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	05/08/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and resident and staff interview it was determined that the facility failed to provide a written notice of transfer that included all the necessary contents to residents' responsible parties at the time of transfer for three of four residents reviewed for hospitalizations (Residents 1, 2, and 79); and failed to provide timely written notice of the facility bed-hold policy to residents' responsible parties at the time of transfer that included all the necessary contents for two of four residents reviewed for hospitalizations (Residents 2 and 79).Findings include: Interview with Resident 2 on May 5, 2026, at 1:02 PM revealed that it was necessary for him to go to the hospital because of his indwelling urinary catheter. Clinical record review for Resident 2 revealed nursing documentation dated November 17, 2025, at 12:21 PM that Resident 2's Foley (indwelling urinary catheter, flexible tubing inserted through the penis into the bladder to drain urine) tubing and urinary collection bag presented with frank blood draining, Resident 2 complained of lower pelvic and mid abdominal pain, and his abdomen was firm and tender to touch. He expelled two large liquid emesis (vomit) and had bilateral upper extremity tremors. Staff notified the doctor who instructed staff to send Resident 2 to the emergency room for evaluation. Nursing documentation dated November 17, 2025, at 12:37 PM indicated that Resident 2 was provided with written notice for the transfer, along with written information regarding the facility's bed hold policy. Nursing documentation dated November 20, 2025, at 8:11 PM (three days later) revealed that Resident 2 returned to the facility at 4:05 PM. Review of an untitled document dated November 21, 2025 (four days after Resident 2's transfer to the hospital and after his readmission to the facility) stipulated, Please let this letter serve as formal NOTICE that pursuant to regulatory requirements 42 C.F.R. 483.15 F623 (facility name, hereinafter facility) is discharging or transferring (Resident 2) from its facility effective November 17, 2025. The facility did not create or mail this notice as soon as practicable after Resident 2's transfer as it was created four business days after Resident 2's transfer to the hospital. The nursing documentation dated November 17, 2025, at 12:37 PM indicated that Resident 2 was provided with the written notice; however, the written notice was not dated until November 21, 2025. The written notice of transfer did not include: The name and address (mailing and email of the entity which receives appeal requests)How to obtain an appeal form and assistance in completing the formThe name, address (mailing and email) and telephone number of the Office of the State Long-Term Care OmbudsmanThe mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilitiesThe mailing and email addresses and telephone numbers of the agencies responsible for the protection and advocacy of individuals with mental disorders Review of an unsigned and undated, Bed Hold Notice of Policy and Authorization, document for Resident 2 revealed instructions to, Initial and date below next to each applicable area to indicate when the form was distributed/filed. The form included the fact that the facility distributed the form to Resident 2 on November 17, 2025; and distributed the form to Resident 2's Representative November 21, 2025 (four days after his transfer); which did not meet the requirement of within 24 hours in the cases of an emergency transfer. The document stipulated that if the hospitalization exceeded the number of days indicated (15 days), or is not covered, one could (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	choose to guarantee the bed hold by following the private pay policy. The private pay policy information did not include the current daily rate for bed hold. The surveyor reviewed the above concerns regarding the provision of required notices upon Resident 2's transfer to the hospital during an interview with the Nursing Home Administrator and the Director of Nursing on May 7, 2026, at 2:10 PM. Clinical record review for Resident 1 revealed documentation dated March 15, 2026, at 8:00 AM that the resident had hematemesis (vomiting blood) and there was an order to send the resident to the emergency department. Clinical record review for Resident 1 dated March 15, 2026, at 2:32 PM revealed the resident had returned from the emergency department. Review of an untitled document (written notice of transfer) dated March 16, 2026, for Resident 1 revealed the resident was sent to the hospital on March 15, 2026. Clinical record review for Resident 79 revealed documentation dated April 18, 2026, at 8:03 PM that the resident had shortness of breath. Clinical