

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 04/17/2025
NAME OF PROVIDER OR SUPPLIER Spring Creek Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 South 28th Street Harrisburg, PA 17111	

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 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47966</p> <p>Based on review of facility policy, resident and staff interviews, and observations, it was determined that the facility failed to provide residents access to grievance forms for three of eight areas identified ([NAME] 2, [NAME] 3, and [NAME] 4).</p> <p>Findings Include:</p> <p>Review of the facility policy, titled Grievance Process Procedure with a last review date of March 2025, revealed 1. All concerns and questions may be presented to any staff member. Concern forms/boxes are available on South 1, South 2, South 3, South 4, [NAME] 1, [NAME] 2, [NAME] 3, [NAME] 4.</p> <p>During the resident group meeting conducted on April 15, 2025, at 11:00 AM, with eight residents (Residents 48, 59, 77, 94, 215, 230, 244, and 337) revealed that residents are not able to file grievances anonymously due to having to ask staff to get them a blank grievance form behind the nurse's station. Residents revealed the grievance forms are not within reach if they are wheelchair bound and have to ask for assistance retrieving one.</p> <p>Observation conducted on April 16, 2025, at 10:40 AM, on [NAME] 2, revealed a locked grievance box in the hallway by the nurses' station with no grievance forms beside it. There were no grievance forms observed in prominent locations on [NAME] 2.</p> <p>Interview conducted with a staff member who was sitting behind the nurses' station on [NAME] 2 on April 16, 2025, at 10:43 AM, when asked where the blank grievance forms were located, revealed they were in a folder behind the nurses' station, out of reach for residents who are wheel chair bound and inaccessible for residents as they are behind the nurses' station.</p> <p>Observation conducted on April 16, 2025, at 10:56 AM, on [NAME] 3, revealed a locked grievance box in the hallway by the nurses' station, with no grievance forms beside it.</p> <p>Interview conducted with a staff member who was sitting behind the nurses' station on [NAME] 3 on April 16, 2025, at 10:58 AM, revealed that the grievance bin was on the wall beside the locked box, however, a resident with behaviors ripped the bin off, so they have to put it back on the wall. Staff member revealed there were blank grievance forms sitting on top of the counter in the nurses' station, however, there was a medical cart sitting in front of them.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation conducted on April 16, 2025, at 11:07 AM, on [NAME] 4, revealed a locked grievance box in the hallway by the nurses' station, with no grievance forms beside it. Further observation revealed blank grievance forms located in in a folder behind the nurses' station, in a bin attached to the top part of a door, out of reach for residents who are wheelchair bound an inaccessible for residents as they are behind the nurses' station.</p> <p>Interview conducted with the Nursing Home Administrator on April 17, 2025, at 10:46 AM, revealed that the grievance bins were placed in the hallway at resident height on [NAME] 2, 3, and 4, and that he would expect them to be within resident reach, however, some resident behavior issues result in ripping the bins off of the hallway wall. Further, he stated the facility would need to come up with a solution to keep them in prominent locations to be accessible to residents.</p> <p>28 Pa code 201.18(b)(2)(3) Management</p> <p>28 Pa code 201.29(a) Resident rights</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the comprehensive care plan was revised to include changes in the resident's status and plan of care for two of 38 residents reviewed (Residents 148 and 290).</p> <p>Findings include:</p> <p>Review of facility policy, titled Care Plans, Comprehensive Person Centered, with a last revised date of March 2022, and a last review date of March 2025, revealed, in part, 11. Assessments of resident's are ongoing, and care plans are revised as information about the residents and the residents' conditions change; and 12d. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required . assessments</p> <p>Review of the clinical record for Resident 148 revealed diagnoses that include dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement) and type 2 diabetes mellitus (body has trouble controlling blood sugar).</p> <p>Resident 148 was admitted to the facility on [DATE], and a dementia diagnoses was was effective July 30, 2021.</p> <p>A review of Resident 148's current care plan was never revised to include a dementia care plan.</p> <p>During a staff interview with the Director of Nursing (DON) on April 17, 2025, at 11:00 AM, the DON revealed the care plan should have been revised to include a dementia care plan.</p> <p>Review of Resident 290's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression.</p> <p>Review of Resident 290's current physician orders revealed an order for olanzapine (an antipsychotic medication) 5 milligrams, give one tablet at bedtime, dated January 6, 2025.