

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2025
NAME OF PROVIDER OR SUPPLIER  Sugar Creek Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of the facility admission process and policies, observations, and staff interviews, it was determined that the facility failed to maintain resident dignity for one of two residents observed related to incontinence care (Resident R1). Findings include: Facility provided documentation of the facility ' s admission packet revealed that a resident has a right to be treated with respect and dignity. Resident rights - The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality. The facility must protect and promote the rights of the resident. Facility policy entitled, Perineal Care, dated 6/04/25, indicated the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition. Review the resident ' s care plan to assess for any special needs of the resident. Facility policy entitled, Activities of Daily Living (ADL), Supporting, dated 6/04/25, indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Resident's R1's clinical record revealed an admission date of 9/05/20, with diagnoses that included spastic hemiplegia affecting left nondominant side (a neuromuscular condition causing constant muscle contractions on the side of the body leading to stiffness, weakness, and limited movement), depression, anxiety, and need for assistance with personal care. Resident R1 ' s care plans dated 9/03/25, revealed a plan of care for bladder incontinence related to impaired mobility with interventions to clean peri-area with each incontinence episode, and staff will provide incontinence products to contain urine, promote skin integrity and provide dignity. Observations on 11/05/25, at 9:30 a.m. revealed Resident R1 was sitting in his/her wheelchair in his/her room on his/her buttocks. Observations at 10:00 a.m., 10:40 a.m., 11:15 a.m., 11:35 a.m., 12:00 p.m., 12:10 p.m., 1:30 p.m., revealed Resident R1 remained sitting in his/her wheelchair in their room on his/her buttocks. At 1:45 p.m. Resident R1 was transferred to his/her bed and incontinence care was provided by Nursing Assistant (NA) Employee E2 and Licensed Practical Nurse (LPN) Employee E3. Resident R1 was observed with his/her incontinence briefs (two briefs) filled with feces overflowing outside of briefs and onto pants and skin of both extremities. Resident R1 ' s peri area and buttocks were observed extremely red. NA Employee E2 and LPN Employee E3 confirmed during incontinence care at 1:45 p.m. that Resident R1 should have been checked/changed every two hours, but was not due to large amount of feces overflowing the two incontinence briefs onto his/her clothing and legs, and Resident R1 had severely reddened skin from not being repositioned and checked/changed timely. NA Employee E2 and LPN Employee E3 confirmed also that having two briefs placed on a resident is not the facility ' s protocol for incontinence/prevention of skin breakdown. Interviews with Resident R1 on 11/05/25, at 10:40 a.m., 11:35 a.m., and 1:30 p.m. indicated he/she had been out of bed sitting in his/her wheelchair since 6:30 a.m. and not checked/changed or repositioned since 6:30 a.m. During an interview on 11/12/25, at 12:30 p.m. the Nursing Home Administrator (NHA), confirmed that the facility failed to maintain dignity for Resident R1 by placing two briefs on for incontinence care. The NHA further confirmed that it is not the facility ' s policy to have two briefs on a resident for incontinence care. 28 Pa. Code 211.12(d)(3)(5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on a review of facility policy, clinical and facility records, resident and staff interviews, and observations, it was determined that the facility failed to provide a bath/shower as resident preference for four of 13 residents (Resident R1, R2, R3, and R4) and failed to assure residents attain or maintain the highest practicable mental and psychosocial well-being by not serving meals in the dining room and having group activities for six of 13 residents (Residents R1, R4, R6, R7, R8, and R9). Findings include: No facility policy was provided for showers. Review of a facility policy entitled Coronavirus Disease dated 6/04/25, indicated The interdisciplinary team reviews an outbreak to see if they should refrain from communal activities. This should be reviewed on a daily basis so it can be lifted as soon as the spread of the infection is determined to have slowed. Resident's R1's clinical record revealed an admission date of 9/05/20, with diagnoses that included