documentation for Resident 79 dated April 18, 2026, at 8:42 PM revealed that the resident was sent to the hospital for evaluation. Review of the census documentation for Resident 79 revealed that the resident returned to the facility on April 23, 2026. Review of an untitled document (written notice of transfer) dated April 20, 2026, for Resident 79 revealed that the resident was sent to the hospital on April 18, 2026, for shortness of breath. Review of an unsigned and undated, Bed Hold Notice of Policy and Authorization, document for Resident 79 revealed that the document stipulated that if the hospitalization exceeded the number of days indicated (15 days), or is not covered, one could choose to guarantee the bed hold by following the private pay policy. The private pay policy information did not include the current daily rate for bed hold. The written notice of transfers for Residents 1 and 79 did not include: The name and address (mailing and email of the entity which receives appeal requests).How to obtain an appeal form and assistance in completing the form.The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.The mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities.The mailing and email addresses and telephone numbers of the agencies responsible for the protection and advocacy of individuals with mental disorders. The above information for Residents 1 and 79 was reviewed in a meeting with the Nursing Home Administrator on May 8, 2026, at 1:30 PM. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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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. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement range of motion devices for two of four residents reviewed for range of motion concerns (Residents 3 and 12).Findings include: Clinical record review for Resident 3 revealed a diagnoses list that included contracture (A medical condition characterized by the shortening and stiffening of soft tissues, such as muscles, tendons, and ligaments. This leads to a loss of elasticity and a reduced range of motion in the affected area, which can significantly impact daily activities), left hand, and contracture, right hand, since November 21, 2025. An active physician order dated February 26, 2026, directed the use of, Restorative splints, No directions specified for order. Documentation Survey Report data (electronic documentation completed by nurse aide staff to attest to the provision of care) dated May 2026 included the intervention, Restorative Program Splint/brace assistance (number one): See care plan/kardex for program description. Review of Kardex (electronic list of interventions accessible to nurse aide staff to inform staff of resident care needs) instructions dated May 7, 2026, revealed instructions that included: Goal: Prevent contractures and maintain skin integrityRestorative splints: BUE (bilateral upper extremity) passive ROM (the movement of a joint or body part performed entirely by staff, without the resident) actively using their muscles) to all UE (upper extremity) joints bilaterallyPalm guards (type of hand splint or protective device designed to prevent skin damage to the palm by creating a barrier between the fingers and the palmar skin) to BUE at all times, remove for hygiene and with any signs skin irritation/redness terry cloth cone orthotics (type of hand cone device covered with terry cloth, designed to assist individuals with involuntary hand closure) to BUE hands, apply in AM and remove in PM. Remove during meals as needed and hand hygiene care as needed Documentation Survey Report data indicated that nurse aide staff documented the application of terry cloth cone orthotics to BUE hands in the AM and removal in the PM on May 6, 2026, at 1:58 PM and May 7, 2026, at 11:32 AM. Observation of Resident 3 on May 6, 2026, at 11:00 AM revealed no splint in either hand. Observation of Resident 3 on May 7, 2026, at 12:39 PM revealed no splint in either hand. Observation of Resident 3 on May 8, 2026, at 1:04 PM revealed no splint in either hand. Interview with Employee 9 (nurse aide) on May 8, 2026, at 1:23 PM revealed that she was the staff assigned to Resident 3's care on day shift on this date. Employee 9 stated that she placed splints in Resident 3's hands, however, described them as soft fabric. The description provided by Employee 9 was determined to be inter-dry (a soft fabric used for skin fold management; it removes moisture from skin-to-skin contact areas). Employee 9 denied knowledge of cone splints. Upon review of Documentation Survey Report data with Employee 9, she confirmed that her initials on the day (7:00 AM to 3:00 PM) shift on May 2, 2026, attested to the application of the cone splints. Observation of Resident 3's room with Employee 9 on May 8, 2026, at 1:25 PM revealed a white