</p> <p>Review of Resident 290's care plan failed to reveal any documentation an antipsychotic medication. Further review of the care plan revealed that he was care planned for receiving an antianxiety medication.</p> <p>Review of Resident 290's physician order history revealed that his antianxiety medication was discontinued on December 24, 2024.</p> <p>During a staff interview with the Nursing Home Administrator and DON on April 17, 2025, at 10:46 AM, the DON confirmed that she would have expected Resident 290's care plan to have been revised when the medication orders changed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42 CFR 483.21(b)(2) Comprehensive Care Plans</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(2)(3)(5) Nursing services</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47966</p> <p>Based on a group meeting with residents, observations, review of facility documentation, and staff interviews, it was determined that the facility failed to provide for an ongoing program of activities designed to meet the interests and physical, mental and psychosocial well-being of the residents for four of eight resident areas (South 2, 3, 4, and [NAME] 4).</p> <p>Findings include:</p> <p>During the resident group meeting conducted on April 15, 2025, at 11:00 AM, with eight residents (Residents 48, 59, 77, 94, 215, 230, 244, and 337) revealed that the facility is short staffed and that activities do not always occur as scheduled.</p> <p>Review of the facility's activity calendar for April 2025 revealed that there was an activity scheduled for 1:00 PM on April 16, 2025, with the activity being activity on unit.</p> <p>Observation conducted on April 16, 2025, at 1:17 PM, on South 2, revealed there were no activities occurring on the unit at that time.</p> <p>Observation conducted on April 16, 2025, at 1:19 PM, on South 3, revealed there were no activities occurring on the unit at that time.</p> <p>Observation conducted on April 16, 2025, at 1:21 PM, on South 4, revealed there were no activities occurring on the unit at that time.</p> <p>Observation conducted on April 16, 2025, at 1:09 PM, on [NAME] 4, revealed there were no activities occurring on the unit at that time.</p> <p>Interview conducted with the Nursing Home Administrator (NHA) on April 16, 2025, at 1:40 PM, revealed that if an activity is scheduled, he would expect it to occur. NHA was unable to provide a description what the activity on unit would consist of on resident units.</p> <p>28 Pa. code 201.29(j) Resident rights</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37817</p> <p>Based on review of the clinical record and staff and resident interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that met each resident's physical, mental, and psychosocial needs for one of 38 residents reviewed (Resident 333).</p> <p>Findings include:</p> <p>Review of Resident 333's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).</p> <p>Interview with Resident 333 on April 14, 2025, at 1:19 PM, revealed that he receives insulin and that his blood sugars (the amount of glucose in your blood) have been running high, although he is on a medication that does elevate blood sugar.</p> <p>Review of Resident 333's physician orders included: NovoLog (Insulin Aspart- rapid acting insulin) Flex-Pen (disposable dial a dose insulin pen) Inject as per sliding scale: if 0 - 200 = 0 units/ml; 201 - 250 = 2 units/ml; 251 - 300 = 4 units/ml; 301 - 350 = 6 units/ml; 351 - 400 = 8 units/ml ; 401 - 450 = 10 units/ml; 451 - 999 = 12 units/ml and notify provider, subcutaneously (under the skin) before meals, with a start date March 29, 2025.</p> <p>Review of Resident 333's March 2025, Medication Administration Record (MAR - documentation of medications that were administered) failed to document NovoLog administration or blood sugar monitoring on March 30th and 31st.</p> <p>Review of Resident 333's vitals monitoring for blood sugar documented 235 ml/dl on March 30th, 2025, at 5:08 AM, and 155 ml/dl on March 31st, 2025, at 7:06 AM. Per the physician's order, Resident should've received 2 units/ml on March 30th and shouldn't have received any insulin on March 31st.</p> <p>During an interview with the Director of Nursing (DON) on April 17, 2025, at 12:13 PM, it was revealed that the expectation is that documentation would be completed on the MAR. It was also revealed that March 30th the Novolog was administered per DON's conversation with the nurse on duty at that time, and on the 31st the Novolog didn't need to be administered.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure each resident receives proper treatment to maintain vision abilities for one of 38 residents reviewed (Resident 290).</p> <p>Findings include:</p> <p>Review of Resident 290's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and glaucoma (a group of eye diseases that can lead to damage of the optic nerve which transmits visual information from the eye to the brain that may cause vision loss if left untreated).