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	08/29/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure physician's orders and resident Pennsylvania Order for Life Sustaining Treatment (POLST - a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 20 residents reviewed (Resident R19). Findings include:A facility policy entitled Advanced Directives dated [DATE], indicated that the plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. Resident R19's clinical record revealed an admission date of [DATE], with diagnoses that included gastro-esophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R19's clinical record revealed a physician's order dated [DATE], for Full Code (staff to implement Cardiopulmonary Resuscitation [CPR] - emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). Further review revealed additional physician's orders dated [DATE], for Full Code - POLST on file; [DATE], Living Will - see chart for instructions; and [DATE], DNR (Do not attempt resuscitation and allow natural death). Resident R19's clinical record revealed a Living Will signed and dated on [DATE], that indicated DNR and to follow if I become incompetent. Further review revealed a POLST signed and dated by Resident R19 and his/her physician on [DATE], indicating Full Code. Resident R19's clinical record revealed progress notes completed by Resident R19's physician dated [DATE], indicating he/she was a Full Code per resident. Further review revealed a progress note dated [DATE], completed by Social Services indicating The resident is no longer a full code, DNR per Living Will [DATE]. Progress note dated [DATE], by nursing indicated Resident's advanced directives updated in electronic chart to match most recent Advance directive/ living will. Progress note dated [DATE], completed by physician indicating Now DNR as of [DATE]. Progress note dated [DATE], completed by physician indicating No CPR- see POLST.During an interview on [DATE], at 2:34 p.m. Licensed Practical Nurse (LPN) Employee E3 stated each unit has a binder with each resident's face sheet and advanced directive or POLST. Review of the binder revealed Resident R19's face sheet and POLST dated [DATE], indicating Full Code were present. During an interview on [DATE], at 11:03 a.m. LPN Employee E3 revealed that the License Nurse Report sheet that included Resident R19 indicated that Resident R19 was a Full Code. LPN Employee E3 reviewed and confirmed that Resident R19's POLST dated [DATE], also indicated he/she was a Full Code, and this was the most recent document signed by Resident R19. LPN Employee E3 reviewed and confirmed that Resident R19's physician's orders indicated he/she was a DNR. LPN Employee E3 confirmed that Resident R19's physician's orders and POLST did not match. 28 Pa. Code 201.18 (b)(1)(e)(1) Management28 Pa. Code 201.29(a) Resident rights28 Pa. Code 211. 5(f)(i) Medical records28 Pa. Code 211.10(c) Resident care policies

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

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	08/29/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to provide resident privacy during medication administration for one of six residents observed (Resident R107). Findings include: Review of facility policy entitled Dignity dated 6/4/25, indicated Residents are treated with dignity and respect at all times. And Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During observation of medication administration for Resident R107 on 8/27/25, at 1:33 p.m. Licensed Practical Nurse (LPN) Employee E2 was administering medications through Resident R107's G-Tube (a tube placed in the stomach to provide nutrition). Resident R107's night gown was pulled up exposing his/her legs, incontinence care product, and stomach. Resident R107 was able to be viewed from the hallway. LPN Employee E2 failed to close the residents' door and/or pull the privacy curtain while administering medications through Resident R107's G-Tube. During an interview on 8/27/25, at 1:54 p.m. LPN Employee E2 confirmed that the door and/or privacy curtain was not closed during medication administration for Resident R107. He/she confirmed that Resident R107 was exposed and was able to be viewed from the hallway and also confirmed that Resident R107's door and/or privacy curtain should be closed during medication administration to maintain privacy. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	08/29/2025