hand splint device on the top of Resident 9's bedside stand. The surveyor reviewed the concerns regarding Resident 3's hand splint omissions during an interview with the Director of Nursing on May 8, 2026, at 1:30 PM. Clinical record review for Resident 12 revealed her diagnoses list included left hand contracture since September 24, 2025. Physician orders for Resident 12 included an active physician order dated June 14, 2025, for staff to apply inter-dry to Resident 12's left palm prior to splint application for prevention/protection every day shift. Review of Resident 12's Treatment Administration Record (TAR, electronic documentation by licensed staff to attest to the implementation of treatments) dated March and April 2026 revealed that licensed staff initialed the application of inter-dry to Resident 12's left palm prior to a splint application for prevention/protection every day shift. The documentation revealed Employee 1 (licensed practical nurse) initialed the treatment as completed on day shift May 5, 6, and 7, 2026. Licensed staff initialed the inter-dry as completed on day shift daily March and April 2026. Observation of Resident 12 on May 6, 2026, at 9:57 AM revealed that she could not fully open the fingers of her left hand from a fist position. Interview with Resident 12 on the date and time of the observation indicated that she did not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know where staff stored her splint device. There was no splint or fabric in Resident 12's left hand. Review of Documentation Survey Report for Resident 12 dated March, April, and May 2026 revealed that nurse aide staff documented the application of a splint on day shift (7:00 AM to 3:00 PM). Observation of Resident 12 on May 7, 2026, at 12:51 PM with Employee 2 (nurse aide) verified Resident 12 had no splint or fabric in her left hand. Interview with Employee 1 and the Director of Nursing on May 7, 2026, at 4:30 PM revealed that the physician order for Resident 12's hand splint was transcribed incorrectly as an intervention for day shift nurse aides, however, evening and night shift nurse aides were to implement the task. The interview confirmed that day shift nurse aide staff were initialing the intervention as implemented, however, the device was not in use during day shift. The evening and night shift nurse aides were not documenting the implementation of the task. Employee 1 stated that she believed that her intervention was for implementation upon the removal of the splint, however, the intervention she documented implementation for instructed to apply to Resident 12's left palm prior to a splint application for prevention/protection every day shift. Nurse aide staff documented the application of the splint on day shift March, April, and May 2026. Licensed nursing staff documented the completion of the treatment before the application of the splint March, April, and May 2026. No staff documented the application of splints evening or night shifts. 483.25 Quality of CarePreviously cited deficiency 6/13/25 28 Pa. Code 211.12(d)1)(3)(5) Nursing services

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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. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the main kitchen of the facility.Findings include: Initial tour of the facility's main kitchen with Employee 19, Dietary Manager, on May 5, 2026, at 9:09 AM revealed the following: A package of waffles in a freezer with no evidence of a date of when they were placed there, opened, or needed to be used by. A package of frozen fish in a freezer. The written date on the item was smudged and unreadable. An open box of salt that was stored on a shelf with spices. The package indicated to use within three years of opening. The item was not dated with an open date. The surface of the shelf was covered with a granule-like substance. There were four packaged rolls of ground beef in a stainless-steel pan located on the bottom shelf of a refrigerator. Employee 19 indicated they were thawing for use later. These items were located next to four, one gallon plastic containers of milk. One of the containers of milk was in direct contact with the pan holding the thawing meat. There was a black colored bag covering a mixer. The bag had an accumulation of dust, hair, and food particles on it. The hood over the stove had a build-up of dust on the inner vents and noted dust on the fire suppression nozzles over the stove. The three-compartment sink was filled and had various cookware in it to be washed. The sanitizer strips used for testing expired in July 2022. An empty food tray cart identified as clean per Employee 19 had a build-up of dried stains located on the underside of the supports used to hold the trays. The curtain that covered a window above the three-compartment sink had stains and was discolored. The top of the window frame had a significant build-up of dust. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 2:00 PM, and May 7, 2026, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview it was determined that the facility failed to ensure complete and accurate clinical records for four of 26 residents reviewed (Residents 3, 5, 10, and 83). Findings include: Clinical record review for Resident 5 revealed that the Immunization tab in the resident's electronic health record (EHR) information indicated that Employee 8 (registered nurse/infection control prevention coordinator) confirmed on October 21, 2025, that education regarding the risks and benefits of the influenza vaccine was provided to Resident 5; and that he refused the immunization. Review of a Patient/Resident Influenza Vaccine Informed Consent document signed by Employee 8 on October 21, 2025, indicated that staff obtained verbal consent to administer the influenza vaccine to Resident 5. Review of Resident 5's Medication Administration Record (MAR, electronic documentation of the administration of medications by licensed staff) dated October 2025 revealed that staff documented Resident 5's refusal of the influenza immunization on October 7, 2025, at 6:27 PM (two weeks before the documentation in Resident 5's EHR Immunization tab of the education regarding the risks and benefits of the immunization and the verbal consent by Resident 5's responsible party). Interview with the Nursing Home Administrator and the Director of Nursing on May 7, 2026, at 2:15 PM confirmed the above findings for Resident 5. They indicated that Resident 5 and his responsible party received education regarding the vaccine's risks and benefits before the attempt to administer the vaccine and staff continued to attempt to administer the vaccine in response to Resident 5's refusals, and that the documentation was incorrect. It was then confirmed that the data entries in the resident's Immunization tab of the EHR could be updated/changed without any date, time, or electronic signature of staff altering the entry as evidenced by Resident 5's influenza immunization information that was updated weeks after his influenza immunization refusal. An additional Immunization Report for Resident 5 provided by the facility via hard copy recorded that staff (no signature or identifier recorded) provided education regarding the 2025-2026 influenza immunization's risks and benefits on October 22, 2025; and that Resident 5 refused multiple attempts to administer the vaccine. Clinical record review for Resident 10 revealed an active physician order dated October 28, 2025, to not resuscitate (DNR, do not provide chest compressions or breathing assistance in the event of no pulse or absence of breathing) in the event of a medical emergency. Review of Resident 10's physical chart revealed a POLST (Physician Order for Life Sustaining Treatment, portable medical order form that records treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) signed by the certified registered nurse practitioner on September 16, 2025, did not have a signature of Resident 10 or her responsible party. Interview with Employee 1 (licensed practical nurse) on May 6, 2026, at 12:00 PM confirmed that the POLST available in Resident 10's clinical record failed to include her responsible party's signature. Interview with Employee 10 (registered nurse/unit manager) on May 6, 2026, at 12:02 PM verified Resident 10's POLST did not include a signature of the resident or the resident's responsible party. Employee 10 confirmed that if the resident were to transfer out of the facility in an emergency, the facility would send the POLST that, in Resident 10's situation, would not have her responsible party's signature to indicate an acknowledgement or agreement with the end-of-life decisions. The surveyor reviewed the above concerns regarding Resident 10's incomplete POLST during an interview with the Director of Nursing and the Nursing Home Administrator on May 6, 2026, at 2:00 PM. Clinical record review for Resident 3 revealed an active physician's order dated March 30, 2026, for DNR, comfort care. Review of Resident 3's physical chart revealed a POLST signed only by the medical practitioner on April 3, 2026. Interview with Employee 1 on May 6, 2026, at 11:42 AM confirmed that no resident or responsible party signed Resident 3's POLST form and no co-signatures of staff on the form attested that the end-of-life decisions recorded on the form were those of Resident 3 and/or her responsible party. Interview with Employee 10 on May 6, 2026, at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:02 PM confirmed that no staff attested to Resident 3 or her responsible party's participation in developing the POLST form (missing signatures of staff). Employee 10 also verified that if Resident 