</p> <p>Review of Resident 290's clinical record progress notes revealed a note dated August 29, 2024, at 7:30 PM, written by the facility psychology consultant, that indicated that the Resident reported he had vision problems and that his vision problems have negatively impacted his ability to engage in recreational activities.</p> <p>Review of Resident 290's clinical record progress notes revealed a nurse's note dated August 30, 2024, at 7:24 AM, that indicated that his physician had placed orders for consults for resident.</p> <p>Review of Resident 290's clinical record progress notes revealed a physician's progress note dated March 6, 2025, at 9:31 AM, that stated Resident 290 had indicated that he was experiencing acute vision loss.</p> <p>Review of Resident 290's clinical record progress notes revealed a nurse's note dated March 7, 2025, at 2:06 PM, that indicated that the facility eye doctor would not be on site until the end of the month, and that Resident 290's provider was called for guidance.</p> <p>A follow-up nurse's note dated March 7, 2025, at 3:10 PM, indicated that the Resident was complaining of loss of eyesight and to send to the emergency room for evaluation.</p> <p>Review of Resident 290's clinical record progress notes revealed a nurse's note dated March 7, 2025, at 11:50 PM, that indicated the Resident had returned to the facility with a diagnosis of cataracts in both eyes.</p> <p>Review of Resident 290's clinical record progress notes revealed a nurse's note dated April 8, 2025, at 2:34 PM, that indicated he had returned from his eye surgeon appointment and that the office would call to set up cataract surgery and no new orders were given.</p> <p>Review of Resident 290's physician order history revealed an order for optometry consult for bilateral cataract complaint dated August 30, 2024, with a discontinuation date of March 6, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 290's clinical record failed to reveal any optometry consult appointments between August 3, 2024, and his emergency room visit on March 7, 2025.</p> <p>Email communication received from the Director of Nursing (DON) on April 17, 2025, at 12:00 PM, she indicated that she had no additional information to provide for Resident 209's vision concern.</p> <p>In a follow-up email communication received from the DON on April 17, 2025, at 12:06 PM, she indicated that she would have expected nursing staff to have set up an optometry appointment for Resident 290's vision concerns when the consult order was given on August 30, 2024.</p> <p>28 Pa code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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, facility incident report review, and staff interviews, it was determined that the facility failed to ensure the resident receives adequate supervision to prevent accidents for one of 38 residents reviewed (Resident 339).</p> <p>Findings include:</p> <p>Review of Resident 339's clinical record revealed diagnoses that included repeated falls, dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), adjustment disorder with anxiety (a mental health condition characterized by emotional or behavioral responses to a significant life change or stressor), and urinary retention (incomplete emptying of the bladder or inability to urinate) with the use of an indwelling foley catheter.</p> <p>Review of Resident 339's care plan revealed a care plan focus for falls that included an intervention for 1:1 (one-to-one observation-one staff member to always be with resident).</p> <p>Review of Resident 339's clinical record progress notes revealed an occurrence note written by a nurse dated February 7, 2025, at 9:45 PM, which indicated that Resident 339 was on the floor in front of his dresser, laying on his left side. He was undressed, his anti-skid socks were not in place, and his foley catheter was dislodged and located on his bed with the balloon still inflated. The note further indicated that the nurse was unable to reinsert a foley catheter and that Resident 339 was sent to the emergency room to have his indwelling foley catheter placed. He had no other injuries at the time of the fall.</p> <p>Review of Resident 339's facility provided incident report investigation revealed that education was provided to staff member to not leave a 1:1 resident unattended.</p> <p>Review of Employee 13's witness statement revealed the following information: she had finished giving care to Resident 339 and he was sleeping; she went to the nursing office to talk to someone; she took only 5 minutes to put the trash outside; when she came back staff were going to Resident 339's room because he had fallen; and that she did not imagine that he could fall that quick.</p> <p>During a staff interview with the Director of Nursing (DON) and the Assistant Nursing Home Administrator on April 17, 2025, at 9:10 AM, the DON confirmed that Employee 13 had just stepped outside of room to speak to nurse. She indicated that staff said Resident 339 was sound asleep and had been for a while. The DON indicated that Employee 13 was only away for a couple of minutes and when she returned, he was on floor. The DON indicated that facility practice for 1:1 supervision was usually only for when residents are awake, but that Resident 339 could be fast in his actions and was to be under 1:1 supervision at all times for his safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up staff interview with the Nursing Home Administrator and DON on April 17, 2025, at 10:54 AM, the DON indicated that she did not feel that leaving the room to remove soiled linens and trash after providing care while the Resident was sleeping was inappropriate. She said that it was truly an accident, and that Employee 13 was educated, and no other incidents have occurred while 1:1 supervision at all times has been provided.