STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395777	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sugar Creek Care Center	351 Causeway Drive Franklin, PA 16323

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, facility documentation, and clinical records and staff interview, it was determined that the facility failed to review and/or revise comprehensive care plans to reflect the current necessary care and services for one of eight residents reviewed (Resident R1). Findings include: A facility policy entitled Care Plans, Comprehensive Person-Centered dated 5/09/25, revealed that each resident's care plan describes the services that will be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; which specialized services are responsible for each element of care; assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change; and the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition. Resident R1's clinical record revealed an admission date of 12/14/24, with diagnoses that included muscle wasting, depression, diabetic foot ulcer, with Parkinson's disease (age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate, and is best known for causing slowed movements, tremors, balance problems and more) being documented throughout the clinical record. A departmental progress note dated 1/06/25, revealed that Resident R1 had wrapped his/her call bell cord around his/her neck and stated, I don't want to live. Continued review of departmental progress notes revealed scattered notations regarding Resident R1 having every 15 minutes checks (visual confirmation of location and safety). An initial psychiatric evaluation dated 3/04/25, revealed a recommendation that Resident R1 continue with behavioral health services. Further review of Resident R1's clinical record lacked evidence that the facility developed and/or implemented a comprehensive care plan in response to Resident R1's current care needs and services. During an interview on 5/07/25, at 3:03 p.m. the Regional Clinical Consultant and Nursing Home Administrator confirmed that the facility failed to update Resident R1's comprehensive care plan to address his/her needs for behavioral health interventions and services. 28 Pa. Code 201.18 (b)(1)(3) Management (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of Pennsylvania Code Title 49 and Title 55: Professional and Vocational Standards, clinical records, facility staffing, and facility policy, and staff interviews, it was determined that the facility failed to have sufficient staff with the appropriate skill sets to provide nursing services including timely medication administration, and post-fall assessments for three of eight residents reviewed (Residents R5, R7, and R8). Findings include: Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.145 a. Prohibited Acts revealed a Licensed Practical Nurse (LPN) may not administer medications or fluids via arterial lines. Review of Pennsylvania Code Title 55. Additional Assessments 2800.225 revealed an LPN, under the supervision of a Registered Nurse (RN), or an RN shall complete additional written assessments for each resident. A facility policy entitled Administering Medications dated 5/09/25, indicated that staffing schedules are arranged to ensure that mediations are administered without unnecessary interruptions, and that medications are administered within one hour of their prescribed time. Resident R5's clinical record revealed an admission date of 4/06/25, with diagnoses that included partial amputation of right foot, dehiscence (the separation or splitting open of a wound, typically after surgery), bacterial infection in the blood stream, and gangrene (serious condition where tissue death occurs due to a lack of blood supply, often accompanied by infection). Resident R5's clinical record revealed a physician's order dated 4/11/25, to insert a new double lumen PICC line (peripherally inserted central line [arterial]- type of central venous access device that has two separate tubes within the catheter [flexible tube] in right arm); a physician's order dated 4/13/25, to administer Vancomycin HCl (antibiotic) 1250 milligrams (mg) intravenously two times a day; and a physician's order dated 4/14/25, to administer Cefazolin (antibiotic) two grams intravenously every 8 hours. Review of Resident R5's medication administration record revealed that on 4/26/25, the midnight dose of Cefazolin and the 6:00 a.m. dose of Vancomycin were not administered through his/her PICC line. Resident R5's departmental progress noted revealed there was no RN available to administer the PICC line medications on 4/25/25, overnight (11 p.m.-7:00 a.m.) shift. Resident R7's clinical record revealed an admission date of 12/18/24, with diagnoses including dementia, stroke, abnormal gait, and lack of coordination. A report of an un-witnessed fall occurring on 4/25/25, at 11:30 p.m. revealed the written assessment of Resident R7 after his/her fall was completed by the LPN, not an RN. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R8's clinical record revealed an admission date of 3/06/25, with diagnoses that included Parkinson's disease (age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate, and is best known for causing slowed movements, tremors, balance problems and more), repeated falls, and neurocognitive disorder with Lewy bodies (type of dementia characterized by cognitive decline, movement problems, and visual hallucinations). A report of an un-witnessed fall occurring on 4/25/25, at 10:30 p.m. revealed the written assessment of Resident R8 after his/her fall was completed by the LPN, not an RN. Review of facility staffing for the 4/25/25, overnight shift revealed there was no RN scheduled to administer Resident R5's PICC line medications and complete written assessments for Residents R7 and R8. During an interview on 5/07/25, at 2:51 p.m. RN Employee E1 confirmed that he/she had already worked 16 hours and was instructed to go home, and he/she did not administer the PICC line medications or complete the written assessments after the above falls. During an interview on 5/07/25, at 2:51 p.m. the Director of Nursing confirmed he/she had worked all day and was not able to stay to cover the shift. During an interview on 5/07/25, at 2:51 p.m. the Nursing Home Administrator confirmed that the facility failed to have an RN available at the facility to cover the above overnight shift. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(4)(5) Nursing services

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on review of facility policy, facility documents and clinical records, and staff interviews, it was determined that the facility failed to make certain residents receive appropriate treatment and services to attain the highest practicable mental and psychosocial well-being for one of eight residents reviewed (Resident R1). Findings include: A facility policy entitled Behavioral Health Services dated 5/09/25, indicated behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care, and residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. Resident R1's clinical record revealed an admission date of 12/14/24, with diagnoses that included muscle wasting, depression, diabetic foot ulcer, with Parkinson's disease (age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate, and is best known for causing slowed movements, tremors, balance problems and more) being documented throughout the clinical record. A departmental progress note dated 1/06/25, revealed that Resident R1 had wrapped his/her call bell cord around his/her neck and stated, I don't want to live. Continued review of departmental progress notes revealed scattered notations regarding Resident R1 having every 15 minutes checks (visual confirmation of location and safety). An initial psychiatric evaluation dated 3/04/25, revealed a recommendation that Resident R1 continue with behavioral health services. Further review of Resident R1's clinical record lacked evidence that the facility continued to provide recommended behavioral health services. During an interview on 5/07/25, at 3:00 p.m. the Nursing Home Administrator confirmed there was no evidence that Resident R1 continued behavioral health services. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services