3 were to have a medical emergency, the POLST form would relay care wishes to the practitioner; there would be no accompanying nurse progress notes that would indicate what Resident 3 or her responsible party decided for end-of-life care. The facility provided a revised POLST form for Resident 3 on May 7, 2026, at 2:18 PM (following the surveyor's questioning) that now included two staff signatures that were not dated. The Director of Nursing confirmed on May 7, 2026, at 2:18 PM that staff did not date when the document was altered to include two staff signatures. Clinical record review for Resident 83 revealed a POLST in her physical chart that was signed by her sister/responsible party; however, did not include a practitioner signature. Interview with Employee 11 (registered nurse) on May 6, 2026, at 11:56 AM confirmed that the POLST available for Resident 83 did not include a practitioner signature. Resident 83's POLST also did not contain staff signatures. Interview with Employee 10 on May 6, 2026, at 12:02 PM confirmed the POLST available to convey end-of-life wishes in the event of an emergency did not contain a physician or staff signatures. An active physician order dated September 23, 2025, instructed staff to not resuscitate (DNR) Resident 83 in the event of a medical emergency. 28 Pa. Code 211.5(f)(i)-(xi)(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview and review of available employee immunization records it was determined that the facility failed to maintain documentation of the COVID-19 vaccination status of each staff member for four of four employees reviewed (Employees 4, 5, 6, and 7).Findings include: The surveyor requested documentation of the facility's tracking of employees' current COVID-19 immunization status during an interview with the Director of Nursing and the Nursing Home Administrator on May 6, 2026, at 2:00 PM; with the Nursing Home Administrator on May 7, 2026, at 6:10 PM; and with Employee 8 (registered nurse/infection control prevention coordinator) on May 8, 2026, at 10:25 AM. Interview with Employee 8 on May 8, 2026, at 10:56 AM indicated that the facility maintains staff immunization documentation in an electronic record keeping system. Employee 8 indicated that once the surveyor provided the names of employees for review, she would be able to access the records for those staff. Interview with Employee 4 (housekeeping/assistant manager) on May 8, 2026, at 11:54 AM revealed that she believed that she had two or three COVID-19 immunization boosters; the last immunization was received September 14, 2022. Interview with Employee 5 (floor technician) on May 8, 2026, at 11:56 AM revealed that he had two COVID-19 immunization boosters; he approximated that his last immunization was in the year 2021. Interview with Employee 6 (laundry district manager) on May 8, 2026, at 11:57 AM revealed that she believed that she was fully vaccinated for COVID-19; however, stated that she received her last COVID-19 immunization at a local grocery store in the year 2024. Employee 6 denied receipt of a COVID-19 immunization for the 2025-2026 season. Interview with Employee 7 (housekeeping) on May 8, 2026, at 11:58 AM revealed that he chose not to receive COVID-19 immunizations. Interview with Employee 8 on May 8, 2026, from 12:15 PM to 12:30 PM revealed that she was unable to access COVID-19 immunization documentation stored in the facility's electronic record system for staff immunization documentation for Employees 4, 5, 6, and 7. Employee 8 confirmed that Employees 4, 5, 6, and 7 are employees provided through a contracted company for housekeeping and laundry services. Employee 8 was able to access her own COVID-19 immunization documentation at that time; however, the names of the four employees interviewed were not recorded in the electronic record. The surveyor reviewed the concern that the facility's staff immunization electronic recording system did not contain documentation of the COVID-19 immunization status for Employees 4, 5, 6, and 7; and could only provide Employee 8's information during an interview with the Director of Nursing and the Nursing Home Administrator on May 8, 2026, at 12:40 PM. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3) Nursing services