</p> <p>201.4(a) Responsibility of licensee</p> <p>201.18(b)(1) Management</p> <p>211.12(d)(1)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>46253</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure residents are assessed and receive appropriate treatment and services for removal of a foley catheter as soon as possible for one of nine residents reviewed (Resident 339).</p> <p>Findings include:</p> <p>Review of Resident 339's clinical record revealed diagnoses that included repeated falls, dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland), and urinary retention (incomplete emptying of the bladder or inability to urinate) with the use of an indwelling foley catheter.</p> <p>Review of Resident 339's clinical record progress notes revealed an orders administration note dated February 18, 2025, at 8:14 AM, that indicated his foley catheter was not removed as ordered.</p> <p>Further review of Resident 339's clinical record progress notes revealed a nurse's note dated February 18, 2025, at 10:02 AM, that indicated the urology office was called to reschedule Resident 339's foley catheter removal and office visit appointment for that date. The appointment was rescheduled for February 25, 2025.</p> <p>During a staff interview with Employee 17 (Registered Nurse) on April 16, 2025, at 2:18 PM, she indicated that Resident 339 had an order for staff to remove his foley catheter on February 17, 2025. She indicated that this was entered as an order to be completed by the night shift nurse. The order also included that nursing staff were to complete a bladder scan intermittently and, if urinary retention was noted, the urology office would see him at 10:00 AM, on February 18, 2025. If retention was too extreme before the office visit time, the facility was to send him to the emergency room. Employee 17 indicated that the appointment had to be rescheduled because the night shift nurse did not remove Resident 339's foley catheter as ordered. She said that the nurse said she didn't feel it was good for the Resident to go that long without catheter. Employee 17 said that the facility contacted urology office and had to reschedule the appointment for February 25, 2025, for the same process. Employee 17 confirmed that the assigned nurse should have followed the physician's orders for Resident 339.</p> <p>During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on April 17, 2025, at 10:52 AM, the DON confirmed that she would have expected the nurse to follow Resident 339's physician's order for removing the catheter.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>37817</p> <p>Based on review of select food service committee meeting minutes, observation, one meal test tray, and resident and staff interviews, it was determined that the facility failed to provide foods that are palatable, attractive, and at appetizing temperatures at one of one meal observed.</p> <p>Findings include:</p> <p>Resident interviews with Residents 81, 331, and, 347, obtained April 14, 2025, between 10:30 AM and 11:57 AM, revealed concerns with the temperature of hot food.</p> <p>A test tray completed on South 3rd floor on April 16, 2025, at 12:47 PM, revealed adequate portions size and the food was palatable for taste and texture for a puree diet; however, the temperature of the puree barbecue chicken and puree lima beans weren't palatable for temperature. The test tray was placed on a meal cart and delivered to South 3 unit with other trays being delivered at that time. 18 minutes had elapsed between the time the test tray was prepared from the service line and presented for evaluation.</p> <p>Employee 3 (Food Service Manager) took temperatures of the food items at the time the test tray was served for evaluation. The following were the recorded highest temperatures:</p> <p>puree barbecue chicken- 129.9 degrees Fahrenheit (F)</p> <p>mashed potato w/gravy - 136 degrees F</p> <p>puree lima beans- 120 degrees F</p> <p>puree peanut butter cookie - room temp</p> <p>milk- 43 degrees F</p> <p>During an interview with the Nursing Home Administrator on April 16, 2025, at 2:30 PM, the surveyor revealed concern regarding food temperature of the puree barbecue chicken and puree lima beans. No further information was provided.</p> <p>28 Pa. Code 201.14. Responsibility of licensee</p> <p>28 Pa code 211.6 - Dietary Services</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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33305</p> <p>Based on observations, facility policy review, clinical record review, Center for Disease Control (CDC) guidelines, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection for three of six residents on transmission based precautions reviewed (Residents 212, 277, and 554) and one of five residents observed for medication administration (Resident 171).