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	08/08/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of the Pennsylvania Code Title 49. Professional and Vocational Standards, facility job descriptions, clinical records, and staff interview, it was determined that the facility failed to follow nursing standards of practice to ensure physician orders were entered into point click care (PCC-a healthcare software used to track and administer healthcare operations in a long-term care facility) upon admission to ensure timely medication availability and timely medication administration for one of 17 residents reviewed (Resident R1). Findings include: Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.11. General functions of the Registered Nurse (RN) (a)(4) stated, Carries out nursing care actions which promote, maintain and restore the well-being of individuals and (b) The RN is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice. Review of the facility's job description for RNs revealed To provide direct nursing care under the medical direction and supervision of the residents' attending physicians, the Director of Nursing Services, and the Medical Director of the facility. Responsible for interpretation and execution of physician's orders and calling the physician as indicated. Is responsible for competent administration of care and treatments according to physicians orders and facility policy and procedure.Prepare residents for admission.Assure documentation is complete and incorporated into the clinical records in compliance with facility policy. Review of Resident R1's clinical record revealed an admission date of 3/4/23, with diagnoses that included idiopathic pulmonary fibrosis (a lung disease that causes irreversible scarring in the lungs), sleep apnea (breathing starts and stops during sleep), and acute and chronic respiratory failure. Resident R1's clinical record revealed he/she returned to the facility from the hospital on 6/12/25, at 4:15 p.m. His/her medication orders were not placed into PCC for floor nurses to be alerted when scheduled medications were due to be administered or for the administration of PRN (as needed) medications until 6/13/25, at 10:31 a.m., which was approximately 18 hours after Resident R1 had returned from the hospital. Resident R1's clinical record progress notes dated 6/13/25, at 2:30 p.m. and 2:34 p.m. documented that Resident R1 was short of breath and his/her pulse ox (test used to measure the amount of oxygen in the blood) was 76% on room air, which was well below the desired percentage of 90% or higher. The nurses on duty had to call the physician for an order to treat the resident due to the orders not being placed in PCC timely. Resident R1 indicated that he/she had not had breathing treatment since returning from the hospital the day prior. Resident R1's admission orders included Albuterol 90 MCG [microgram] inhaler (medication used to treat and prevent breathing difficulties) 2 puffs every 4 hours PRN and Budesonide 2 milliliters (medication used to reduce inflammation and swelling in the airways making it easier to breath) twice a day via nebulizer (a machine used to convert liquid medication into an inhalable mist), which could have been used during their documented episode of respiratory distress, had the medications been entered in PCC timely. During an interview on 8/7/25, at 2:07 p.m. the Director of Nursing confirmed that the RN failed to enter physician orders timely and that it is the RN's responsibility to ensure orders are entered into PCC timely upon admission to the facility. 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to enter physician's orders timely resulting in a delay in treatment for one of 17 residents reviewed (Resident R1).Findings include: Review of facility policy entitled, Administering Medications 5/9/25, indicated, Medications are administered in a safe and timely manner, and as prescribed. Review of Resident R1's clinical record revealed an admission date of 3/4/23, with diagnoses that included idiopathic pulmonary fibrosis (a lung disease that causes irreversible scarring in the lungs), sleep apnea (breathing starts and stops during sleep), and acute and chronic respiratory failure. Resident R1's clinical record revealed he/she returned to the facility from the hospital on 6/12/25, at 4:15 p.m. His/her medication orders were not placed into point click care (PCC-a healthcare software used to track and administer healthcare operations in a long-term care facility) for floor nurses to be alerted when scheduled medications were due to be administered or for the administration of PRN (as needed) medications until 6/13/25, at 10:31 a.m., which was approximately 18 hours after Resident R1 had returned from the hospital. Resident R1's clinical record progress notes dated 6/13/25, at 2:30 p.m. and 2:34 p.m. documented that Resident R1 was short of breath and his/her pulse ox (test used to measure the amount of oxygen in the blood) was 76% on room air, which was well below the desired percentage of 90% or higher. The nurses on duty had to call the physician for an order to treat the resident due to the orders not being placed in PCC timely. Resident R1 indicated that he/she had not had breathing treatment since returning from the hospital the day prior. Resident R1's admission orders included Albuterol 90 MCG [microgram] inhaler (medication used to treat and prevent breathing difficulties) 2 puffs every 4 hours PRN and Budesonide 2 milliliters (medication used to reduce inflammation and swelling in the airways making it easier to breath) twice a day via nebulizer (a machine used to convert liquid medication into an inhalable mist), which could have been used during their documented episode of respiratory distress, had the medications been entered in PCC timely. During an interview on 8/7/25, at 2:07 p.m. the Director of Nursing confirmed that the facility failed to enter physician's orders timely which resulted in a delay in treatment related to Resident R1's episode of respiratory distress. 28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.12(d)(1)(5) Nursing Services