p>Findings include:</p> <p>During an interview with Resident 180 on May 20, 2024, at 2:28 PM, he revealed he doesn't always get what is on the menu or what is listed on his meal tickets.</p> <p>Observation of tray line meal service on May 22, 2024, between 12:25 PM and 12:50 PM, failed to reveal desserts being served on trays.</p> <p>During an interview with Employee 2 (Certified Dietary Manager) on May 22, 2024, at 12:44 PM, revealed desserts would be served on the units as the dessert was sherbet for regular diets and vanilla wafers for the consistent carbohydrate restricted diet, but they vanilla wafers were not available to order that week, so those residents should get a cookie instead. When the surveyor questioned if the dietitian was aware of the substitution, she stated I forgot to tell her. Employee 4 (Registered Dietitian) was in the kitchen office at the time and signed the substitution log for a cookie in place of vanilla wafers, only three delivery carts were left to be delivered to the floors for lunch at that time.</p> <p>Tour of [NAME] 2nd floor on May 22, 2024, at 12:55 PM, failed to reveal desserts served to residents on the floor.</p> <p>Interview with Resident 139 on May 22, 2024, at 12:50 PM, she revealed she didn't receive a dessert on her lunch tray, and she would have liked one.</p> <p>Interview with Resident 127 on May 22, 2024, at 12:56 PM, revealed she was finished eating her lunch and was not served dessert, and would have preferred to have dessert with her meal.</p> <p>Interview with Resident 50 on May 22, 2024, at 12:58 PM, revealed he was finished eating his lunch and was not served dessert, and would have preferred to have dessert with his meal.</p> <p>Interview with Resident 236 on May 22, 2024, at 1:02 PM, revealed he was finished eating his lunch and his tray had been taken by nursing staff, he said he was not served dessert and would have preferred to have dessert with his meal.</p> <p>Interview with Resident 288 on May 22, 2024, at 1:04 PM, revealed he was finished eating his lunch and his tray had been taken by nursing staff, he said he was not served dessert and would have preferred to have dessert with his meal.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee 3 (Licensed Practical Nurse) on May 22, 2024, at 1:05 PM, she revealed desserts usually come on the trays during lunch, and she was not aware nursing staff should be serving desserts on the unit that day.</p> <p>Review of Resident 127 and 236 tray tickets from lunch service on May 22, 2024, revealed they should have been served a sherbet cup for dessert.</p> <p>Review of Resident 50, 139, and 288 tray tickets from lunch service on May 22, 2024, revealed they should have been served vanilla wafers for dessert.</p> <p>During an interview with the Nursing Home Administer on May 22, 2024, at 1:54 PM, the surveyor revealed the concern with the five residents who didn't receive dessert at lunch that day, as well as the observations of the entire [NAME] 2nd floor unit not provided dessert at lunch, the surveyor also questioned how staff would know what to substitute for dessert for the carbohydrate controlled diets, as the dietitian was just made aware and signed off on the substitution with only 3 of 13 meal carts left to be delivered to the units.</p> <p>During a follow-up interview with the Nursing Home Administer on May 23, 2024, at 11:05 AM, he revealed he would have expected dessert to be provided at the lunch meal on May 22, 2024, and that a substitute dessert in place of the vanilla wafers should have been provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen and on eight of eight nursing unit pantry areas.</p> <p>Findings include:</p> <p>Review of facility policy, titled Food Receiving and Storage last revised [DATE], read, in part, Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Beverages must be dated when opened and discarded after three days.</p> <p>Review of facility policy titled Food and Nutrition Services Use By Dating Guidelines not dated, read, in part, Ready to eat foods including prepared salads have a use by date of seven days after opening. Frozen foods stored in the freezer have a use by date of three months after opening and properly closed.</p> <p>Review of facility policy titled Foods Brought by Family/Visitors last revised [DATE], read, in part, Perishable foods must be stored in re-sealable containers with tight fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item, and the use by date. The nursing staff will discard perishable foods on or before the use by date. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger.</p> <p>Observation of the dry storage area in the main kitchen on [DATE], at 9:10 AM, revealed a bin of rice with a scoop in the rice.</p> <p>Interview with Employee 2 (Certified Dietary Manager) on [DATE], at 9:11 AM, revealed scoops should not be stored directly in food, and that there is a hook at the top of the bin for the scoops.