

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to assist dependent residents with activities of daily living for two of four residents reviewed for activities of daily living concerns (Residents 21 and 53). Findings include: Clinical record review for Resident 21 revealed an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that revealed Resident 21 as totally dependent on the physical assistance of two staff for transferring (moving between surfaces including from bed to wheelchair). Active physician orders for Resident 21 indicated that Resident 21 required a passive mechanical lift to transfer. Observation of Resident 21 on November 12, 2024, at 11:28 AM revealed she was in bed. Observation of Resident 21 on November 13, 2024, at 11:10 AM revealed she was in bed. Interview with Employee 4 (nurse aide) on November 13, 2024, at 11:13 AM revealed that Resident 21 was still in bed because there were no slings for the lift that she required for her transfers out of bed. Employee 4 stated that there was no other reason why Resident 21 remained in bed. The surveyor reviewed the above findings regarding Resident 21 during an interview with Employee 1 (assistant director of nursing) and the Nursing Home Administrator on November 13, 2024, at 2:00 PM. Observation and interview with Resident 53 on November 12, 2024, at 12:54 PM revealed that her hair was disheveled. She stated that she recently returned from dialysis. When questioning Resident 53 she was unable to state when she last received a shower/bath. Clinical record review for Resident 53 revealed her annual MDS dated [DATE], noted staff assessed her as requiring partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for bathing. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 53's clinical record revealed task documentation (electronic system of nurse aide documentation of activities of daily living care) noting her last shower was November 1, 2024. There was one documented refusal, and two bed baths. There were no further attempts to assist Resident 53 with a shower/bath. These findings were reviewed during a meeting with the Nursing Home Administrator and Employee 1 on November 13, 2024, at 2:39 PM, and they confirmed there was no further documentation. Further interview with Employee 1 on November 15, 2024, at 9:20 AM revealed that if a resident refuses a shower/bath, another staff member is to offer at a later time, and if the resident refuses the second time, nursing staff should document that in the clinical record. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered devices or a care planned intervention for two of 17 residents reviewed (Residents 21 and 25); a deep brain stimulator for one of 17 residents reviewed (Resident 25); and a central venous catheter for one of 17 residents reviewed (Resident 163). Findings include: Clinical record review for Resident 21 revealed a physician's order dated February 24, 2023, that instructed staff to apply a left ankle splint at 6:30 AM and remove the splint at 1:30 PM daily. Staff are to perform passive range of motion exercises before applying the splint. A plan of care developed by the facility to address Resident 21's limited physical mobility related to bilateral hand, elbow, and ankle contractures (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) indicated that Resident 21 had contractures of her bilateral ankles, hands, and elbows. Interventions listed in the plan of care included the implementation of a restorative nursing program to perform passive range of motion exercises prior to a splint/orthotic placement. Observation of Resident 21 on November 13, 2024, at 11:13 AM with Employee 4 (nurse aide) confirmed that staff did not apply Resident 21's left ankle splint as ordered. The black splint was stored on top of furniture in Resident 21's room while she was in bed. The surveyor reviewed the above findings for Resident 21 during an interview with Employee 1 (assistant director of nursing) and the Nursing Home Administrator on November 13, 2024, at 2:00 PM. The facility policy entitled, Infusion Therapy Responsibilities and Scope of Practice, last reviewed without changes on January 3, 2024, revealed that responsibilities in infusion therapy include maintaining an infusion care plan for each resident receiving infusion services. Additional documentation for midline catheters and PICCs includes to document at established intervals: The external length of the catheter and the original length of the catheter inserted Arm circumference before insertion of the PICC, after insertion at regular intervals, and when clinically indicated (to check for edema and rule out deep vein thrombosis), measure the arm 10 centimeters above the antecubital fossa, and characterize any edema as pitting or non-pitting. The facility policy did not address the implementation of limb restrictions or emergency procedures for the duration of PICC infusion therapy. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 163 revealed that the facility admitted her on November 2, 2024. A physician's order dated November 2, 2024, instructed staff to change the primary intermittent tubing for an intravenous (IV) peripherally inserted central catheter (PICC, thin, soft, flexible tube inserted through a vein in the arm and passed through to the larger veins near the heart for the administration of fluids or medication) every 24 hours. Physician orders dated November 3, 2024, instructed staff to perform the following: Monitor an IV PICC for signs and symptoms of infection or infiltration (complication of IV therapy when IV fluid or medication accidentally leaks into the surrounding tissues outside the intended vein; this can happen when the IV catheter dislodges, punctures the vein, or is not secured properly) Administer Unasyn (intravenous antibiotic) three grams four times a day until November 23, 2024 Flush the IV PICC when being used intermittently with 10 ml (milliliters) of NS (normal saline); infuse medication and then flush with 10 ml NS four times a day for IV antibiotic Review of plans of care developed by the facility to address Resident 163's care needs revealed that the plan of care to address Resident 163's PICC line was not initiated until November 5, 2024 (three days after her admission to the facility with the device). The plan of care did not include verbiage to address restricting the use of her left arm, restrictions to bathing, or additional measures to protect the site during bathing, or emergency procedures in the event of tubing complications or bleeding. Interview with Resident 163 on November 12, 2024, at 12:25 PM confirmed that she was admitted to the facility for intravenous antibiotic therapy. Resident 163 pointed to the antecubital area (anterior elbow area) of her left arm and stated that was the intravenous access site staff used four times a day to administer the medication. Observation of Resident 163's room at the time of the interview revealed no indication that there were measures in place to prevent the inadvertent use of Resident 163's left arm (e.g., for blood pressure assessments or venipuncture for lab testing); or that there were emergency procedures in place (e.g., clamps or dressings) in the event of a complication from the intravenous site (e.g., a break in tubing patency or bleeding). Observation of Resident 163 on November 12, 2024, at 12:41 PM revealed Employee 5 (licensed practical nurse) entered the room to disconnect the intravenous tubing. Interview with Employee 5 and Employee 6 (licensed practical nurse) on November 12, 2024, at 12:50 PM confirmed that Resident 163's room was not equipped with signage or supplies to implement limb restrictions or emergency procedures required for Resident 163's left arm PICC. Employee 6 then telephoned additional facility staff to obtain supplies to implement an emergency kit in Resident 163's room. The surveyor reviewed the above concerns regarding care and services for Resident 163's PICC device during an interview with Employee 1 and the Nursing Home Administrator on November 13, 2024, at 2:00 PM. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Employee 1 on November 15, 2024, at 12:01 PM confirmed that the facility policy would require nursing staff measure the length of Resident 163's IV tubing and the circumference of her arm; however, neither instruction was incorporated into her plan of care or physician orders. The interview also confirmed that Resident 163's baseline care plan (initiated on her admitted [DATE]) did not include the presence of her PICC until November 5, 2024 (more than the required 48 hours after admission). Clinical record review for Resident 25 revealed a diagnosis list that contained a history of pressure ulcers. Review of Resident 25's care plan revealed an intervention that included Geri-sleeves (a type of sleeve worn on the arm to prevent skin injury) or long sleeves at all times other than during care to protect the skin integrity on their arms. Review of the current task list for Resident 25 revealed that, Geri-sleeves or long sleeves to be worn at all times, except for personal care. Observation of Resident 25 revealed the following: October 13, 2024, at 9:34 AM: resident observed in bed with a short-sleeved shirt on and no Geri-sleeves. October 14, 2024, at 11:00 AM: resident observed in bed with a short-sleeved shirt on and no Geri-sleeves. October 14, 2024, at 12:20 PM: resident observed out of bed and sitting at the bedside awaiting lunch; had on a short-sleeved shirt with no Geri-sleeves. October 14, 2024, at 2:53 PM: resident observed out of bed and sitting at the bedside with a visitor; had on a short-sleeved shirt with no Geri-sleeves. Observation on November 14, 2024, at 3:14 PM with Employee 1, assistant director of nursing, revealed Resident 25 was sitting at the bedside with a visitor. The resident had on a short-sleeved shirt and no Geri-sleeves. A conversation between Employee 1 and an unidentified staff member at the nurse's station immediately following this observation indicated that Resident 25 may have soiled the Geri-sleeves during lunchtime earlier today and the Geri-sleeves are being washed in laundry. However, observations just prior to lunch on November 14, 2024, at 11:00 AM and 12:20 PM by the surveyor revealed that the resident did not have on Geri-sleeves at that time. A review of the task list documentation on November 14, 2024, at 3:15 PM revealed only one entry documented up to this time that revealed staff documented yes at 1:59 PM that the task of Resident 25's Geri-sleeves or long sleeves were to be worn at all times except for personal care was completed as directed. However, multiple observations by the surveyor on November 14, 2024, did not find the resident was wearing any Geri-sleeves. The facility failed to follow the care planned intervention for Resident 25 regarding Geri-sleeves. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administrator was informed of the above information for Resident 25 on November 15, 2024, at 12:25 PM. Further review of Resident 25's clinical record revealed a diagnosis list that included the Presence of a Neurostimulator present upon admission on August 26, 2022. There was no care plan noted in Resident 25's clinical record that was associated with the neurostimulator. An attempted interview with Resident 25 on November 13, 2024, at 9:34 AM revealed the resident could not provide any information on the neurostimulator. An interview with Employee 15, registered nurse, and Employee 12, license practical nurse, on November 14, 2024, at 12:30 PM revealed the staff were not aware of a care plan associated with Resident 25's neurostimulator or any specific care interventions or precautions and would have to look further into it. Nursing documentation for Resident 25 dated May 9, 2024, at 5:00 PM revealed that the resident had a video visit with neurology. The settings were increased on the deep brain stimulator and staff are to monitor for possible side effects that included slurred speech, difficulty swallowing, and sedation. The neurology clinic was to be contacted if any issues, concerns, or questions and the telephone number and extension was listed. The facility failed to implement a care plan for Resident 25's implanted neurostimulator that addressed specific care needs or precautions pertinent to the care of the resident. The above information for Resident 25's care plan was reviewed in a meeting with the Nursing Home Administrator and Employee 1 on November 14, 2024, at 2:30 PM. 28 Pa. Code 201.18(d) Management 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44738 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practical care to promote pressure ulcer healing for one of two sampled residents with pressure ulcers (Resident 25). Findings include: Current physician orders for Resident 25 revealed an order dated November 13, 2024, that instructed staff to apply Medihoney Wound and Burn Dressing External Paste (a type of topical medication used to treat certain skin wounds) to the right ischium (one of the bones of the pelvis) topically every shift for open skin areas on the buttocks and groin and to mix with zinc equal parts and specified half an ounce. Further review of the physician orders for Resident 25 revealed a second order dated October 24, 2024, that instructed staff to apply Zinc Oxide External Paste 40 percent topical to open skin areas every shift for open wound areas to the groin and buttocks and add equal parts to the Medihoney and specified half an ounce. A skin/wound note for Resident 25 dated November 11, 2024, at 2:55 AM revealed the resident had a pressure ulcer to the right ischium with a scant amount of serosanguineous exudate (a type of drainage excreted by the wound). The treatment recommendations included the following: cleanse with normal saline, apply medical grade honey / Desitin (a topical medication containing zinc oxide) to base of the wound, leave open to air, and change every shift and as needed. Observation of wound care for Resident 25 on November 14, 2024, at 11:05 AM revealed Employee 12, licensed practical nurse, prepared Medihoney and Zinc Oxide 20 percent paste by measuring both and then mixing them together - a half ounce of each topical medication. Employee 12 then administered the medications topically to the wound after cleaning with normal saline. The Desitin as recommended by the wound care staff, or the 40 percent concentration of zinc oxide paste as noted in the physician order was not administered as ordered. A follow-up interview with Employee 12 after wound care revealed that the Zinc Oxide paste administered topically to Resident 25 was only 20 percent. An interview with Employee 1, assistant director of nursing, on November 14, 2024, at 2:24 PM revealed that the facility does have the Desitin cream and would obtain additional information. A follow-up interview with Employee 1 on November 15, 2024, at 10:30 AM confirmed the facility does have the Desitin topical treatment as recommended by the wound care staff and the concentration of zinc oxide in the cream is 40 percent. It is unclear why the 40 percent concentration was not administered topically to Resident 25 as recommended by the wound care staff. The Nursing Home Administrator was advised of the above findings on November 15, 2024, at 12:25 PM. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	483.25(b)(1)(i)(ii) Treatment/Services to Prevent/Heal Pressure Ulcer Previously cited deficiency 2/23/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing care services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 18229 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to ensure the application of physician ordered supplemental oxygen consistent with professional standards of practice for three of three residents reviewed for supplemental oxygen concerns (Residents 4, 5, and 15). Findings include: Clinical record review for Resident 4 revealed an active physician's order dated November 29, 2023, for staff to apply supplemental oxygen at two liters per minute (lpm) continuously every shift for shortness of breath. Observation of Resident 4 on November 12, 2024, at 11:01 AM, and November 13, 2024, at 10:03 AM, revealed Resident 4 was in bed with oxygen on and running at three lpm. Resident 4 was not short of breath during the conversation with her. Interview with Resident 4 on November 12, 2024, at 11:01 AM revealed that she recently had an upper respiratory infection and staff increased her oxygen due to her illness. Interview with Employee 1 (assistant director of nursing) on November 15, 2024, at 10:54 AM confirmed the findings for Resident 4. Clinical record review for Resident 5 revealed an active physician's order dated February 14, 2014, for staff to apply oxygen at three lpm every shift for shortness of breath and to check oxygen saturation (a measurement of how much oxygen is in your blood relative to the maximum amount of oxygen your blood could carry) every shift to keep saturation above 90 percent. Further review of Resident 5's clinical record revealed a diagnosis of chronic obstructive pulmonary disease (COPD, common lung disease making it difficult to breathe), with a plan of care initiated March 11, 2024, indicating Resident 5 has altered respiratory status related to his COPD and nursing staff are to administer his oxygen as ordered by his physician. Clinical record revealed nursing documentation dated September 21, 2024, at 9:37 AM that Resident 5's oxygen saturation was 92 percent and had oxygen running at six lpm. Nursing documentation dated September 21, 2024, at 10:25 AM revealed Resident 5 was sitting in their wheelchair with oxygen running at five lpm. Nursing documentation dated September 22, 2024, at 8:19 AM revealed Resident 5's oxygen saturation was 92 percent and had oxygen running at six lpm. Nursing documentation dated September 22, 2024, at 9:03 AM revealed Resident 5's oxygen saturation was 95 percent and had oxygen running at five lpm. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation dated September 22, 2024, at 8:48 PM noted Resident 5's oxygen saturation was in the low 90s and had oxygen running at five lpm. Nursing documentation dated September 22, 2024, at 12:00 PM noted Resident 5's oxygen saturation was currently 94 percent on five lpm with no difficulty breathing at this time. Nursing documentation date September 25, 2024, at 12:28 PM revealed Resident 5 continued on five lpm. Review of Resident 5's oxygen saturation summary for the last two months revealed no documentation of Resident 5's oxygen saturation below 90 percent. Interview with Employee 1 (assistant director of nursing) on November 15, 2024, at 11:12 AM confirmed these findings for Resident 5. Clinical record review for Resident 15 revealed a physician's order dated August 10, 2021, for staff to administer supplemental oxygen at three lpm continuously. Observation of Resident 15 on November 12, 2024, at 11:59 AM revealed she was in bed without supplemental oxygen. Resident 15 stated that she wears it all the time, that she, .should have it on. An oxygen room concentrator (medical device that concentrates the oxygen in room air to administer an oxygen-enriched air supply back to the user) at Resident 15's bedside was running; however, the tubing for the nasal cannula (thin tube that runs from the device to the face with two open prongs placed inside the nostrils to administer supplemental oxygen) was on the floor. Resident 15 activated her call bell to obtain staff assistance with her oxygen administration. Observation of Resident 15 on November 12, 2024, at 12:00 PM revealed that Employee 14 (nurse aide) entered the room, obtained the nasal cannula tubing off the floor, and assisted Resident 15 to apply the supplemental oxygen tubing under her nose. Interview with Employee 14 on November 12, 2024, at 2:08 PM confirmed that she did not replace the nasal cannula tubing for Resident 15 but assisted her to use the tubing that was on the floor and potentially contaminated from the unsanitary surface of the floor. Observation of Resident 15 on November 14, 2024, at 12:46 PM revealed she was in her wheelchair in the common dining/activity area, without supplemental oxygen. Interview with Resident 15 on the date and time of the observation revealed that she did not have supplemental oxygen on because the facility did not have portable oxygen tanks for her use when she is in the wheelchair. Resident 15 confirmed that she sometimes gets short of breath without her supplemental oxygen. Interview with Employee 6 (licensed practical nurse) on November 14, 2024, at 12:58 PM confirmed that Resident 15's physician orders instructed staff to ensure Resident 15 utilized supplemental oxygen at all times. Employee 6 confirmed that Resident 15 did not have the necessary equipment to mount a supplemental oxygen tank to her wheelchair; therefore, unless Resident 15 remained in her room, she did not have a supplemental oxygen supply. The surveyor reviewed the above concerns regarding Resident 15's supplemental oxygen use during an interview with Employee 1 on November 14, 2024, at 1:15 PM. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 20725 Based on review of select facility policies and procedures, clinical record review, observation, resident and staff interview, and review of personnel records, it was determined that the facility failed to ensure specific competencies necessary to care for resident needs for one of one resident reviewed for intravenous access concerns (Resident 163; Employees 5, 7, 8, 9, 10, and 11). Findings include: The facility policy entitled, Infusion Therapy Responsibilities and Scope of Practice, last reviewed without changes on January 3, 2024, revealed that clinicians administering infusion therapies will practice within the scope of practice for their licensure and applicable state laws, and within their clinical level of competency as established by the facility training and competency evaluation programs. Nursing responsibilities in infusion therapy include performing functions and procedures that are consistent with current standards of care, facility policies and procedures, and that are within the scope of the state nurse practice act. Facility/administration responsibilities in infusion therapy include providing education or verifying qualifications of the staff that will be providing infusion therapy. This may include IV fundamental classes, precepting, and/or clinical competency evaluations. According to, Pennsylvania Code, Title 49, Chapter 21, Functions of the LPN, an LPN (licensed practical nurse) may perform only the IV (intravenous) therapy functions for which the LPN possesses the knowledge, skill, and ability to perform in a safe manner. Clinical record review for Resident 163 revealed that the facility admitted her on November 2, 2024. A physician's order dated November 2, 2024, instructed staff to change the primary intermittent tubing for an intravenous (IV) peripherally inserted central catheter (PICC, thin, soft, flexible tube inserted through a vein in the arm and passed through to