STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395512	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunbury Skilled Nursing and Rehabilitation Center	901 Court 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. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide comprehensive skin assessments that are consistent with professional standards of practice, to promptly identify changes to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident 1). This deficiency is cited as past noncompliance Findings include: A review of the facility policy titled, Skin Integrity and Wound Management, dated October 15, 2024, revealed that, a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin and wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revision to the plan of care as needed. Notify Medical Director, Director of Nursing, and Administrator, if deviation from protocol is requested by the physician, advanced practice provider, managed care company, or others. Review of the policy revealed a section titled, Practice Standards, that indicated the licensed nurse will evaluate any reported or suspected skin changes or wounds, perform and document skin inspection on all newly admitted and readmitted patients weekly thereafter, and with any significant change of condition; and complete a wound evaluation upon admission or readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. Clinical record review for Resident 1 revealed a diagnoses list that included unspecified protein calorie malnutrition (when the body does not receive enough protein and calories to maintain a healthy status), Type 2 diabetes mellitus with chronic kidney disease (when the body does not properly use sugar that leads to high blood sugar levels that also negatively impacts the kidneys (two bodily organs that filter the blood), and generalized muscle weakness. Review of Resident 1's current care plan revealed the resident has cognitive loss as evidenced by a low BIMS (Brief Interview for Mental Status) and forgetfulness secondary to the resident's medical history. An attempted interview with the resident on April 15, 2025, at 2:55 PM revealed the resident was cognitively impaired and unable to complete the interview with the surveyor. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order for Resident 1 dated February 3, 2025, instructed staff to perform a body audit with skin evaluation every Wednesday on evening shift. Further review of the physician orders for Resident 1 revealed current orders for wound cleaning and dressing change for a sacral (a bone at the base of the spine) wound to be completed daily. Nursing documentation for Resident 1 dated February 27, 2025, at 1:37 PM revealed that staff observed an open area to the sacrum, the wound was measured, and treatment initiated. The physician and responsible party were made aware. Wound care documentation by the facility wound care nurse dated February 27, 2025, noted moisture associated skin damage (MASD, damage to the skin caused by moisture) to the sacrum that measured 2.07 centimeters (cm) x 2.07 cm x 0.1 cm. Skin check documentation in the progress notes dated March 5, 2025, at 3:38 PM noted a new skin issue to the buttocks documented as MASD. The wound measurements were noted as not documented as part of this assessment, because the measurements were completed by wound nurse. There were no further assessments provided of the resident's wound (such as wound description, size, tissue status, indicators of infection, inflammation, etc.). Wound care documentation by the facility wound care nurse did not note any assessment for March 5, 2025, as indicated in the above skin check documentation. Wound care documentation for Resident 1 by the facility wound care nurse on March 12, 2025, measured the wound as 2.07 cm x 2.07 cm x 0.1 cm. A skilled nursing evaluation for Resident 1 dated March 18, 2025, at 11:48 AM revealed that there was MASD on the buttocks and measurements were not documented because the resident is being followed by wound nurse for MASD issues. There was no further assessment provided of the resident's sacral wound. A skilled evaluation for Resident 1 dated March 19, 2025, at 10:34 AM revealed that there was MASD on the buttocks and measurements were not documented because the resident is being followed by wound nurse. The staff made a skin note that indicated, .MASD to sacrum/buttocks and is followed by wound nurse for same. There was no further assessment provided of the resident's sacral wound. A skilled evaluation for Resident 1 dated March 20, 2025, at 11:55 AM revealed that there was MASD on the coccyx (tailbone) and measurements were not documented because the resident is being followed by wound nurse. The progress was documented as stalled. There was no further assessment provided of the resident's wound. Wound care documentation by the facility staff for Resident 1 dated March 21, 2025, revealed that the resident's wound now measured 5.34 cm x 3.77 cm x (no depth documented), which indicated a deterioration in the wound. Nursing documentation dated March 22, 2025, at 3:27 PM revealed the resident was sent to the emergency department for abnormal vital signs. The resident was admitted to the hospital for acute kidney injury. The resident returned to the facility from the hospital on March 25, 2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital physician documentation dated March 23, 2025, at 8:28 AM revealed the resident has a sacral ulcer on exam and per wound nurse, the resident only had a blanchable redness back in January and therefore current stage 2/3 ulcer is fairly new. Wound care consultation (a third party wound management service that is contracted by the facility to perform various wound care needs/treatments/assessments) dated March 26, 2025, noted an initial wound evaluation that indicated Resident 1 had a deep sacral pressure ulcer that is unstageable at this time due to slough covering most of the wound and a debridement (removal of damaged tissue) was completed. An interview with the Director of Nursing on April 15, 2025, at 12:29 PM revealed there should have been wound documentation from the wound care nurse between February 27, 2025, and March 12, 2025, and again on March 19, 2025. These assessments were not completed by the facility wound care nurse who was following Resident 1's wound. The next wound assessment on March 21, 2025, after the missed assessment by the facility wound care nurse on March 19, 2025, revealed a deterioration in Resident 1's wound. The facility failed to provide comprehensive skin assessments that are consistent with professional standards of practice, to promptly identify changes and promote healing of a pressure ulcer. The facility identified the issue with Resident 1's skin assessments on March 21, 2025, and as a result, disciplinary action was taken against Employee 1, licensed practical nurse, and a full house audit was conducted to identify any further residents impacted. The facility conducted staff education that included the following: Skin Integrity and Wound Management on March 21, 2025. Emergency Response and Preparedness; Abuse Prohibition; Skin Integrity; and Wound Management on March 27, 2025. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 15, 2025, at 3:15 PM. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services