</p> <p>Findings Include:</p> <p>Facility policy, Isolation precautions, revised September 2022, read, in part, when a resident is placed on Transmission-Based Precautions (TBP), appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and type of precaution. The signage informs the staff of the type of Center for Disease Control (CDC) precaution, instructions for use of Personnel Protective Equipment (PPE) and/or instructions to see a nurse before entering the room. When TBP are in effect, non-critical resident-care equipment items such as a stethoscope will be dedicated to a single resident when possible. Contact precautions are implemented for a resident suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors are to wear: gloves when entering the room and gloves are removed and hand hygiene is performed before leaving the room; and a disposable gown upon entering the room and remove before leaving the room.</p> <p>Facility policy, Enhanced Barrier Precautions (EBPs), April 2024, read, in part, EBPs are utilized to prevent the spread of multi-drug-resistant organisms to residents. A gown and gloves are used during high contact resident care activities when contact precautions do not otherwise apply. Signs are posted on the door indicating the type of precautions and PPE required.</p> <p>Facility policy, Clostridium Difficile (CDI-inflammation of the colon caused by the bacteria clostridium difficile), revised October 2018, read, in part, the primary reservoirs for CDI are infected people and surfaces. Spores can persist on resident-care items and surfaces for several months and are resistant to some common cleaning and disinfection methods. Residents with diarrhea associated with CDI are placed on Contact Precautions. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior for the mechanical removal of CDI spores from hands.</p> <p>Review of Resident 212's clinical record revealed diagnoses that include Clostridium difficile (C. diff-a bacterium that can cause infections, primarily diarrhea and colitis) and Lupus (a chronic autoimmune disease where the body's immune system mistakenly attacks its own tissues, causing inflammation and damage).</p> <p>Review of the clinical record for Resident 212 revealed the Resident had loose stools (diarrhea) and a positive culture that confirmed C. diff infection (CDI) on April 2, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on policy review the facility references Centers for Disease Control Guidelines for infection control, The CDC provides comprehensive guidelines for preventing and managing CDI that included isolate patients with possible C. diff immediately, even if you only suspect CDI. Wear gloves and gown when treating patients, even during short visits. When CDI is confirmed, continue isolation and contact precautions. Clean room surfaces daily with an EPA-approved spore-killing disinfectant while treating a C. diff patient.</p> <p>Observations on April 14, 2025, and April 15, 2025, revealed Resident 212 with EBP signage instead of contact precautions. Resident 212's care plan failed to include wearing a gown during care and touching surface areas, and the enhanced barrier precautions limits the use of a gown.</p> <p>During an interview on April 17, 2025, at 10:15 AM, with Employee 2 (ICP-Infection Control Preventionist) the ICP confirmed that Resident 212 should have signage indicating contact precautions instead of EBP.</p> <p>During an interview with the Director of Nursing (DON) on April 17, 2025, at 11:00 AM the DON confirmed that Resident 212 should have signage indicating contact precautions.</p> <p>Observation of Resident 277 on April 15, 2025, at 11:30 AM, revealed Employee 10 (Nurse Aide) entering Resident 277's room, walk up next to the Resident's bed, asked Resident 277 what he needed, and turned the call bell light off before exiting the room. At no time did Employee 10 apply any personal protective equipment (PPE).</p> <p>Observation of Resident 277 on April 16, 2025, at 10:42 AM, revealed Employee 11 (Nurse Aide) entering Resident 277's room without putting on any PPE and shut the door behind her.</p> <p>Observation of Resident 277 on April 16, 2025, at 11:37 AM, revealed Employee 12 (Activities Aide) entering Resident 277's room, walked up next to the Resident's bed, handed Resident 277 a bag of snacks from the gift shop, and then exited Resident 277's room. At no time did Employee 12 apply any PPE.</p> <p>Review of Resident 277's clinical record revealed diagnoses that included Klebsiella (a type of bacteria normally found in human feces that can cause healthcare-associated infections) and benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland).</p> <p>Review of Resident 277's current physician orders revealed an order for Resident 277 to be on contact precautions due to Klebsiella in his urine from April 8, 2025, until April 17, 2025, at 11:59 PM.</p> <p>Review of Resident 277's care plan revealed a care plan for, infection of Klebsiella in urine, with a revision date of April 8, 2025, with an intervention of Isolation-contact precaution.