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	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunbury Skilled Nursing and Rehabilitation Center	901 Court Street Sunbury, PA 17801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 29512 Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on one of two nursing units (First Floor Nursing Unit, Residents 11, 30, 74, and 91). Findings include: Observation of the facility on July 7, 2024, at 10:52 AM revealed environmental concerns on the First Floor Nursing Unit. There was a smell of urine upon entry to the floor with the urine smell becoming very strong when nearing Resident 91's room and continued onto Residents 74 and 11's room. This strong/intense smell of urine continued to be noted on the south hall of the First Floor Nursing Unit, especially around Resident 91, 11, 74, and 101's rooms, on July 8, 2024, at 9:50 AM, and July 10, 2024, at 11:02 AM. Upon entry to Resident 91's room on July 7, 2024, at 10:53 AM, July 8, 2024, at 9:52 AM, and July 10, 2024, at 11:06 AM, an intense, extremely strong smell of urine was noted, especially by the resident's bed and nightstand area, to the point of causing this surveyor's eyes and nose to burn and water from the stench. Further observation of the First Floor Nursing Unit on July 7, 2024, at 10:58 AM of Resident 30's room revealed the paint was chipped and peeling across the wall below and on each side of the windows and the baseboard was peeling away from the wall under the heating/air conditioning unit. Continued observation of the First Floor Nursing Unit on July 7, 2024, at 11:01 AM revealed that on the hallway wall near the first floor dining room there was a five inch by 6 inch rough, unpainted drywall patch on top of the wallpaper. The surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on July 9, 2024, at 2:10 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 8/18/23 28 Pa. Code 201.18(b)(3) Management (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 207.2(a) Administrator's responsibility

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and staff interview, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of a transfer to the hospital for 2 of 12 residents reviewed (Residents 14 and 114). Findings include: Clinical record review for Resident 14 revealed the resident was transferred to the hospital and admitted on [DATE], for kidney stones. There was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman of Resident 14's transfer to the hospital. Closed clinical record review for Resident 114 revealed the resident was admitted to the facility on [DATE], and sent to the hospital and admitted on [DATE], due to physical aggression. Resident 114 did not return to the facility. There was no evidence the facility notified Office of the State Long-Term Care Ombudsman of Resident 114's transfer to the hospital/discharge. In an interview with Employee 3, admissions coordinator, on July 9, 2024, at 10:37 AM she indicated that she was providing monthly reports to the ombudsman, but Resident 14, and 114 were missed. The above findings were reviewed in an interview with the Nursing Home Administrator and Director of Nursing on July 9, 2024, at 2:51 PM. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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NAME OF PROVIDER OR SUPPLIER Sunbury Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Court Street Sunbury, PA 17801	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 18229 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding a splint recommended by therapy to improve range of motion for one of five residents reviewed (Resident 98). Findings include: During an interview and observation with Resident 98 on July 8, 2024, at 9:50 AM revealed that she had contractures of her bilateral hands. Resident 98 stated staff are supposed to apply splints to her hands at night, but they usually forget or don't know how to apply the splints. Interview with Employee 4 (rehab therapy director) on July 10, 2024, at 12:28 PM revealed that he recommended staff apply Resident 98's bilateral splints on May 24, 2024. Employee 4 provided documentation dated May 24, 2024, titled Daily Interdisciplinary Eagle Room Report, noting staff is to apply a comfy grip orthotic splint to Resident 98's left upper extremity and resting hand orthotic splint during the nighttime hours. Further review of Resident 98's clinical record revealed no documentation that staff applied Resident 98's bilateral hand splints during the nighttime hours. An interview with the Director of Nursing on July 10, 2024, at 12:42 PM confirmed the above findings for Resident 98 and revealed that therapy's recommendation for bilateral splints to Resident 98's hands was never added to her clinical record. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 36798 Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate treatment and services to prevent potential complications of a feeding tube for one of two residents reviewed (Resident 107). Findings include: The facility policy entitled, Medication Administration: Enteral Tubes, last reviewed without changes on August 23, 2023, revealed that the nursing care center will assure the safe and effective administration of enteral formulas and medications. The policy indicated that enteral tubes (a tube inserted into the stomach for the purpose of providing nutrition or medications) would be flushed with at least 15 milliliters (ml) of water before administering any medications and after all medications have been administered. Clinical record review of Resident 107's current orders revealed that her oral medications were to be administered through her Percutaneous endoscopic gastrostomy (PEG tube, a tube passed into the stomach through the abdominal wall to provide a means of feeding or administering medications when oral intake is no feasible or adequate) tube. Further review of Resident 107s orders revealed that there were no current orders related to flushing the PEG tube before or after administration of medications. The surveyor reviewed the above noted concerns related to Resident 107's PEG tube flushes with medication administration with the Director of Nursing during an interview on July 9, 2024, at 2:21 PM. The Director of Nursing provided the surveyor with physician orders for PEG tube flushes with medication administration on July 10, 2024, at 9:30 AM, and confirmed at this time that the orders were obtained after the surveyor brought this to the facility's attention on July 9, 2024. The facility failed to implement appropriate treatment and services to prevent potential complications of a PEG tube for Resident 107. 28 Pa.Code 211.12 (d)(1)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 18229 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care consistent with professional standards of practice for one of one resident reviewed for dialysis concerns (Resident 31). Findings include: Interview with Resident 31 and her husband on July 7, 2024, at 12:12 PM revealed that she goes to dialysis (a process of purifying the blood of a person whose kidneys are not working normally) Tuesday, Thursday, and Saturday. Clinical record review revealed the facility admitted Resident 31 on March 7, 2024. A review of the nursing admission summary dated March 7, 2024, at 5:44 PM revealed Resident 31 is a hemodialysis patient with her dialysis days being Tuesday, Thursday, and Saturday. Documentation further revealed that Resident 31 has an AV (arteriovenous) fistula (one access type that is created by connecting the artery to the vein under the skin) in her left upper arm with positive bruit and thrill (indicates the fistula is functioning properly) noted. Review of Resident 31's physician orders revealed that she did not have an order to go to dialysis, including the specific days of the week, and there were no orders for the care of her AV fistula. There was no further documentation in Resident 31's clinical record since March 7, 2024, that facility staff checked for bruit and thrill to ensure Resident 31's AV fistula was working properly. Further review of Resident 31's clinical record revealed the facility failed to develop a comprehensive plan of care to ensure that Resident 31 received appropriate care and services related to her dialysis. There was no plan of care to include which days of the week she attends dialysis, what times she leaves and returns to the facility, who provides transportation, if she requires a meal before dialysis, monitoring of her AV fistula site, or emergency procedures if needed. There was also no documented evidence in Resident 31's clinical record to indicate that the facility coordinated care with dialysis or her physician to determine if Resident 31's medications were to be given at a different time or if they were appropriate to be skipped on dialysis days. An interview with the Director of Nursing on July 10, 2024, at 12:22 PM confirmed these findings for Resident 31. The facility failed to provide the highest practicable care regarding the coordination of dialysis services and administration of physician-ordered medications for Resident 31. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 38839 Based on observation, clinical record review and staff and resident interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of two residents reviewed for mood/behavior (Resident 7). Findings include: Clinical record review revealed the facility admitted Resident 7 on January 26, 2023, and added a diagnosis of Chronic Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) on November 8, 2023. Further clinical record review for resident 7 revealed the resident is documented as having frequent episodes of hallucinations, delusions, paranoia, yelling out, and refusing care. In an interview and observation with Resident 7 on July 7, 2024, at 12:10 PM the resident was observed lying calmly in bed and had just finished his lunch. The resident was able to carry on a conversation conveying accurate information informing the surveyor of his shower days, and information about a wound on his toe. Upon questioning the resident about his diagnosis of PTSD, the resident acknowledged the diagnosis and indicated watching certain shows on the television such as any war pictures or listening to certain songs, although, not able to specify which songs, were triggers for him. There was no evidence in Resident's 7's plan of care or clinical record to indicate the facility had attempted to identify the resident's history of trauma or identify potential triggers (everyday situations that cause a person to re-experience the traumatic events as if it was reoccurring), from the resident, family, friends, or any other healthcare professionals (such as psychologists, and mental health professionals), to prevent or minimize the triggers from occurring in his environment. A review of Resident 7's plan of care for PTSD only revealed interventions as to how to control, comfort, and handle the resident when having the hallucinations, delusions, etc. These findings were reviewed with the Nursing Home Administrator and Director of Nursing on July 9, 2024, at 3:00 PM. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 18229 Based on clinical record review and resident and staff interview, it was determined that the facility failed to assist a resident to obtain routine dental services for one of two residents reviewed for dental concerns (Resident 2). Findings include: Interview with Resident 2 on July 7, 2024, at 9:49 AM revealed that she could not remember when she last saw the dentist. Clinical record review for Resident 2 revealed that the facility admitted her on November 3, 2019, with payment sources that included the state Medicaid benefit. Review of Resident 2's request for service dated November 21, 2019, revealed she requested to receive dental services. Further review of Resident 2's clinical record revealed she last saw the dentist on January 20, 2022. A review of this progress note revealed that Resident 2 was due for her next visit for prophylactic dental cleaning in six months. There were no further dental visits. The facility provided documentation that Resident 2 was offered a prophylactic cleaning on January 9, 2023, which she refused. An interview with the Director of Nursing and Nursing Home Administrator on July 9, 2024, at 2:04 PM confirmed these findings and no further information was provided to indicate that Resident 2 was offered routine dental services every six months as the State plan allows. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service/storage equipment in a safe and sanitary manner in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on July 7, 2024, at 9:28 AM revealed a large gray garbage can in the dishwashing area. The exterior lid and sides were covered in dried food and liquid spills. The wall behind the garbage can was covered in dried food and liquid spills. Dried food splatter was observed over the dish machine area on the ceiling. The ceiling beside the dish machine area was observed with visible dust hanging from the light covers, on the ceiling, and surrounding the ceiling vent. A metal cart was observed in the kitchen tray line area along the wall with multiple labels of different kinds of cereal. Plastic trays were observed on the cart beside each label with several bowls full of cereal. Cereal was observed scattered on the trays around the bowls. A cart near the steam table contained dust and debris around and under the plate pellet heating system. The metal hood unit above the cooking area contained a buildup of dust/grease on the exterior hood components. The lower shelves of two food preparation tables where dry milk, sugar, and trays with other equipment were stored had dust, dried food debris, and dried liquid spills. A clear container with a white powdery substance was observed sitting on a preparation table near the food processor. A scoop was observed in the container in the product. The container was not labeled or dated. Employee 1, dietetic technician, indicate it was a food thickening agent. A two-compartment sink located beside the preparation area in the kitchen was observed with brown stains and brown/black build up around the faucet and sides of the sink. Employee 1 indicated that staff utlilized the sink to dump ice. A two-door upright freezer was observed to have multiple bags of food, which had been removed from shipping boxes. A clear bag with oval shaped patties was observed with no label of its contents or date to indicate when it was placed there or needed to be used by. Employee 1 indicated the item was chicken fried steak. A plastic container covered very loosely with saran wrap which slid off the container as the door opened was observed labeled as pork 6/19-7/19, the product was cooked and ground up. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A two-door cooler was observed with a clear plastic container labeled sloppy joe 6/18 -7/18, which appeared as cooked ground up meat. Upon request for a cool down log for the prior cooked pork and sloppy joe stored in the freezer and cooler noted above revealed that Employee 1 was not able to show any evidence of a cool down log for the products. Concurrent interview with Employee 2, cook, indicated he had worked at the facility for a year and a half and had never heard of a cool down log. A rack of multiple bread products including hamburger rolls, hot dog rolls, sub rolls, loaves of white bread, and loaves of wheat bread were observed in the dry storage area. None of the products were dated as to when they were placed there or when they needed used by. Employee 1 indicated the bread products are received frozen and they are good for seven days when pulled from the freezer. There was no evidence to indicate when the products were pulled from the freezer. Three significantly brown liquid-stained ceiling tiles were observed in the corner of the dry storage area directly over multiple boxes of food service paper products. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing during an interview on July 8, 2024, at 2:20 PM. 483.60 (i)(2) Food storage safe and sanitary Previously cited 8/18/23 28 Pa. Code 201.14(a) Responsibility of licensee