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on clinical record review, review of select facility policies and procedures, observation, and resident and staff interviews. it was determined that the facility failed to promote resident choices about aspects of his or her life in the facility that are significant to the resident regarding food brought in from home for one of 26 sampled residents (Resident 65). Findings include: The policy entitled Food Brought in for Patients/Residents, last reviewed without changes August 27, 2025, revealed food and beverages may be brought in from outside the facility for individual patients/residents but must not be offered to other residents. Food brought to residents by family or visitors will be handled and stored in a safe and sanitary manner. Food may be reheated in microwaves by staff only. Interview with Resident 65 on May 8, 2026, at 10:22 AM revealed his daughter brought him some homemade gluten free spaghetti and the facility would not let him eat it stating they will not reheat food brought in from home. Interview with Employee 20 (licensed practical nurse) on May 5, 2026, at 12:06 PM revealed that the facility removed the microwaves from the nursing units. Clinical record review for Resident 65 revealed nursing documentation dated April 9, 2026, at 4:30 PM revealed the interdisciplinary team reviewed Resident 65's behavioral incident on April 8, 2026. Documentation revealed Resident 65 became agitated when informed that outside food (spaghetti brought from family) could not be reheated per facility infection control and food safety guidelines. Resident 65 punched the wall in his room, sustaining a small open area to the right hand. Interview with the Nursing Home Administrator and Director of Nursing on May 8, 2026, at 9:27 AM confirmed the pantries for the first and second Floor Nursing Units did not contain a device for heating food. 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 205.25 (b) Kitchen

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 26 residents reviewed (Resident 12).Findings include: Clinical record review for Resident 12 revealed her diagnoses list included left hand contracture (A medical condition characterized by the shortening and stiffening of soft tissues, such as muscles, tendons, and ligaments. This leads to a loss of elasticity and a reduced range of motion (ROM) in the affected area, which can significantly impact daily activities.) since September 24, 2025. Physician orders for Resident 12 included an active physician order dated June 14, 2025, for staff to apply inter-dry (a soft fabric used for skin fold management; it removes moisture from skin-to-skin contact areas) to Resident 12's left palm prior to splint application for prevention/protection every day shift. Review of Resident 12's Treatment Administration Record (TAR, electronic documentation by licensed staff to attest to the implementation of treatments) dated March and April 2026 revealed that licensed staff initialed the application of inter-dry to Resident 12's left palm prior to a splint application for prevention/protection every day shift. Observation of Resident 12 on May 6, 2026, at 9:57 AM revealed that she could not fully open the fingers of her left hand from a fist position. Interview with Resident 12 on the date and time of the observation indicated that she did not know where staff stored her splint device. Review of Documentation Survey Report (electronic documentation by nurse aide staff to attest to the care provided to a resident) data for Resident 12 dated March, April, and May 2026 revealed that nurse aide staff documented the application of a splint on day shift (7:00 AM to 3:00 PM). A Medicare five-day MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], assessed Resident 12 with ROM (range of motion) impairment of her bilateral upper extremities. Staff assessed Resident 12 as dependent on staff for eating, oral hygiene, toileting, upper and lower body dressing, personal hygiene, transfers, and bed mobility. An admission MDS dated [DATE], assessed Resident 12 with ROM impairment of her bilateral upper extremities. Resident 12 remained dependent on staff for care; Resident 12 was not independent for any care noted above. Quarterly MDS assessments dated June 8, 2025, September 7, 2025, and December 7, 2025; and an annual MDS assessment dated [DATE], no longer assessed a ROM impairment for Resident 12's upper extremities. Resident 12 required supervision/touching assistance for eating and continued to be dependent on staff for oral hygiene, toileting, upper and lower body dressing, personal hygiene, transfers, and bed mobility. A plan of care created January 7, 2026, to address Resident 12's splint and brace use, noted that, Patient cannot apply and remove splint/brace r/t (related to) functional deterioration. The surveyor reviewed the concern regarding MDS accuracy for Resident 12 during an interview with the Nursing Home Administrator and the Director of Nursing on May 8, 2026, at 9:40 AM. Interview with Employee 3 (registered nurse assessment coordinator) on May 8, 2026, at 11:12 AM confirmed that Resident 12 had a diagnosis of a left hand contracture, had a plan of care that identified her functional limitation, had MDS assessments that confirmed she required staff assistance for all activities of daily living, that staff documented the application of a splint to her left hand, and she had physician ordered treatment to address her potential for left hand injury (inter-dry). The interview confirmed that the facility had no information or evidence that Resident 12 had a resolution of her range of motion impairment identified on her MDS assessments until June 2025. The interview confirmed that the RAI (Resident Assessment Instrument, MDS) instructions to complete the ROM section instructs that ROM deficits capture the limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury. 28 Pa. Code 211.5(f)(ix) 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395512	A. Building B. Wing	05/08/2026