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 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 review of facility policies, clinical records, and staff interviews it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day); failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital; and failed to complete a discharge summary for four of 20 residents reviewed (Residents R1, R2, R103, and R105). Findings include: Review of facility policy entitled “Bed-Holds and Returns” dated 6/4/25, indicated “All residents/representatives are provided written information regarding the facility bed-hold policies… at the time of transfer…” Review of facility policy entitled “Discharge Summary and Plan” dated 6/4/25, indicated that when a facility anticipates a resident’s discharge to a private residence, another nursing care facility a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living arrangements. The discharge summary will include a recapitulation of the resident’s stay at the facility and a final summary of the resident’s status at the time of discharge. The policy further stated that a copy will be provided to the resident and receiving facility and a copy will be filed in the resident’s medical records. Review of facility policy entitled “Transfer or Discharge, Emergency” dated 6/4/25, indicated “Should it become necessary to make an emergency transfer… to a hospital… prepare a transfer form to send with the resident.” Resident R1’s clinical record revealed an admission date of 1/5/23, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), obstructive and reflux uropathy (a condition that will not let the urine drain naturally), and chronic obstructive pulmonary disease (when your lungs do not have adequate air flow). Resident R1’s progress notes revealed a note dated 4/23/25, indicating a transfer to the hospital. The clinical record lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer. Resident R2’s clinical record revealed an admission date of 12/8/22, with diagnoses that included congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Resident R2’s progress notes revealed a note dated 3/14/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that the resident and/or his/her representative were provided with a copy of the bed-hold policy upon transfer. (continued on next page)

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	08/29/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R103's clinical record revealed an admission date of 6/11/25, with diagnoses that included sciatica (pain that radiates along the sciatic nerve from the lower back through the buttocks and down the back of the thigh), hypertension, and hyperlipidemia. Resident R103’s progress notes revealed a note dated 7/11/25, indicating a transfer to the hospital. The clinical record also lacked evidence indicating that the resident and/or their representative were provided with a copy of the bed-hold policy upon transfer. Resident R105’s clinical record revealed an admission date of 7/1/25, with diagnoses that included ulnar fracture (broken bone in forearm), gastro-esophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and high blood pressure. Resident R105’s clinical record revealed he/she was discharged to home on 7/23/25. The clinical record lacked evidence that a discharge summary was completed and/or provided to Resident R105 at the time he/she was discharged home. During an interview on 8/29/25, at 11:10 a.m. the Director of Nursing (DON) confirmed that there was no evidence that Residents R1, R2 and R103 and/or their representatives were provided with a copy of the bed-hold policy that included the cost per day. The DON also confirmed that there was no evidence that Resident R2’s necessary clinical information was provided to the receiving healthcare provider upon transfer and that when the transfers occurred the resident and/or his/her representative should have been provided with bed hold policy and clinical information should be provided to the receiving healthcare provider upon transfer. During an interview on 8/29/25, at 11:11 a.m. the DON confirmed that Resident R105’s clinical record lacked evidence of a discharge summary being completed and/or provided to Resident R105 at the time he/she was discharged home. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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	08/29/2025

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 and clinical records and staff interview, it was determined that the facility failed to review and/or revise resident care plans to reflect resident's current condition for one of 20 residents reviewed (Resident R38).Findings include: Review of facility policy entitled Care Plan Completion, Updating, Reviews, and Auditing Compliance Process dated 6/2/25, revealed that care plan reviews are required to be an interdisciplinary review and goal setting for each resident. Resident R38's clinical record revealed an admission date of 6/19/25, with diagnoses that included Cellulitis of Left Lower Leg (a skin infection caused by bacteria, most commonly affecting the lower legwith symptoms incluing swelling, pain, warmth, and redness), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Review of Resident R38's care plans on 8/28/25, revealed a focus or problem initiated on 6/30/25, Resident is on enhanced barrier precautions related PICC line and wounds. Clinical record progress notes revealed PICC line was dislodged and removed on 7/30/25. Review of Resident R38's care plans on 8/28/25, revealed a focus or problem initiated on 6/27/25, Resident is on IV antibiotics related to cellulitis of the left foot. Clinical record progress notes revealed the last dose of IV antibiotics was received on 7/30/25. Review of Resident R38's care plans on 8/28/25, revealed a focus or problem initiated on 8/1/25, Resident has C-Difficile related to C-Diff. Clinical record progress notes revealed that on 8/8/25, Resident R38's C-diff results were negative and isolation was discontinued. Review of Resident R38's clinical record progress notes dated 8/22/25, indicated a care plan meeting was held. During an interview on 8/29/25, at 8:54 a.m. the Director of Nursing confirmed that Resident R38's care plans were not updated to reflect Resident R38's current status and care needs. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211. 12(d)(3)(5) Nursing services