spastic hemiplegia affecting left nondominant side (a neuromuscular condition causing constant muscle contractions on the side of the body leading to stiffness, weakness, and limited movement), depression, anxiety, and need for assistance with personal care. Resident R1 ' s bath/shower documentation for 10/09/25, through 11/07/25, revealed he/she was scheduled for a bath/shower on Tuesday/Friday 7-3 p.m., however, no bath/shower was provided on the following dates: 10/10/25, 10/14/25, 10/17/25, 10/21/25, 10/24/25, 10/28/25, and 10/31/25. Resident's R2 ' s clinical record revealed an admission date of 3/07/23, with diagnoses that included high blood pressure, chronic kidney disease, coronary artery disease (a condition where the arteries to the heart becomes narrowed or blocked due to build up of plaque), and cardiac heart failure (a condition where the heart is unable to pump the blood effectively to give the body its normal supply). Resident R2 ' s bath/shower documentation for 10/09/25, through 11/07/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, no bath/shower was provided on: 10/11/25 10/15/25, marked as N/A (not applicable) 11/01/25, marked as N/A (not applicable). During an interview with Resident R2 on 11/05/25, at 11:00 a.m. he/she stated, I would like to have two showers or baths a week, but I ' m lucky if I get one. Resident's R3's clinical record revealed an admission date of 10/21/25, with diagnoses that included fracture of facial bones, rhabdomyolysis (a serious condition where damaged muscle tissue breaks down and releases muscle fiber content into the blood), high blood pressure, and diabetes mellitus (a condition when you blood sugar is too high due to pancreas not making or releasing enough insulin or both). Resident R3 ' s bath/shower documentation for 10/09/25, through 11/07/25, revealed he/she was scheduled for a bath/shower on Tuesday/Friday 3-11 p.m. however, no bath/shower was provided on: 10/24/25 10/28/25, marked as N/A (not applicable) 10/29/25, marked as N/A (not applicable) 10/30/25, marked as N/A (not applicable) 10/31/25, marked as Resident not available 11/01/25, marked as N/A (not applicable) 11/03/25, marked as N/A (not applicable) 11/04/25, marked as N/A (not applicable). During an interview with Resident R3 on 11/05/25, at 12:20 p.m. he/she stated, I ' ve only received two showers since I ' ve been here. It would feel great to get more, but it hasn ' t happened. An observation at that time revealed Resident R3 with greasy hair. Resident's R4's clinical record revealed an admission date of 12/13/24, with diagnoses that included anoxic brain damage (a type of brain injury caused by a lack of oxygen to the brain), spastic hemiplegia affecting unspecified side, long term use of anticoagulants (a medication that slows down the body ' s process of making clots), and hypothyroidism (a condition that happens when the thyroid gland doesn ' t make enough thyroid hormone to meet the body ' s needs). Resident R4 ' s bath/shower documentation for 10/09/25, through 11/07/25, revealed he/she was scheduled for a bath/shower on Monday and Thursday 3-11 p.m. however, no bath/shower was provided on: 10/20/25, marked as N/A (not applicable) 10/27/25, marked as N/A (not applicable). During an interview on 11/05/25, at 1:20 p.m. Resident R4 indicated that he/she does not always get his/her bath as scheduled, and the staff tell him/her if they have time, he/she will get one. Resident R4 indicated that their preference is Monday and Thursday. An observation at that time revealed Resident R4 with greasy hair. An interview with the Nursing Home Administrator (NHA) on 11/07/25, at 1:30 p.m. confirmed showers are given per resident ' s preference and are encouraged twice a week. The NHA further confirmed that baths/showers were not provided according to Resident R1, R2, R3, and R4 ' s scheduled days and preference for the period of 10/09/25, through 11/07/25. The facility line listing report for respiratory illness on 11/12/25, revealed no new positive residents since 11/4/25, which indicated that the spread of the infection had slowed. Resident interviews on 11/5/25, between 11:35 a.m. and 12:30 p.m. with Residents R1, R4, R6, R7, R8, and R9 indicated they enjoy eating their meals in the dining room with other residents. They also indicated that they</p>		