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, observation, and staff interview it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a cardiac pacemaker for one of 26 residents reviewed (Resident 1). Findings Include: Clinical record review for Resident 1 revealed a diagnosis list that included the presence of a cardiac pacemaker (an electronic device to help regulate the beating of the heart), sick sinus syndrome (a malfunctioning of the heart that impacts the heart's natural pacemaker node), and atrial fibrillation (an irregular heart rhythm). Medical provider documentation for Resident 1 dated May 5, 2026, at 1:00 AM revealed that the resident has a pacemaker. Cardiology documentation dated September 5, 2025, at 3:39 PM revealed that Resident 1 had a leadless pacemaker implanted in May 2022. Review of Resident 1's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 2:00 PM. A follow-up observation of Resident 1's room on May 8, 2026, at 9:11 AM revealed that there was a transmittal device on the resident's dresser located next to the bed. A concurrent interview with Employee 20, licensed practical nurse, revealed that the device was utilized to transmit data from the resident's pacemaker so that it can be remotely monitored. A follow-up review of Resident 1's care plan revealed a care plan created on May 6, 2026, (after the initial surveyor findings), that noted the resident is at risk of complications related to the pacemaker / internal defibrillator. The care plan did not address the transmittal device and/or associated care. The additional information for Resident 1 was reviewed with the Nursing Home Administrator and Director of Nursing on May 8, 2026, at 12:46 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on clinical record review, review of facility documentation, observation, and resident and staff interview, it was determined that the facility failed to appropriately assess a side rail for entrapment zone risks and obtain informed consent for side rail use for one of six residents reviewed for accident hazards (Resident 69).Findings include: Clinical record review for Resident 69 revealed a diagnosis list that included muscle weakness and hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated February 10, 2026, revealed that facility staff assessed Resident 69 as having a BIMS (Brief Interview for Mental Status) of 15, which indicated no cognitive impairment. Observation and concurrent interview with Resident 69 on May 6, 2026, at 10:30 AM revealed a side rail that was attached to the resident's right side of the bed. The side rail appeared to be in the down position but was visible several inches above the mattress. The resident reported she uses the side rail to get in and out of bed. Based on the interview that Resident 69 reported she utilizes the side rail to get in and out of bed, documentation (consents, assessments, entrapment zone measurements) was requested by the surveyor during a meeting with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 2:00 PM. The facility reported the related documentation should be in the electronic health record (EHR). Review of the EHR for Resident 69 revealed no documentation for Resident 69 related to consent for use of the side rail and any entrapment zone measurements. Therapy documentation for Resident 69 provided by the facility dated May 23, 2025, at 12:03 PM revealed an assessment summary that noted the resident was referred to therapy services and has received a bed assist rail. The documentation noted the resident is demonstrating ability to place and remove rail to bedside height safely and the railing has improved the resident's ability to perform bed mobility from her baseline. Physical Therapy Discharge Summary documentation provided by the facility dated June 12, 2025, at 2:55 PM noted, the resident has received services to ensure she is safe with the use of bed assist railing and has demonstrated good safety and management of railing. Facility documentation titled, Bed Safety Evaluation - V2, dated March 19, 2026, at 11:43 AM revealed documentation that questioned if there was a gap between the head or foot board and mattress which was marked as no. There was no further indication that