</p> <p>Observation of walk-in refrigerator 1 on [DATE], at 9:12 AM, revealed: one container of chocolate pudding labeled use by [DATE]; one container of pickles labeled use by [DATE]; one open container of Amish style salad with an open date of [DATE]; one container of chocolate pudding labeled use by [DATE]; one container of diced pears not dated; and one tray of individual puddings not dated.</p> <p>Observation of walk-in freezer 1 on [DATE], at 9:15 AM, revealed one box of croissants labeled use by [DATE].</p> <p>Observation of the walk-in refrigerator 1 and walk-in freezer 1 temperature logs on [DATE], at 9:16 AM, failed to reveal recorded temperatures on [DATE]-18, 2024, AM and PM shifts; and [DATE], PM shift.</p> <p>Observation in the main kitchen on [DATE], at 9:17 AM, revealed a container of salt with a spoon in the salt.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the walk-in freezer 2 temperature log on [DATE], at 9:22 AM, failed to reveal recorded temperatures on [DATE]-18, 2024, AM and PM shifts; and [DATE], PM shift.</p> <p>Observation of the ice machine in the main kitchen on [DATE], at 9:23 AM, failed to reveal an air gap between the drainpipe from the ice machine and the floor drain.</p> <p>Observation of the three-compartment sink temperature log in the main kitchen on [DATE], at 9:28 AM, failed to reveal a recorded concentration of the sanitizer water on [DATE], ,d+[DATE], and 16, 2024, for breakfast, lunch, and dinner.</p> <p>Observation in the main kitchen on [DATE], at 9:32 AM, revealed a bin of flour with a scoop in the flour.</p> <p>Observation of the [NAME] 1st Floor pantry area freezer on [DATE], at 9:37 AM, revealed a blue bag of frozen dinners and three of them were expired; three bins of ice cream labeled [DATE] that were heavily freezer burned; and seventeen individual sherbet cups not labeled with use by dates.</p> <p>Observation of the [NAME] 1st Floor pantry area refrigerator on [DATE], at 9:40 AM, revealed a container of fortified nutritional shake open without an open date.</p> <p>Observation of the [NAME] 2nd Floor pantry area refrigerator on [DATE], at 9:49 AM, revealed an open container of mango juice without an open date; one tray of puddings not dated; one open thickened lemon water without an open date; and one open thickened apple juice without an open date.</p> <p>Observation of the [NAME] 2nd Floor pantry area freezer on [DATE], at 9:50 AM, revealed two individual sherbet cups not labeled with use by dates; and a frozen meal without a resident's name that was dated use by [DATE].</p> <p>Observation of the [NAME] 3rd Floor pantry area refrigerator on [DATE], at 9:57 AM, revealed two individual puddings not dated; one individual applesauce not dated; one open thickened lemon water without an open date; and one open thickened cranberry juice without an open date.</p> <p>Observation of the [NAME] 4th Floor pantry area refrigerator on [DATE], at 10:01 AM, revealed one open thickened cranberry juice without an open date.</p> <p>Observation of the [NAME] 4th Floor pantry area freezer on [DATE], at 10:02 AM, revealed three individual sherbet cups not labeled with use by dates; and an open container of Amish style macaroni salad not labeled with a resident name.</p> <p>Observation of the [NAME] 1st, 2nd, and 4th Floor pantry areas on [DATE], between 9:35 AM and 10:00 AM, revealed bins containing a variety of snacks, including some that weren't individually labeled with use by dates.</p> <p>Observation of the South 1st Floor pantry area freezer on [DATE], at 10:10 AM, revealed three individual sherbet cups not labeled with use by dates.</p> <p>Observation of the South 2nd Floor pantry area freezer on [DATE], at 10:15 AM, revealed two individual sherbet cups not labeled with use by dates.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the South 3rd Floor pantry area freezer on [DATE], at 10:20 AM, revealed forty-three individual sherbet cups not labeled with use by dates.</p> <p>Observation of the pantry area on South 2nd, 3rd and 4th floor nursing units, on [DATE], between 10:14 AM and 10:25 AM, revealed bins containing a variety of snacks, including some that weren't individually labeled with use by dates.</p> <p>During an interview with Employee 2 on [DATE], at 10:25 AM, the surveyor revealed the concerns of the initial tour of the kitchen and pantries, Employee 2 confirmed she would expect labeling and dating and management of kitchen equipment in accordance with professional standards.</p> <p>Interview with the Nursing Home Administrator on [DATE]st, 2024, at 12:59 PM, revealed it is the facility's expectation that food and beverages are labeled and dated with use by dates per facility policy and discarded once expired, and food items and kitchen equipment are stored and utilized in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>		