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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.  (continued on next page)		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policies, clinical records, and the Long Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual 2025 (RAI-assessment guide used to plan the provision of care for residents), observations, and resident and staff interviews, it was determined that the facility failed to provide care in accordance with professional standards for repositioning and pressure relief for two of two residents reviewed (Residents R1 and R5), and incontinence care for one of two residents observed (Resident R1). Findings include: Facility policy entitled Repositioning dated 6/04/25, indicated Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. and Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Facility policy entitled, Perineal Care, dated 6/04/25, indicated the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition. Review the resident ' s care plan to assess for any special needs of the resident.Facility policy entitled, Activities of Daily Living (ADL), Supporting, dated 6/04/25, indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Resident's R1's clinical record revealed an admission date of 9/05/20, with diagnoses that included spastic hemiplegia affecting left nondominant side (a neuromuscular condition causing constant muscle contractions on the side of the body leading to stiffness, weakness, and limited movement), depression, anxiety, and need for assistance with personal care. Resident R1 ' s care plans dated 9/03/25, revealed a plan of care for potential impairment to skin integrity/potential for pressure ulcer related to fragile skin/incontinence/limited mobility, with interventions to encourage resident to be turned and repositioned for comfort and relief of pressure. Care plans for limited mobility revealed the resident has limited physical mobility related to limited mobility with interventions for the Maxi lift (a mechanical lift to move a person from a chair to bed/bed to chair) as needed for all transfers and for out of bed to chair and resident is able to complete bed mobility with a two person assist. Care plans for bladder incontinence revealed the resident has bladder incontinence related to impaired mobility with interventions to clean peri-area with each incontinence episode, and staff will provide incontinence products to contain urine, promote skin integrity and provide dignity. Resident R1 ' s MDS (Minimum Data Set) dated 9/03/25, under section GG0170 mobility revealed A. roll left and right response was 01 Dependent, E. chair to bed/bed to chair transfer response was 01 Dependent. Section H0300 urinary continence revealed the resident is frequently incontinent of urine. Section H0400 bowel continence revealed the resident is frequently incontinent of bowel. Section C0500 Brief Interview for Mental Status (BIMS) revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired. Resident R1 ' s BIMS is 15/15. Resident R1 ' s clinical documentation revealed a note from the wound Nurse Practitioner dated 10/23/25, indicated resident ' s wounds to be resolved and recommend applying zinc-based barrier cream to the peri sacral region at least three times daily and as needed incontinence/prevention.Observations on 11/05/25, at 9:30 a.m. Resident R1 was sitting in his/her wheelchair in his/her room on his/her buttocks. Observations at 10:00 a.m., 10:40 a.m., 11:15 a.m., 11:35 a.m., 12:00 p.m., 12:10 p.m., 1:30 p.m., Resident R1 remained sitting in his/her wheelchair in his/her room on his/her buttocks. At 1:45 p.m. Resident R1 was transferred to his/her bed and incontinence care was provided by Nursing Assistant (NA) Employee E2 and Licensed Practical Nurse (LPN) Employee E3. Resident R1 was observed with his/her incontinence briefs (two briefs) filled with feces overflowing outside of briefs and onto pants and skin of both extremities. Resident R1 ' s peri area and buttocks were observed extremely red. NA Employee E2 and LPN Employee E3 confirmed during incontinence care at 1:45 p.m. that Resident R1 should have been checked/changed every two hours, but was not due to large amount of feces overflowing the two incontinence briefs onto his/her clothing and legs, and Resident R1 had severely reddened skin from not being repositioned and checked/changed timely. NA Employee E2 and LPN Employee E3 confirmed also that having two briefs placed on a resident is not the facility ' s protocol for incontinence/prevention of skin breakdown. Interviews with Resident R1 on 11/05/25, at 10:40 a.m., 11:35 a.m., and 1:30 p.m. indicated he/she had been out of bed sitting in their wheelchair since 6:30 a.m. and not checked/changed or repositioned since 6:30 