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	05/14/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility document review, resident and staff interviews, and facility policy review, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement and exhibiting exit seeking behaviors (Resident 334). This failure resulted in an immediate jeopardy situation for Resident 334 as evidenced by an elopement from the facility to the airport. Findings include: Review of facility policy, titled Emergency Procedure - Missing Resident, revised March 21, 2025, read, in part; 1. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. Review of Resident 334's clinical record revealed diagnoses that included aphasia (a neurological disorder caused by brain damage that impairs a person's ability to speak, write, and understand language, while leaving their intelligence entirely intact), and chronic atrial fibrillation (a continuous, sustained arrhythmia where the heart's upper chambers beat irregularly). Review of Resident 334's clinical record revealed a psychiatry progress note written on October 21, 2025, noted that the Resident had previously left AMA (against medical advice) from another facility and ended up at the airport attempting to board a plane. The note further stated the Resident had reported confusion and altered mental status and was taken to the ER (Emergency room) for further evaluation. Further review of Resident 334's clinical record revealed a social worker (SW) note written on January 27, 2026, that read, in part; SW met with resident in SW office. Resident is aphasic and has difficulty verbalizing/articulating thoughts and feelings. Resident wrote on a piece of paper ?9:00' and made an airplane sound with his mouth while pretending his arm was an airplane. SW asked resident if he was planning on booking a flight at this time. Resident answered in the affirmative and stated that he was planning on discharging next Tuesday (February 3, 2026). SW discussed unsafe discharge with resident along with AMA procedure and asked if resident had a plan for after he arrives at his destination. The resident offered no post discharge plan. Review of Resident 334's clinical record revealed a progress note on January 29, 2026, that the Resident had a BIMS (brief interview for mental status) of 6, which indicates severe impairment. Further review of Resident 334's clinical record revealed a nursing progress note on February 2, 2026, at 3:09 PM, that the Resident tried to leave the facility and was placed on 15-minute checks until a wander guard was in place. Another nursing note was documented at 4:38 PM as a late entry that read, in part, At approximately 2:00 PM, this writer received a call from the receptionist stating the resident had managed to get out of the front door after she opened the door for a visitor to leave. The receptionist immediately followed the resident. The resident was brought back inside the facility within less than a minute. Review of Resident 334's physician's orders revealed an order for an alarming security bracelet wander guard on his wheel chair, with a start date of February 3, 2026. Review of Resident 334's elopement risk evaluation completed on February 3, 2026, revealed that the Resident was at risk for elopement with an intervention to have a wander guard/alarming security bracelet placed on the Resident's chair. Review of Resident 334's comprehensive care plan revealed the Resident was an elopement risk (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	related to cognitive impairment, with an intervention for a wander bracelet in place, initiated on February 2, 2026. Review of Resident 334's psychiatry progress note on March 9, 2026, revealed the Resident expressed wanting his wander guard removed so he can go off of the unit. Review of Resident 334s' psychiatry progress note on March 16, 2026, revealed the Resident was fixated on wanting his wander guard removed so he can go to activities. Review of Resident 334's clinical record revealed a care plan/IDT note on March 19, 2026, that read, Residents wander guard removed, no longer an elopement risk. Review of Resident 334's physician's orders revealed the order for alarming security bracelet wander guard on chair was discontinued on March 19, 2026. Review of Resident 334's elopement risk evaluation completed on March 20, 2026, revealed the Resident is no longer at risk for elopement. Further review of the evaluation read, in part, 4. Does the patient have a history of leaving facility with out needed supervision? 5. Does the patient have a history of leaving facility without notifying staff? Both answers were documented as No despite him leaving the facility the previous month. Review of Resident 334's clinical record revealed a progress note on May 6, 2026, that the Resident had a BIMS of 8, which indicates moderate impairment. Review of the facility provided incident report for Resident 334 indicated that on May 9, 2026, at 5:57 PM, Resident was observed self-propelling in wheel chair throughout the facility. Resident was alert and in pleasant mood. Resident was dressed for the day, and with rubber soled shoes on bilateral feet. Resident was last seen on unit at 1:30 PM at which lunch time was provided by the assigned certified nurse aid in his room. Resident was observed by the operator, sitting in the lobby in his wheelchair turning pages of a magazine while sitting in his wheelchair. This writer was alerted at 5:57 PM by an airport dispatcher, ?We have one of your residents here at the ticket gate wanting to purchase a ticket to fly to St. [NAME]. He is here in a wheelchair and doesn't have the means to purchase a plane ticket, and he seems to be confused. He is very adamantly and refusing to go back to your facility.' The resident was transported to the hospital to be further evaluated at 8:26 PM. Under the section