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	08/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to prevent the opportunity for potential unauthorized access of medications and failed to appropriately discard outdated medications for two of three medication carts reviewed (Medication carts 400 and 600).Findings include: Review of facility policy entitled Administering Medication dated 6/4/25, indicated The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse., and The cart must be clearly visible to the personal administering medications. Review of manufacturer's guidelines revealed that an open pen of Aspart Insulin must be used within 28 days after opening or be discarded. Review of manufacturer's guidelines revealed that an open pen of Victoza must be used within 30 days after opening or be discarded even if some medicine is left in the pen. Observations of drug storage on 8/26/25, at 11:38 a.m. of the 400 medication cart revealed an open Aspart Insulin pen with no date indicating when the insulin pen was open, an open pen of Victoza with no date indicating when the pen was open, and an open bottle of loratadine tablets with an expiration date of 1/2025. During an interview at the time of observations with Licensed Practical Nurse (LPN) Employee E1, he/she confirmed that the open pens of Aspart and Victoza lacked open dates, and staff were unable to determine the discard dates. LPN Employee E1 also confirmed that the open bottle of loratadine tablets were beyond their expiration date and that the open bottle of loratadine tablets, the Aspart and Victoza pens should have been discarded. Observation on 8/27/25, at 1:33 p.m. revealed that LPN Employee E2 prepared medications for a resident from the 600 hall medication cart parked in the hall outside of a resident's room. LPN Employee E2 then proceeded into the resident room to administer medications. Upon entering the resident room LPN Employee E2 proceeded to the side of the resident's bed with his/her back toward the doorway. LPN Employee E2 did not securely lock the 600 hall medication cart. LPN Employee E2 was unable to view the medication cart from the resident's bedside. During an interview on 8/27/25, at 1:54 p.m. LPN Employee E2 confirmed that he/she left the medication cart unlocked while it was parked in the hallway outside of the resident's room, which was out of his/her view during administration of medications and confirmed that the medication cart should be locked when out of his/her view. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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	08/29/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on review of facility policy, clinical records, resident council minutes, and resident and staff interview, it was determined that the facility failed to provide dental services in a timely manner for one of 20 residents reviewed (Resident R97). Findings include: The facility policy entitled Dental Services, dated 6/4/25, revealed Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting dental services; and the reason for the delay. Resident R97's clinical record revealed an admission date of 9/6/19, with diagnoses that included major depressive disorder, cerebral infarction (stroke-blood flow to the brain is interrupted), and hypothyroidism (thyroid gland does not produce enough thyroid hormones). Review of Resident R97's clinical record progress notes revealed that on 3/17/25, and 3/18/25, the Speech Therapist documented that Resident R97 requested pureed/ground foods until he/she receives his/her dentures. On 4/30/25, the physician documented that Resident R97 was very unhappy that the dentist extracted his/her lower teeth, took impressions, but still does not have dentures after waiting for months, and attributes his/her eating difficulties to the lack of lower teeth and when he/she goes out to eat with his/her family he/she has to order soft foods or soups. The Registered Nurse (RN) documented on 4/30/25, indicating a new order was received from the physician to follow up with dental regarding lower dentures. On 6/25/25, the physician documented that Resident R97 still does not have lower dentures. The RN documented on 6/26/25, a new order was received from the physician to follow up on dentures. On 8/13/25, the physician documented no lower dentures yet. Resident R97's clinical record revealed his/her remaining lower teeth were extracted on 9/27/24, indicating he/she has not had lower teeth for almost an entire year. Review of resident council minutes from July 2025, revealed that Resident R97 attended and inquired regarding his/her dentures from the 360 Dental Program. Resident council minutes in August 2025, revealed a follow up indicating that the 360 Dental Program is changing the frequency of their services and will only be coming every 90 days rather than every 30 days. During an interview on 8/26/25, Resident R97 revealed he/she is very upset regarding not having lower dentures for several months. Resident R97 indicated that he/she has been waiting way too long to get lower dentures and that not having lower dentures makes it difficult to eat the things he/she would like to eat, and it is affecting his/her quality of life. During an interview on 8/28/25, at 1:45 p.m. the Director of Nursing confirmed that Resident R97 has not received his/her lower dentures in a timely manner. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.15 Dental services