the larger veins near the heart for the administration of fluids or medication) every 24 hours. Physician orders dated November 3, 2024, instructed staff to perform the following: Monitor an IV PICC for signs and symptoms of infection or infiltration (complication of IV therapy when IV fluid or medication accidentally leaks into the surrounding tissues outside the intended vein; this can happen when the IV catheter dislodges, punctures the vein, or is not secured properly) Administer Unasyn (intravenous antibiotic) three grams four times a day until November 23, 2024 Flush the IV PICC when being used intermittently with 10 ml (milliliters) of NS (normal saline); infuse medication and then flush with 10 ml NS four times a day for IV antibiotic Interview with Resident 163 on November 12, 2024, at 12:25 PM confirmed that she was admitted to the facility for intravenous antibiotic therapy. Resident 163 pointed to the antecubital area (anterior elbow area) of her left arm and stated that was the intravenous access site staff used four times a day to administer the medication. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 163 on November 12, 2024, at 12:41 PM revealed Employee 5 (licensed practical nurse, LPN) entered the room to disconnect the intravenous tubing. Employee 5 donned gloves, disconnected the IV tubing from Resident 163's left arm, used a prepackaged syringe of 0.9 percent normal saline to flush the IV tubing, and directed Resident 163 to pull her sleeve over the IV access site. Interview with Employee 5 and Employee 6 (LPN) on November 12, 2024, at 12:50 PM revealed that Employee 5 disconnected the IV medication from Resident 163 because Employee 5 had specialized IV certification and Employee 6 (who was the assigned LPN on Resident 163's nursing unit) did not. Review of Resident 163's MAR (medication administration record, an electronic system used by the facility to document the administration of medications) dated November 2024 revealed that Employee 6 initialed that she administered Resident 163's Unasyn IV medication on November 12, 2024, at 12:00 PM and flushed Resident 163's PICC with saline at 12:00 PM. Further review of Resident 163's MAR dated November 2024, revealed that at least six LPNs initialed the completion of PICC line care and/or IV Unasyn administration from November 3, 2024, through November 13, 2024: Employees 5, 7, 8, 9, 10, and 11 (LPNs). The surveyor requested any intravenous or PICC line competencies or specialized trainings (per Pa. Code 21.145b., IV therapy curriculum requirements, an IV therapy course provided as part of the LPN education curriculum (relating to specific curriculum requirements for LPN programs); or as a stand-alone course offered by a provider) completed with Employees 5, 7, 8, 9, 10, and 11, during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on November 13, 2024, at 2:00 PM, and November 14, 2024, at 2:00 PM. Interview with Employee 1 and the Nursing Home Administrator on November 14, 2024, at 2:00 PM revealed that the facility had no evidence of any competencies or specialized trainings completed with Employees 5, 7, 8, 9, 10, or 11, pertaining to intravenous medication administration via a PICC line. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development 28 Pa Code 211.12 (c)(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 18229 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed and responded appropriately to pharmacy recommendations for three of five residents reviewed (Residents 4, 32, and 15). Findings include: Clinical record review for Resident 4 revealed a consultant pharmacy recommendation dated March 10, 2024, requesting Resident 4's physician consider a trial dose reduction of Resident 4's Buspirone (an antianxiety medication) and Venlafaxine (an antidepressant medication). Interview with Employee 1 (assistant director of nursing) on November 15, 2024, at 10:34 AM confirmed that the facility had no evidence that Resident 4's attending physician addressed the March 10, 2024, consultant pharmacist recommendation requesting a review of the possibility of a trial dose reduction, taper, or discontinuation of Resident 4's Buspirone and Venlafaxine. Further review of Resident 4's clinical record on November 14, 2024, revealed there was no evidence the consultant pharmacist reviewed Resident 4's medication regime in June 2024. Interview with Employee 1 on November 15, 2024, at 10:34 AM confirmed these findings for Resident 4 Clinical record review for Resident 32 revealed a consultant pharmacy recommendation dated September 23, 2024, requesting nursing complete an AIMS evaluation (Abnormal Involuntary Movement Scale, a rating scale to measure involuntary movements) due to Resident 32's use of Risperidone (an antipsychotic medication). There was no documentation in Resident 32's clinical record at the time of the pharmacy recommendation nursing staff completed an AIMS evaluation. Interview with Employee 1 on November 15, 2024, at 11:22 AM, confirmed these findings for Resident 32. Clinical record review for Resident 15 revealed a consultant pharmacy recommendation dated May 19, 2024, that requested the physician evaluate the potential for a gradual dose reduction of her psychoactive medications Clonazepam (antianxiety medication), Duloxetine (antidepressant medication), and Olanzapine (antipsychotic medication). Resident 15's clinical record did not contain evidence that Resident 15's attending physician acted upon this recommendation. Interview with Employee 1 on November 15, 2024, at 11:25 AM confirmed that Resident 15 's primary care physician did not respond to the consultant pharmacist's recommendation dated May 19, 2024. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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. 