Actions taken as a result revealed, in part, Resident taken to hospital from the airport and is currently being evaluated as per registered nurse. At 10:27 PM writer contacted daughter and made her aware of the above findings. Daughter shared concerns that she is unable to care for him and that St. [NAME] does not have the infostructure to take care of him medically and ?he doesn't understand that.' Review of Resident 334's clinical record revealed a nursing note on May 10, 2026, at 10:30 AM, that he returned to the facility and was placed under close observations 1:1 and a head-to-toe assessment was performed. Review of employee witness statements revealed that Resident 334 was last seen by staff at 3:00 PM on May 9, 2026, sitting in a wheelchair in the lobby, reading a magazine. The employee did not see where the Resident went. During an interview with Resident 334 on May 11, 2026, at 1:33 PM, he confirmed that he left the facility, called an Uber and went to the airport and was going to buy a plane ticket to go to St. [NAME]. Resident 334 said that he lived in St. [NAME] for 20 years and was going back to see a friend, however, the cops came and figured out he was a Resident at this facility and ended up back here. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 11, 2026, at 2:25 PM, it revealed that the facility was first made aware Resident 334 had eloped when they received a call from the airport. NHA revealed that video footage was reviewed and it was determined that the receptionist opened the door for a gentleman that was leaving carrying big boxes and the Resident just left with him. The receptionist did not see the Resident leave the facility. Further interview conducted with the NHA and DON on May 13, 2026, at 1:55 PM, revealed that after they removed Resident 334's wander guard on March 19, 2026, there were no other elopement interventions put in place and that it was an error to have his wander guard removed. During an interview with Employee 3 (Licensed Practical Nurse/Unit Manager) on May 14, 2026, at 9:40 AM, it was confirmed that they were the nurse who completed Resident 334's elopement risk evaluations in February 2026 and March 2026 and answered the questions in March by here say. Employee 3 confirmed it was an error in documentation and received education. Employee 3 revealed that after Resident 334's wander guard was removed in March 2026, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Resident would go sit in the courtyard for the majority of the day and would leave the floor to do his own laundry. Employee 3 revealed the Resident would sign himself out whenever he left the unit. Employee 3 revealed that residents who have a wander guard are able to leave the unit with staff assistance and supervision, however, the facility does not have enough staff to accompany every resident who wants to go off the unit. During an interview conducted with Employee 4 (Assistant Director of Nursing) on May 13, 2026, at 1:28 PM, revealed that residents who are not an elopement risk are able to leave their units and sign out off the floor at the nurse's station. Employee 4 revealed that if a resident has a wander guard on, someone has to be with them to leave the unit. Employee 4 stated that residents are not confined to their units because of a wander guard and that they make sure the resident has the supervision needed to leave the unit. The facility is adjacent to a main road, thus, the Resident could have entered onto main road and suffered a serious adverse outcome. The Resident was found at the airport trying to buy a plane ticket out of the country. The airport is 8.5 miles from the facility. The facility failed to implement interventions, supervision, and effective safety measures to prevent elopement. The NHA was provided with the immediate jeopardy template on May 12, 2026, at 12:34 PM, and an immediate action plan was requested. The facility initiated immediate interventions on May 9, 2026, after the incident. Documents and actions provided by the facility to address the Immediate Jeopardy included the following: The receptionist was immediately re-educated on May 9, 2026, on visualizing every person that exits the facility and not leaving a resident out of the building and disciplinary action taken. Education was completed for receptionist currently working. One receptionist was on vacation, and another was per diem and will be educated before they work their next shift. Education was initiated to facility residents who leave the unit to go around the facility on the process of signing out when leaving the unit. A review was completed of residents who were previously considered an elopement risk and had their code alert bracelet removed in the last year. No concerns were identified. Completion date May 10, 2026. An audit was conducted to determine like residents completed on May 10, 2026. Residents with exit seeking behaviors were reviewed to confirm that facility procedures regarding facility elopement policies are followed. An exit seeking audit to include a review of elopement risk, will be completed daily for one week and weekly for three weeks for new admissions and resident with a change in condition to determine if they are at risk for elopement. Any Residents identified at risk in an audit will have a code alert bracelet applied, and care plan initiated. The daily audit was completed on May 10 and continued on May 11, and 12, 2026, and will continue daily for one week. The Medical Director was notified on May 9, 2026. Review of Resident 334's care plan revealed it was revised to include that Resident 334 was an elopement risk with the following interventions: 1:1 observation every shift, accompany to meals and scheduled activities due to risk of elopement attempts, allowed to vent feeling and/or frustration as needed, encourage socialization with others to provide recreational