a.m. Review of Resident R5 ' s clinical</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>Based on review of facility policy and records, observations, and resident and staff interview it was determined that the facility failed to provide food that was palatable and at an appetizing temperature for one of one test trays completed. Findings include:A facility policy entitled, Meal Service Line dated 6/4/25, revealed Food will be prepared by methods that conserve nutritive value, flavor and appearance, and will be placed on trays in an attractive manner as near to the time of actual tray service as possible. This is done to ensure acceptable temperatures of food when the tray is served to the resident. Resident council and food committee minutes from 8/5/25, and 10/13/25, indicated that a toasted cheese sandwich was cold and that lunch and dinner trays on the unit are being served up to 45 minutes late. During an interview on 11/5/25, at 12:30 p.m. Resident R6 who resides on 600 Hall indicated his/her food is often served cold. Review of temperature logs completed by kitchen staff on 11/5/25, revealed the following lunch meal temperatures: Pork 170 degrees Fahrenheit (F)Baked Potatoes 170 degrees FCorn 169 degrees FObservations on 11/5/25, at approximately 11:55 a.m. in the main kitchen revealed Cart 1 for the 600 Hall had just left the kitchen. Tray line was observed for Cart 2 of the 600 Hall and a test tray was prepared last and placed on the cart. The Dietary Manager escorted the cart to the 600 Hall at 12:26 p.m. and arrived at the 600 Hall at 12:27 p.m. Cart 1 was still sitting in the hall and had not been passed to the residents. Tray pass was completed for 600 Hall Cart 1 and Cart 2 at 12:42 p.m.A test tray at the conclusion of resident room tray delivery on the 600 Hall was completed at 12:42 p.m. and revealed the following temperatures:Pork 138 degrees FBaked Potatoes 145 degrees FCorn 143 degrees FALL the items were tasted and were not palatable due to the cool temperatures. Dietary Manager Employee E4 confirmed the unacceptable temperatures and poor palatability at the time of the tray testing. 28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to prevent the potential for cross-contamination during completion of incontinence care (care provided for someone who has lost control of their bladder and/or bowel movements) for two of two residents observed (Residents R1 and R5). Findings include: Review of facility policy entitled Perineal Care dated 6/4/25, indicated Steps in the procedure . discard disposable items into designated containers. Review of facility policy entitled Diarrhea and Fecal Incontinence dated, 6/4/25, indicated Disposable items soiled with feces (i.e., disposable briefs .) must be handled as so to prevent contamination of the environment with feces. Observations on 11/5/25, at 1:45 p.m. revealed Nursing Assistant (NA) Employee E1, NA Employee E2, and Licensed Practical Nurse (LPN) Employee E3 completing incontinence care for Resident R1. During incontinence care NA Employee E2 removed resident R1 ' s pants and brief (a disposable incontinence pad) which was soiled (contained urine and feces). NA Employee E1 then placed the pants and brief onto the floor. After completing incontinence care NA Employee E2 picked up Resident R1 ' s pants and brief and placed them in a garbage can. Employees E1, E2 and E3 walked across the floor where the soiled pants and soiled brief had been lying. Observations on 11/5/25, at 2:15 p.m. revealed NA Employee E1 and NA Employee E2 completing incontinence care for Resident R5. During incontinence care NA Employee E1 removed resident R5 ' s pants and brief, NA Employee E1 then placed Resident R5 ' s soiled brief onto the floor. After completing incontinence care, NA Employee E1 picked up Resident R5's soiled brief and took it out of the room. Both NA Employees E1 and E2 walked across the floor where the soiled brief had been lying. During an interview on 11/5/25, at 2:35 p.m. NA Employees E1 and E2 confirmed that Resident R1 and Resident R5 ' s briefs contained urine and feces, and the soiled briefs were placed on the floor. They confirmed that they had walked across the floor where the soiled briefs had been lying, and the floor should have been sanitized after the briefs were removed. During an interview on 11/5/25, at 2:40 p.m. the Director of Nursing confirmed that soiled briefs should not be placed on the floor and that the soiled briefs should be placed in a designated container. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		