any additional zones were assessed. The staff selected that All questions have been answered ?yes' - RAILS/DEVICES Are Not Required. A request for any entrapment zone measurements or documentation of informed consent for use of the side rail was made during a meeting with the Nursing Home Administrator and Director of Nursing on May 7, 2026, at 2:00 PM and May 8, 2026, at 9:45 AM. An interview with Employee 29, Director of Therapy, on May 8, 2026, at 9:38 AM revealed that therapy does the resident safety assessments for any bed rails and not entrapment zone assessments. An interview with Employee 21, maintenance staff, on May 8, 2026, at 12:37 PM revealed that Employee 21 could find no entrapment zone checks related to Resident 69's side rail. Employee 21 revealed that he just assessed the side rail after it was brought to the facility staff's attention by the surveyor and provided a form titled, Bed System Measurement Device Test Results Worksheet, dated May 8, 2026, that indicated the resident's right-side rail was just assessed. Employee 21 indicated that he was not aware that the side rail was on the bed. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 8, 2026, at 12:45 PM. The facility reported they could not find any informed consents related to Resident 69's side rail. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with a PICC line, and catheter care, for four of four employees reviewed for competencies (Employees 1, 22, 23, and 24).Findings include: A review of the facility documentation revealed that the facility had a total of five residents with indwelling catheters (insertion of a tube into the bladder to remove urine), and one resident with a discontinued PICC line (peripherally inserted central catheter, a long flexible tube inserted into a vein in the arm that reaches a large central vein near the heart). A request for nursing staff competencies for PICC line and catheter care revealed the facility was unable to provide these competencies for Employees 1 and 24 (LPN, licensed practical nurse), and Employees 22 and 23 (RN, registered nurse). Interview with Employee 28 (registered nurse educator) on May 8, 2026, at 1:21 PM confirmed that the facility could provide no documentation that ensured Employees 1, 22, 23, and 24 had specific competencies and skill sets to care for the residents' needs listed above. The findings were reviewed with the Director of Nursing on May 8, 2026, at 1:25 PM. 28 Pa Code 201.20(a) Staff development

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations and resident and staff interviews, it was determined that the facility did not provide food in accordance with resident preferences for one of 26 residents reviewed (Resident 47).Findings include: The facility policy entitled Dining and Food Preferences, last reviewed without changes August 27, 2025, revealed individual dining, food, and beverage preferences are identified for all residents. The dining services director, or designee will interview the resident or resident representative to complete a food preference interview within 72 hours of admission. The purpose of this interview will be to identify individual preferences for dining location, mealtimes, including times outside of the routine schedule, and food and beverage preferences. The food preference interview will be entered into the medical record. Food and fluid preferences will be entered in the menu management software system. Clinical record review revealed the facility admitted Resident 47 on April 1, 2026. Interview with Resident 47 on May 5, 2026, at 2:35 PM revealed that Resident 47 told staff she needs gravy, or extra sauce with all her meals due to having swallowing issues. Resident 47 said she frequently cannot eat the meal provided and must ask for a toasted cheese due to the kitchen not providing her extra sauce or gravy. Resident 47 stated that no one has talked to her about her food preferences since admission. Observation of Resident 47's lunch meal on May 6, 2026, at 12:22 PM revealed that Resident 47 did not receive any gravy or extra sauces, and her meal ticket did not note her preferences. Interview with Employee 19 (dietary manager) on May 8, 2026, at 1:13 PM confirmed that no one interviewed Resident 47 regarding her food preferences until after the surveyor's questioning. Employee 19 confirmed that she was asked to add extra gravy to Resident 47's meal ticket earlier that day. Nursing documentation dated May 8, 2026, at 11:39 AM revealed the registered dietitian spoke with Resident 47 regarding her meal preferences. Reviewed findings with the Nursing Home Administrator and Director of Nursing on May 8, 2026, at 1:25 PM. They confirmed the facility failed to obtain Resident 47's meal and beverage preferences within 72 hours of her admission to the facility. 28 Pa. Code 211.6 (a) Dietary services