20725 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure controlled substance medication accountability and security on one of two nursing units (second floor, Residents 12 and 35, Employee 6). Findings include: The facility policy entitled, Controlled Substances, last reviewed without changes on January 3, 2024, revealed that the facility would comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. An individual resident controlled substance record must be made for each resident who will be receiving a controlled substance (one prescription per page). The information on the record must include number on hand, time of administration, and signature of nurse administering the medication. The charge nurse on duty will maintain the keys to controlled substance containers. The Director of Nursing will maintain a set of backup keys for all medication storage areas including keys to controlled substance containers. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. The policy did not include that the licensed staff who are assigned to medication administration on the nursing unit will possess keys to controlled substance containers in the nursing unit's medication cart. The policy also did not stipulate that the licensed nurse who administers a controlled substance to a resident during a shift will ensure the controlled substance count at the time of administration (versus waiting until the end of the shift to ensure that there are no discrepancies). The facility policy entitled, Medication Administration - General Guidelines, last reviewed without changes on January 3, 2024, revealed that during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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	Observation of a medication administration pass on the second-floor nursing unit on November 12, 2024, at 1:03 PM revealed Employee 6 (licensed practical nurse) prepared medications for administration to Resident 12. Employee 6 accessed a separately locked controlled substance container within the medication cart to obtain one Phenobarbital (anticonvulsant used to control seizures) 32.4 milligram (mg) tablet for Resident 12. Employee 6 did not refer to the controlled substance record for Resident 12's Phenobarbital medication (contained in a book on the nurses' station desk) to ensure the remaining tablet count of the medication in the medication cart agreed with the record. Interview with Employee 6 on November 12, 2024, at 1:05 PM confirmed that she was finished preparing medications for Resident 12 and was going to his room down the hall to administer the medications to him. Employee 6 stated that she signs for the administration of medications, including controlled substances, upon return to the medication cart. Employee 6 left the nurses' station, and medication cart, at that time. Employee 6 did not lock the medication cart, which was left unattended and not within her sight. Upon return to the nurses' station on November 12, 2024, at 1:07 PM Employee 6 identified that she left the medication cart unlocked. Employee 6, then locked the medication cart and obtained the controlled substance record for Resident 12's Phenobarbital medication. Employee 6 recorded that there were 32 tablets left; however, Employee 6 did not obtain the medication from the medication cart to compare the number of tablets left. Interview with Employee 6 on November 12, 2024, at 1:08 PM confirmed that she documented the number of tablets without obtaining the medication from the medication cart to ensure the accurate count of remaining medication tablets. Employee 6 then obtained the Phenobarbital medication to reconcile the number of tablets left in the medication cart with the number of tablets recorded on the controlled substance record. Interview with Employee 6 on November 12, 2024, at 1:30 PM revealed that she was going to prepare medications to administer to Resident 35 for her 2:00 PM medication administration. Employee 6 began by accessing the controlled substance storage in the medication cart to obtain Resident 35's Tramadol (narcotic controlled substance pain medication). Employee 6 reviewed the controlled substance record for Resident 35's Tramadol and noted that the record indicated that there should be 86 tablets of medication. The two containers of Tramadol 50 mg in the medication cart for Resident 35 revealed that she had 85 tablets of the medication remaining. Employee 6 then stated that she, must have already done her, because the narcotic count indicated that there was one less tablet available. Employee 6 then confirmed that she did not document the administration of Resident 35's 2:00 PM medications at the time of administration; or reconciled the number of tablets left of Resident 35's Tramadol at the time of administration. Employee 6 then documented on Resident 35's controlled substance record that she administered one tablet on November 12, 2024, at 1:00 PM. Resident 35 approached the nurses' station on November 12, 2024, at 1:35 PM. Employee 6 questioned Resident 35 if she wanted her scheduled breathing treatment (scheduled for 2:00 PM) to which Resident 35 agreed. Employee 6 then prepared Resident 35's Ipratropium Bromide inhalation medication and administered the treatment to Resident 35 at her bedside. Review of a Medication Administration Competency Checklist dated January 10, 2024, for Employee 6, revealed that the actions reviewed did not include the appropriate administration of a controlled substance. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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	Interview with Employee 1 (assistant director of nursing) on November 15, 2024, at 11:21 AM indicated that it is the facility's expectation that the nurse who administers a controlled substance signs for the medication at the time of administration, documents the date and time of the administration on the controlled substance record, and ensures that the number of medications is correct. The interview indicated that the facility policy provided was not correct in that the Director of Nursing and the charge nurse have a set of keys to controlled substance containers. The interview indicated that the licensed practical nurse has a set of keys to the medication cart that they are assigned for the shift and the Director of Nursing has a master set of keys. The interview confirmed that the facility policy did not direct staff to reconcile the number of tablets left of a controlled substance at the time of administration. 483.45(g)(h)(1)(2) Label/store Drugs and Biologicals Previously cited deficiency 1/19/24 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 18229 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in a safe and sanitary manner and prevent the potential for food contamination in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on November 12, 2024, at 9:15 AM revealed the following: In the freezer there was a bag of French fries, sausage, meatballs, and tater tots opened, not secured, and no open/use by date. There was an open bag of corn with a use by date of November 10, 2024, past the expiration. In the walk-in refrigerator there was a gallon size container of ranch dressing with a use by date of October 19, 2024, past the expiration. There was a gallon of reduced fat and a gallon of whole milk opened with no use by date. In the dry storage room, there were open bags of rice, pasta, and potato flakes with no open/use by dates. Interview with Employee 3 (registered dietician) on November 15, 2024, at 11:31 AM revealed that staff are to date the food when received, then date again with a use by date once the food product is opened. The exterior of the convection oven contained significant grease and debris buildup on the top of the oven and underneath. The controls were covered in black grease. The floor under the sink contained a significant amount of dust and debris. There was broken glass on the floor. Next to the sink there were plastic racks containing clean dishes, the area contained a significant amount of dirt and food debris where the clean dishes were. The cart that contained the stacks of clean resident meal trays was observed with debris and food crumbs on each shelf. The above findings were reviewed with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on November 13, 2024, at 2:17 PM. 28 Pa. Code 201.14 (a) Responsibility of licensee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44738 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for 1 of 17 residents reviewed (Resident 45). Findings include: Clinical record review for Resident 45 revealed a physician's order dated October 11, 2024, that instructed staff to weigh the resident weekly. Dietary documentation dated October 11, 2024, at 4:27 PM revealed that Resident 45 had lost weight. An intervention from dietary included adding weekly weights to monitor the resident. The weights documented in Resident 45's electronic health record included the following: 10/7/24: 126.0 pounds (lbs) 11/7/24: 124.5 lbs 11/11/24: 125 lbs There was no evidence in Resident 45's clinical record that indicated the weekly weights ordered by the physician and recommended by the dietary staff were completed. The above information was reviewed in a meeting with the Nursing Home Administrator and Employee 1, assistant director of nursing, on November 14, 2024, at 2:24 PM. Employee 1 reported she will attempt to obtain additional information. Facility documentation provided by the facility and titled, Weight Entry, revealed Resident 45's weekly weights were documented (written in by hand) on the sheet along with multiple additional residents. A follow-up interview about Resident 45's weights with Employee 1 on November 15, 2024, at 12:32 PM revealed that dietary staff usually transcribe the newly obtained weights into the electronic health record; however, Resident 45's obtained weights were not transcribed and not part of her clinical record. The facility failed to ensure a complete and accurate clinical record for Resident 45. 28 Pa. Code 211.5(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44738 Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for two of 17 residents reviewed (Residents 25 and 163). Findings include: Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of the facility policy titled, Enhanced Barrier Precautions, last reviewed without changes on January 3, 2024, revealed that EBP are utilized by the facility to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Further review of the policy revealed that EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply (gloves and gown are applied prior to performing the high contact resident care activity, personal protective equipment (PPE) is changed before caring for another resident, and face protection may be used if there is a risk of splash or spray). The facility further noted examples of high-contact resident care activities that require the use of gown and gloves for EBPs included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use (such as central line, urinary catheter, feeding tube, tracheostomy /ventilator, etc.), and wound care (any skin opening requiring a dressing). A review of the current physician orders for Resident 25 revealed a physician's order dated November 13, 2024, that instructed staff to apply Medihoney Wound and Burn Dressing External Paste (a type of topical medication used to treat certain wounds) to the right ischium (one of the bones of the pelvis) topically every shift for open skin areas on the buttocks and groin and to mix with zinc in equal parts that specified half an ounce. Further review of the physician orders for Resident 25 revealed a second order dated October 24, 2024, that instructed staff to apply Zinc Oxide External Paste 40% topical to open skin areas every shift for open wound areas to the groin and buttocks and add equal parts to the Medihoney and specified half an ounce. A skin/wound note for Resident 25 dated November 11, 2024, at 2:55 AM revealed the resident had a pressure ulcer to the right ischium with a scant amount of serosanguineous exudate (a type of drainage excreted by the wound). There was no evidence in the clinical record to indicate that Resident 25 was on any type of enhanced barrier precautions or any type of isolation for the wound. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation outside of Resident 25's room on November 14, 2024, at 11:00 AM revealed a sign on the wall adjacent to the resident's door that indicated Enhanced Barrier Precautions and a gown, and gloves must be worn for high-contact resident activities. There was a number 1 written with a black colored marker and circled in the upper left hand corner of the sign. There was a plastic storage container located in the room that contained personal protective equipment such as gowns and gloves to use for care. Observation of wound care for Resident 25 on November 14, 2024, at 11:05 AM revealed Employee 12, licensed practical nurse (LPN), entered the resident's room with no gown. Employee 12 proceeded to clean the wound and apply the physician ordered treatments. Employee 12 did not utilize a gown and only wore gloves during the high-contact resident activity. Employee 13, LPN, was also present at the time of Resident 25's wound care. Employee 13 assisted with bed mobility and positioning during the wound treatment. Employee 13 did not utilize a gown. An interview with Employee 12 outside of Resident 25's room regarding the EBP sign and personal protective equipment revealed that the employee believed the EBPs were for Resident 25's roommate. An interview with Employee 1, Assistant Director of Nursing, on November 14, 2024, at 11:49 AM regarding Resident 25's wound care confirmed that the resident was on EBP, and staff should have utilized EBPs during the wound care. Employee 1 also revealed the circled 1 on the EBP sign outside the resident's door indicated which resident in the room was on EBPs, which would have been Resident 25. Employee 1 further noted that the EBPs for Resident 25 should be located, at a minimum, in the resident's care plan to alert staff the resident is on EBPs. Employees 12 and 13 failed to wear the appropriate personal protective equipment during wound care for Resident 25. This surveyor informed the Nursing Home Administrator of the above information during an interview on November 15, 2024, at 12:25 PM. Clinical record review for Resident 163 revealed that the facility admitted her on November 2, 2024. A physician's order dated November 2, 2024, instructed staff to change the primary intermittent tubing for an intravenous (IV) peripherally inserted central catheter (PICC, thin, soft, flexible tube inserted through a vein in the arm and passed through to the larger veins near the heart for the administration of fluids or medication) every 24 hours. Physician orders dated November 3, 2024, instructed staff to perform the following: Monitor an IV PICC for signs and symptoms of infection or infiltration (complication of IV therapy when IV fluid or medication accidentally leaks into the surrounding tissues outside the intended vein; this can happen when the IV catheter dislodges, punctures the vein, or is not secured properly) Administer Unasyn (intravenous antibiotic) three grams four times a day until November 23, 2024 Flush the IV PICC when being used intermittently with 10 ml (milliliters) of NS (normal saline); infuse medication and then flush with 10 ml NS four times a day for IV antibiotic (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Nursing and Rehabilitation at the Mansion		STREET ADDRESS, CITY, STATE, ZIP CODE 1040-52 Market Street Sunbury, PA 17801	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident 163 on November 12, 2024, at 12:25 PM confirmed that she was admitted to the facility for intravenous antibiotic therapy. Resident 163 pointed to the antecubital area (anterior elbow area) of her left arm and stated that was the intravenous access site staff used four times a day to administer the medication. Observation of Resident 163's room at the time of the interview revealed no indication that there were measures in place for enhanced barrier precautions. Observation of Resident 163 on November 12, 2024, at 12:41 PM revealed Employee 5 (LPN) entered the room to disconnect the intravenous tubing. Employee 5 donned gloves, disconnected the IV tubing from Resident 163's left arm, used a prepackaged syringe of 0.9 percent normal saline to flush the IV tubing, and directed Resident 163 to pull her sleeve over the IV access site. Employee 5 donned gloves to perform the care; however, Employee 5 did not don a gown. Interview with Employee 5 and Employee 6 (LPN) on November 12, 2024, at 12:50 PM confirmed that Resident 163's room was not equipped with signage or supplies to implement the enhanced barrier precautions required due to Resident 163's left arm PICC. Employee 6, then, telephoned additional facility staff to obtain supplies to implement enhanced barrier precautions. The surveyor reviewed the above concerns regarding Resident 163's enhanced barrier precautions during an interview with Employee 1 and the Nursing Home Administrator on November 13, 2024, at 2:00 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 1/19/24 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		