programming as tolerated, engage in activities/tasks to keep occupied, wander bracelet in place, when exhibiting exit seeking behavior, redirect to an appropriate area and provide supervision. Review of Resident 334's clinical record revealed orders to check placement of code alert (wander guard) per protocol of facility every shift, with a start date of May 10, 2026. Review of Resident 334's elopement risk evaluation conducted on May 10, 2026, revealed that the Resident was at risk for elopement, and has a wander guard/alarming security bracelet in place. The facility demonstrated past non-compliance by initiating immediate interventions by May 10, 2026, following the incident. Documents and actions provided by the facility to address the Immediate Jeopardy were reviewed and no concerns were identified. Audits were reviewed to ensure residents with exit seeking behaviors were reviewed and confirmed the facility's procedures regarding facility elopement policies are followed. Audits were reviewed for exit seeking residents with an elopement risk for new admissions and residents with a change in condition and there have been no other elopements that have occurred since this incident. The receptionist working during the day of the incident has been educated. Facility staff were interviewed during the onsite survey regarding the facility's Immediate (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Plan and demonstrated knowledge of the education. Observations made during the on-site survey on May 12, 2026, revealed there were no additional resident elopements that occurred out of the facility. The Immediate Jeopardy was lifted on May 12, 2026, at 4:26 PM, after ensuring that the immediate action plan had been implemented. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that a discharge summary was completed in a timely manner for one of three closed record charts reviewed (Resident 375). Findings include: Review of facility policy, titled Discharge Summary and Plan, last reviewed March 2026, it stated, When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed. Review of the facility check list for closed record, titled Discharge/Death Checklist, it stated for the Physician Planned/Unplanned D/C Summary Completed and Signed. Review of Resident 375's clinical record revealed a diagnoses that included End-Stage Renal Disease (ESRD-kidneys can no longer filter waste and excess fluid from the blood). Resident 375 required hemodialysis (a life-sustaining treatment for kidney failure that uses a machine to remove waste products and excess fluid from the blood). Review of Resident 375's clinical record revealed a transfer to the hospital on March 30, 2026. Review of Resident 375's clinical record revealed the Resident passed away at the hospital on March 31, 2026. Review of Resident 375's clinical record on May 12, 2026, revealed no discharge summary for March 2026 hospital transfer. Review of Resident 375's clinical record on May 13, 2026, revealed a discharge summary for March 31, 2026, that was put into the clinical record on May 13, 2026, at 1:29 PM. During an interview with the Nursing Home Administrator on May 14, 2026, at 11:09 AM, he confirmed that the discharge summary should be completed on schedule, which is 30 days after discharge. 28 Pa. Code 211.5(d) Medical records

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, for one of 35 residents reviewed (Resident 379).Findings include: Review of the facility policy, titled Wound Care last reviewed March 31, 2026, read, in part, Verify the physician's order for this procedure. The following information should be recorded in the resident's medical record: How the resident tolerated the procedure. If the resident refused the treatment and the reason why. Report other information in accordance with facility policy and professional standards of practice. Review of Resident 379's clinical record revealed diagnoses that included acquired absence of eye, schizophrenia (a chronic mental health condition characterized by disruptions in thought, perception, and behavior), and dysphagia (difficulty chewing and/or swallowing). Review of Resident 379's physician orders revealed an order for Cleanse right eyelid with NSS, pat dry, cover with 4x4 gauze, and secure with tape every day and as needed every night shift, with a start date of May 8, 2026. Observations of Resident 379 on May 11, 2026, at 12:03 PM; May 12, 2026, at 9:16 AM and 1:13 PM; and May 13, 2026, at 9:14 AM; revealed she did not have any gauze covering over her right eyelid. Interview with Resident 379 on May 13, 2026, at 9:14 AM, revealed the gauze covering was not over her eyelid because it does not stay in place. Review of Resident 379's May Treatment Administration Record revealed the order for the gauze was signed as completed on May 10, 11, and 12, 2026, on night shift. During an interview with Employee 1 (Registered Nurse) on May 13, 2026, at 9:18 AM, she revealed the gauze should be in place at all times, and she did not see anything in nursing report between shifts that the gauze was not in place. During an interview with Employee 2 (Licensed Practical Nurse) on May 13, 2026, at 9:19 AM, she revealed Resident 379 has behaviors of self-removing the gauze, but she had not yet noted anything in the clinical record. Review of Resident 379's behaviors nurse aide task failed to note any behaviors since her admission on [DATE]. Review of Resident 379's care plan failed to reveal behaviors of refusing treatment of self- removing the gauze to her eyelid. During an interview with the Director of Nursing on May 13, 2026, at 1:47 PM, the surveyor revealed the concern with the lack of Resident 379's treatment in place during observations and failure of any notation in the clinical record as to why it was not in place. No further information was provided. 28 Pa. Code 211.12(d)(1)(5) Nursing services