</p> <p>Interview of the DON on April 17, 2025, at 12:15 PM, revealed the expectation that the employees would have used the appropriate PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on April 15th, 16th, and 17th, 2025, on the wall to the right of Residents' 554 and 555 room, were two signs. The top sign documented Enhanced Barrier Precautions; wear gloves and gown upon entering room and complete hand hygiene prior to leaving the room; and a letter D in the top left corner. Under the aforementioned sign was another sign containing a red stop sign with handwriting documenting to see the nurse; without notation of window W or door bed D.</p> <p>Interview with Employee 15 (Occupational Therapist) on April 15, 2025, at 10:05 AM, revealed he wasn't sure of the what the infection/concern was in Residents' 554 and 555 room. However, when the sign is present, you must wear the PPE that is stated when providing direct care.</p> <p>Interview with Employee 16 (Registered Nurse) on April 17, 2025, at 9:37 AM, revealed the aforementioned signs on the wall outside of Residents' 554 and 555 room pertained to Resident 554, who has CDI.</p> <p>Review of Resident 554's clinical record revealed diagnoses that included enterocolitis (inflammation of the colon) due to clostridium difficile.</p> <p>Review of Resident 554's physical chart on April 17, 2025, at 9:39 AM, it failed to contain documentation on the outside of the chart the Resident was on contact precautions.</p> <p>Review of Resident 554's current physician orders included: isolation precautions-contact due to clostridium difficile, start date April 2, 2025; Vancomycin 125 milligrams (mg) 1 capsule every 6 hours related to clostridium difficile for 10 Days then, one capsule every 8 hours for 7 days, then one capsule every 12 hours for 7 days, then one capsule one time a day for 7 days, then one capsule every other day for 7 days, then one capsule one time a day every 3 days for 7 days, with a start date of April 2, 2025.</p> <p>Review of Resident 554's care plan included: Infection of clostridium difficile, date-initiated April 2, 2025, revised April 3, 2025. Interventions included: isolation- contact precautions: wash hands with antimicrobial soap upon leaving room taking care not to touch environmental surfaces, date initiated April 2, 2025; and isolation- contact precautions: wear gloves during care, date initiated April 2, 2025; proper handwashing after each contact, date initiated April 2, 2025.</p> <p>Review of Resident 554's bowel tracking documentation revealed loose, watery stool documented for April 2nd through 16th, 2025.</p> <p>Review of Resident 555's (Resident 554's roommate) clinical record documented diagnoses that included a wound on the left lower extremity with use of a wound vacuum.</p> <p>Review of Resident 555's care plan included: at risk for infection related to wound date-initiated April 14, 2025, with an intervention for enhanced barrier precautions, date initiated April 14, 2025.</p> <p>Interview with DON on April 17, 2025, at 10:35 AM, revealed the enhanced barrier precaution pertained to Resident 555, and the transmission-based contact precaution noted by the stop sign pertained to Resident 554.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Electronic communication with the DON on April 17, 2025, at 11:23 AM, it was confirmed that Resident 555 doesn't get out of bed or utilize the restroom.</p> <p>The facility failed to delineate the specific infection control practice (enhanced barrier precaution/transmission base precaution) for Residents 554 and 555 per the signage posted outside of the Resident's room. The signage lacked clarity as to which precaution pertained to each Resident. Although gloves and a gown must be worn for both Residents. The transmission-based contact precaution differed in the hand hygiene procedure (hand washing not use of a hand sanitizer) and always use PPE, to include potential contact with surfaces in the room vice just for direct care.</p> <p>Review of Facility policy, titled Administrating Medications, last revised April 2019, revealed that subsection 25 stated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.</p> <p>During medication administration observation on April 17, 2025, at approximately 9:18 AM, Employee 14 (Licensed Practical Nurse) was observed preparing medications for administration for Resident 171. Observation revealed one of the medication tablets did not go into the medication cup where Employee 14 was dispensing medication tablets. The medication tablet was observed on the medication cart computer's mouse pad. Once identified by Employee 14, Employee 14 used her bare hand to pick up them medication and place it in the medicine cup. Employee 14 was then observed crushing Resident 171's medications and subsequently administered them at approximately 9:23 AM.</p> <p>During a staff interview on April 17, 2025, at approximately 10:35 PM, the DON revealed that staff should not handle medications with their bare hands and that Employee 14 should have discarded the medication tablet that fell on to the mouse pad.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		