STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395777	A. BLDG: 00 B. WING:	01/03/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUGAR CREEK CARE CENTER STATE LICENSE NUMBER: **220602**	**351 CAUSEWAY DRIVE** **FRANKLIN, PA 16323**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Follow-Up Survey completed on January 3, 2025, it was determined that Sugar Creek Care Center failed to correct all the deficiencies cited during the survey of November 19, 2024, and continued to be out of compliance with the following requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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P 5520		P 5520		

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	"The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements." 1. The facility cannot correct that the nurse aide staffing ratio was not met on 12/19,12/22, 12/24, 12/25, 12/26, 12/28, and 12/29/24. 2. System changes will be put into place to ensure minimum requirements to be put into place will include: 3. Facility currently has multiple nursing staff members in the onboarding process to start	Completion Date: **01/24/2025** Status: **APPROVED** Date: **01/09/2025**

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P 5520	Continued from page 2	P 5520	employment at the facility. 4. All nursing positions are actively posted in recruitment. 5. Holding open interview day 6. Bonuses are offered on an as needed basis. 7. Staff are mandated as appropriate. 8. Call offs will continue to be monitored, and disciplines will be issued, as appropriate. 9. When call offs occur, all available staff members will be called to ask it they will fill the vacancy to ensure the appropriate staffing levels. 10. On a daily basis, the facility reviews the ability to take admissions based on the staffing numbers. 11. All RN's and staffing coordinator will be educated on staffing ratios. 12. RN supervisors will be educated that they will need to mandate staff for call off to make sure facility does not fall below staffing ratios per DOH regulations. 13. Daily meetings will be held to	

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P 5520	Continued from page 3	P 5520	review schedule with ratio's. 14. Nursing supervisors will monitor on weekends. If the facility is projected to not meet staffing ratios the nursing supervisor/or designee will call off duty facility staff, will notify Director of Nursing and will utilize pick-up bonuses. DON (Director of Nursing) or designee will monitor staffing ratios by reviewing the current working schedule and assignment sheets prior to the day and after the day is complete to ensure compliance daily x 10 days then weekly x 6 weeks, then Q monthly x2 to ensure compliance. The DON (Director of Nursing), NHA (Nursing Home Administrator), and staffing coordinator will be in the daily meetings to monitor staffing ratios. This will be reviewed at the Quarterly QAPI meetings.	

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P 5520	Continued from page 4 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the Nurse Aide (NA) ratios for one NA per 10 residents on day shift for four of 14 days reviewed (12/19/24, 12/25/24, 12/28/24, and 12/29/24); failed to meet the NA ratio for one NA per 11 residents on the evening shift for four of 14 days reviewed (12/24/24, 12/25/24, 12/26/24, and 12/28/24; and failed to meet the NA ratio for one NA per 15 residents on the overnight shift for one of 14 days reviewed (12/22/24). Findings include: Review of facility nursing staffing documents for the time period from 12/18/24, through 12/31/24, revealed the following NA shortages for the day shift where the NA ratios were not met: 12/19/24 census of 96 residents 9.43 NAs worked and 9.60 were required	P 5520		

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P 5520	Continued from page 5 12/25/24 census of 95 residents worked and 9.50 were required 9.34 NAs 12/28/24 census of 96 residents worked and 9.60 were required 9.29 NAs 12/29/24 census of 95 residents worked and 9.50 were required 8.38 NAs Review of facility nursing staffing documents for the time period from 12/18/24, through 12/31/24, revealed the following NA shortages for the evening shift where the NA ratios were not met: 12/24/24 census of 96 residents worked and 8.73 were required 8.49 NAs 12/25/24 census of 95 residents worked and 8.64 were required 8.36 NAs 12/26/24 census of 95 residents worked and 8.64 were required 8.26 NAs 12/28/24 census of 96 residents worked and 8.73 were required 8.43 NAs Review of facility nursing staffing documents for the time period from 12/18/24, through 12/31/24,	P 5520		

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P 5520	Continued from page 6 revealed the following NA shortage for the overnight shift where the NA ratios were not met: 12/22/24 census of 96 residents 6.28 NAs worked and 6.40 were required During a telephone interview on 1/03/25, at 12:48 p.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum NA ratios for the above days and shifts.	P 5520		
P 5640		P 5640		

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P 5640	Continued from page 7 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. The facility cannot correct that the State required PPD (per patient day) minimum hours of 3.20 was not met on 12/19, 12/21, 12/22, 12/23, 12/24, 12/25, 12/26, 12/28, 12/29, and 12/31/24. 2. Nursing supervisors will be re-educated regarding the daily PPD by the Director of Nursing/or Designee. 3. Daily meetings will be held to review the schedule with PPD. 4. Nursing supervisors will monitor on weekends. If the facility is projected to not meet staffing PPD the scheduler/or designee will call off duty facility staff, notify the Director of Nursing and will utilize pick-up bonuses. 5. All nursing positions are actively posted in recruitment 6. Call offs will continue to be monitored, and disciplines will be issued, as appropriate. 7. On a daily basis, the facility reviews the ability to take admissions based on the staffing numbers.	Completion Date: **01/24/2025** Status: **APPROVED** Date: **01/10/2025**

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P 5640	Continued from page 8	P 5640	DON or designee will monitor PPD by reviewing the current working schedule and assignment sheets prior to the day and after the day is complete to ensure compliance daily x 10 days then weekly x 6 weeks, then Q monthly x2 to ensure compliance. The DON (Director of Nursing), NHA (Nursing Home Administrator), and staffing coordinator will be in the daily meetings to monitor PPD. This will be reviewed at the Quarterly QAPI meetings.	

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P 5640	Continued from page 9 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the 3.2 minimum number of general nursing care hours for each 24-hour period for ten of 14 days reviewed (12/19/24, 12/21/24, 12/22/24, 12/23/24, 12/24/24, 12/25/24, 12/26/24, 12/28/24, 12/29/24, and 12/31/24). Findings include: Review of facility nursing staffing documents for the time period 12/18/24, through 12/31/24, revealed the following general nursing care hours was below the minimum 3.2 per patient day (PPD) on the following days: 12/29/24 3.17 PPD 12/21/24 3.17 PPD 12/22/24 3.08 PPD 12/23/24 3.15 PPD 12/24/24 3.11 PPD	P 5640		

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P 5640	Continued from page 10 12/25/24 3.12 PPD 12/26/24 3.16 PPD 12/28/24 3.07 PPD 12/29/24 3.10 PPD 12/31/24 3.13 PPD During a telephone interview on 1/03/25, at 12:48 p.m. the Nursing Home Administrator confirmed that the facility did not meet the 3.2 PPD minimum direct nursing care hours on the above dates.	P 5640		

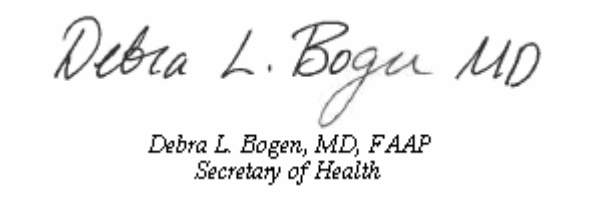
Certified End Page

SUGAR CREEK CARE CENTER

STATE LICENSE NUMBER: 220602

SURVEY EXIT DATE: 01/03/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY