

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395953	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Sunset Ridge Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Ridge Road Bloomsburg, PA 17815	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of select facility policy and clinical records, and staff interviews, it was determined that the facility failed to timely notify the physician and the resident's representative of an incident with the potential to require physician intervention and cause psychosocial harm to one resident out of 19 sampled (Resident 45).</p> <p>Findings include:</p> <p>A review of facility policy entitled Notification of Changes last reviewed January 2024, revealed that it is the policy of the facility that a change in a resident's condition are to be shared with the resident's representative and reported to the attending physician.</p> <p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>Further review of Resident 6's clinical record revealed a progress note dated January 15, 2024, at 4:57 PM which indicated Resident 6 was in the dining room when he wheeled himself over to Resident 45, a female resident, who was sitting at a table by herself. Staff observed Resident 6 touching Resident 45 under her nightgown in the upper thigh area.</p> <p>An interview with Employee 3, nurse aide, on April 24, 2024, at 2:19 PM revealed that Employee 3 witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area near her private area.</p> <p>A review of Resident 45's clinical record revealed no documented evidence that the facility had notified the resident's representative or attending physician that Resident 45 had been the victim of sexual abuse.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing and Nursing Home Administrator on April 25, 2024, at approximately 1:45 PM confirmed the facility failed to notify the resident's representative and attending physician of the incident of sexual abuse.</p> <p>28 Pa Code 211.12 (c)(d)(3)(5) Nursing services</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that two residents (Resident 45 and 42) were free from sexual abuse perpetrated by one resident (Resident 6) out of 19 sampled residents.</p> <p>Findings include:</p> <p>A review of the current facility policy entitled Abuse Prevention Program, last reviewed by the facility January 2024, revealed that the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.</p> <p>A review of the facility policy entitled Identifying Types of Abuse last reviewed January 2024, revealed sexual abuse is non-consensual sexual conduct of any type with a resident. Sexual abuse includes but is not limited to unwanted intimate sexual touching of any kind especially to the breasts or perineal area. Further it is indicated that sexual contact is non-consensual if the resident appears to want the contact to occur but lacks the cognitive ability to consent.</p> <p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with a diagnosis of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>An Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated January 3, 2024, revealed that the resident was moderately cognitively impaired.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with a diagnosis of hypertensive heart disease. A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>A social services note dated November 20, 2023, at 4:41 PM revealed that the Social Services Director spoke with Resident 6 about his interactions with female residents and told Resident 6 that he will need to refrain from touching female residents.</p> <p>A nursing note dated January 6, 2024, at 5:12 PM revealed that Resident 6 was inappropriate with a peer.</p> <p>Nursing noted on January 8, 2024, at 8:16 AM that a new order was obtained to monitor Resident 6 for socially inappropriate behavior, sexual acts towards residents or staff, every shift, for inappropriate sexual behaviors and provide additional details in the progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a progress note dated January 15, 2024, at 4:57 PM revealed that Resident 6 was in the dining room. Resident 6 wheeled himself over to another resident, a female resident, who was sitting at a table by herself. Staff observed Resident 6 touching the other female resident (Resident 45) under her nightgown in the upper thigh area and the RN (Registered Nurse) was made aware.</p> <p>An interview with Employee 7, a nurse aide, on April 23, 2024, at approximately 1:15 PM revealed Resident 6 can be sexually inappropriate and needs to be told he cannot touch females, residents or staff. Employee 7 stated that she has seen the resident touch other female residents on the arms and hands. She stated that he has touched her on her bottom before and he had to be told to stop, that it was not appropriate.</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that the employee witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area, near her private area.</p> <p>An interview with Employee 5, a nurse aide, on April 24, 2024, at 2:26 PM revealed the employee stated that she was aware that Resident 6 had his hand up Resident 45's nightgown was touching her upper thigh area, by her private area.</p> <p>An interview with Employee 4, LPN (license practical nurse), on April 25, 2024, at 9:47 AM revealed that this employee was coming down the hall with her medication cart and witnessed Resident 6 and Resident 45 seated at a dining room table. Employee 4 stated that she saw Resident 6's hand up Resident 45's nightgown on her upper thigh area, by Resident 45's private area. The employee stated she made Employee 6, RN Supervisor, aware of the incident.</p> <p>An interview with Employee 6, RN, on April 25, 2024, at 11:06 AM revealed that she was called to the floor the night the incident happened when staff observed Resident 6 inappropriately touching Resident 45 in a sexual manner. Employee 6 stated that staff made her aware that Resident 6 had touched Resident 45 upper thigh area and she then made the Director of Nursing (DON) aware. Employee 6 stated that Resident 6's behaviors have been an ongoing concern, that administration was aware, and it is talked about in report almost every day.</p> <p>A review of Resident 45's clinical record revealed that the facility failed to document that Resident 45 was touched in a sexual nature by Resident 6 on January 15, 2024.</p> <p>Applying the reasonable person concept, in the case of Resident 45, who is unable to speak for herself, and the assessment of how most people would react to the situation of being sexually abused by Resident 6, Resident 45 would have suffered psychosocial harm and humiliation.</p> <p>The facility failed to fully investigate and report this incident of sexual abuse of Resident 45. The facility failed to develop and implement necessary interventions for a resident with a known history of sexual inappropriate behaviors to prevent the sexual abuse of Resident 45. The facility failed to develop and implement interventions after the sexual abuse occurred to prevent further incidents of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of behavior tracking for January 2024 revealed that on January 15, 2024, during the night shift and January 16, 2024, during the day shift, staff documented that Resident 6 had continued to display sexually inappropriate behaviors. There was no documentation in Resident 6's clinical record describing these behaviors and to whom they were directed.</p> <p>A review of clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination).</p> <p>A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that this employee had witnessed Resident 6 grab Resident 42's breasts. The employee could not remember the exact date but stated that the Resident 6 is known for targeting and being inappropriate with Resident 42 and Resident 45.</p> <p>An interview with Employee 5, a nurse aide, on April 24, 2024, at 2:26 PM revealed that she was aware and had witnessed Resident 6 grope Resident 42's breasts. She stated she was not sure of the date that this occurred, but other staff were aware that this happened.</p> <p>An interview with Employee 4, LPN, on April 25, 2024, at 9:47 AM revealed that the employee stated she, and other employees, had witnessed Resident 6 groping Resident 42's breasts. Employee 4 stated that she documented this behavior in Resident 6's behavior tracking and made Employee 6, RN, aware.</p> <p>An interview with Employee 6, RN, on April 25, 2024, at 11:06 AM confirmed that she was aware that Resident 6 and touched Resident 42's breasts. She stated that everyone knows about the resident's behaviors, and they do their best to keep him away from female residents. Employee 6 stated that she has made the DON aware of these ongoing behaviors.</p> <p>A review of Resident 6's Behavior Tracking For February 2024 revealed that Employee 4 documented that Resident 6 was being sexually inappropriate on February 4, 2024, during the evening shift, but failed to note that Resident 6 had groped Resident 42's breast as reported during employee interviews at the time of the survey ending April 25, 2024.</p> <p>A review of Resident 42's clinical record revealed that the facility failed to document that Resident 42 was the victim of sexual abuse perpetrated by Resident 6.</p> <p>The facility failed to investigate and report this incident of sexual abuse. Further the facility failed to prevent the sexual abuse of Resident 42 perpetrated by Resident 6 who has a known history of being sexually inappropriate with female residents and had sexually abused another female resident on January 14, 2024.</p> <p>Applying the reasonable person concept, in the case of Resident 42, who is unable to speak for herself, and the assessment of how most people would react to the situation of being sexually abused by Resident 6, Resident 42 would have suffered psychosocial harm and humiliation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 1:45 PM confirmed the facility failed to ensure that Residents 45 and 42 were free from sexual abuse perpetrated by Resident 6.</p> <p>Refer to F609, F610</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>28 Pa. Code 211.12 (c)(d)(5) Nursing Services</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of select facility policy and clinical records, and staff interviews it was determined that the facility failed to timely report sexual abuse of two residents (Resident 45 and 42) out of 19 residents sampled to the State Survey Agency.</p> <p>Findings include:</p> <p>A review of facility policy entitled Investigation of Allegations of Abuse, Neglect, or Misappropriation of Resident Property last reviewed January 2024 revealed within 24 hours all incidents of abuse will be reported electronically to the [NAME] Field Office Pennsylvania Department of Health. Alleged or proven incidents of abuse involving staff, resident, or other healthcare workers will be reported on a PB22 to the [NAME] Field office of the Pennsylvania Department of Health (the state survey agency) within five working days of the incident. The police are to be called immediately in cases of sexual abuse.</p> <p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>A review of an Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated January 3, 2024, revealed that the resident was moderately cognitively impaired.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>A review of a progress note dated January 15, 2024, at 4:57 PM indicated that Resident 6 was in the dining room when he wheeled himself over to another resident, Resident 45, who was sitting at a table by herself. Staff witnessed Resident 6 touching Resident 45 under her nightgown in the upper thigh area.</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that this employee had witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area near her private area.</p> <p>An interview with Employee 5, a nurse aide, on April 24, 2024, at 2:26 PM revealed that this employee stated that she was aware that Resident 6 had his hand up Resident 45's nightgown was touching her upper thigh area by her private area.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Employee 4, LPN (license practical nurse), on April 25, 2024, at 9:47 AM revealed that she was coming down the hall with her medication cart and witnessed Resident 6 and Resident 45 sitting at a dining room table. Employee 4 stated that she saw Resident 6's hand up Resident 45's nightgown on her upper thigh area by Resident 45's private area. The employee stated she made Employee 6, RN Supervisor, aware of the incident.</p> <p>An interview with Employee 6, RN, on April 25, 2024, at 11:06 AM revealed that staff called her to the floor in response to the incident during which Resident 6 inappropriately touched Resident 45 in a sexual nature. Employee 6 confirmed that staff made her aware that Resident 6 had sexually touched Resident 45 and that she made the Director of Nursing (DON) aware. The employee stated Resident 6's behaviors have been an ongoing concern, that administration was aware, and it is talked about in report almost every day.</p> <p>The facility failed to report this incident of resident abuse to the State Survey Agency.</p> <p>A review of clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination). A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that this employee witnessed Resident 6 grab Resident 42's breasts, but could not remember the exact date. Employee 3 stated that Resident 6 is known to staff for targeting and being inappropriate with Resident 42 and Resident 45.</p> <p>An interview with Employee 5, nurse aide, on April 24, 2024, at 2:26 PM revealed that she was aware, and has witnessed Resident 6 grope Resident 42's breasts. She stated she was not sure of the date that this occurred, but other staff were aware this happened at the time.</p> <p>An interview with Employee 4, LPN, on April 25, 2024, at 9:47 AM revealed this employee stated she, and other employees, had witnessed Resident 6 groping Resident 42's breasts. The employee stated that she documented this behavior in Resident 6's behavior tracking and made Employee 6 aware.</p> <p>A review of Resident 6's Behavior Tracking for the month of February 2024 revealed Employee 4 documented that Resident 6 was sexually inappropriate on February 4, 2024 during the evening shift.</p> <p>An interview with Employee 6, RN Supervisor, on April 25, 2024, at 11:06 AM revealed that she was aware that Resident 6 had touched Resident 42's breasts and that she made the DON aware of Resident 6's ongoing behaviors.</p> <p>The facility failed to report the sexual abuse of Resident 42 to the State Survey Agency.</p> <p>The facility failed to report these incidents of sexual abuse to the State Survey Agency, [NAME] Field Office Pennsylvania Department of Health. The facility failed to submit a completed investigation, PB22, to the [NAME] Field office of the Pennsylvania Department of Health within five working days of the incident. Further the facility failed to contact local law enforcement in response to the incidents of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 1:45 PM confirmed that the facility had failed to report the sexual abuse of Resident 45 and Resident 42 to the local police department and to the State Survey Agency, [NAME] Field Office of Pennsylvania Department of Health</p> <p>28 Pa. Code 201.14 (a)(c) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(c) Resident Rights</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing Services</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and select facility policy and staff interviews it was determined that the facility failed to conduct a timely and thorough investigation into sexual abuse of two residents out of 19 sampled (Resident 45 and 42).</p> <p>Findings included:</p> <p>A review of facility policy entitled Investigation of Allegations of Abuse, Neglect, or Misappropriation of Resident Property last reviewed January 2024 revealed when notified of abuse, the Registered Nurse Supervisor or Department Head shall immediately initiate an investigation which includes the removal of the alleged perpetrator and notify the administrator/designee. Abuse situations include but are not limited to sexual abuse. When an allegation of sexual abuse is made or suspected the following steps should be implemented. Do not display alarm or disbelief. Reassure the abuse is not their fault. Arrange for medical attention. Document and preserve any evidence. Do not touch or disturb the scene. Further it is indicated written statements will be obtained from all appropriate individuals on duty at the time of the incident. Statements obtained will include a response to the incident and will include individuals who had contact with the resident during that time.</p> <p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>A review of an Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated January 3, 2024, revealed that the resident was moderately cognitively impaired.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>A review of a progress note dated January 15, 2024, at 4:57 PM indicated Resident 6 was in the dining room and wheeled himself over to another resident, Resident 45, who was sitting at a table by herself. Staff witnessed Resident 6 touching Resident 45 under her nightgown in the upper thigh area.</p> <p>An interview with Employee 3, NA (nurse aide), on April 24, 2024, at 2:19 PM revealed the employee witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area near her private area.</p> <p>An interview with Employee 5, NA, on April 24, 2024, at 2:26 PM revealed that the employee stated that she was aware that Resident 6 had his hand up Resident 45's nightgown was touching her upper thigh area by her private area.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Employee 4, LPN (license practical nurse), on April 25, 2024, at 9:47 AM revealed that she was coming down the hall with her medication cart and witnessed Resident 6 and Resident 45 sitting at a dining room table. Employee 4 stated that she saw Resident 6's hand up Resident 45's nightgown on her upper thigh area by Resident 45's private area. The employee stated she made Employee 6 RN Supervisor aware of the incident.</p> <p>An interview with Employee 6, RN, on April 25, 2024, at 11:06 AM revealed she was called to the floor that night and made aware that Resident 6 had touched Resident 45 in a sexual manner. The employee stated that she made the Director of Nursing (DON) aware.</p> <p>A review of clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination). A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that this employee witnessed Resident 6 grab Resident 42's breasts. The employee could not remember the exact date this sexual abuse occurred.</p> <p>An interview with Employee 5, a nurse aide, on April 24, 2024, at 2:26 PM revealed that she was aware and had witnessed Resident 6 grope Resident 42's breasts. She stated she was not sure of the date that this occurred, but staff were aware this happened.</p> <p>An interview with Employee 4, LPN, on April 25, 2024, at 9:47 AM revealed this employee stated she and other employees had witnessed Resident 6 groping Resident 42's breasts. The employee stated that she documented this behavior in Resident 6's behavior tracking and made Employee 6 aware.</p> <p>A review of Resident 6's Behavior Tracking For February 2024 revealed that Employee 4 documented that Resident 6 was sexually inappropriate on February 4, 2024 during the evening shift.</p> <p>An interview with Employee 6, RN, on April 25, 2024, at 11:06 AM revealed she was aware that Resident 6 and touched Resident 42's breasts. The employee further indicated that she has made the DON aware of these ongoing behaviors.</p> <p>The facility failed to initiate an investigation into the sexual abuse of Resident 45 and 42 perpetrated by Resident 6.</p> <p>There is no documented proof the facility followed their policy for investigating sexual abuse by seeking medical attention for Resident 45 and Resident 42.</p> <p>The facility staff did not document and preserve evidence of the sexual abuse.</p> <p>Further Employee 6, RN, failed to obtain witness statements from all staff on duty, and other potential witnesses, during the incidents of sexual abuse of Resident 45 and Resident 42.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sunset Ridge Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Ridge Road Bloomsburg, PA 17815	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 1:45 PM confirmed that the facility did not complete investigations into the sexual abuse of Resident 45 and 42 by Resident 6.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(c) Resident Rights</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing Services</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice regarding facility initiated transfers to the hospital was provided to the residents and their representatives for five of 19 residents sampled (Resident 27, 7, 59, 66, and 29)</p> <p>Findings include:</p> <p>A review of Resident 27's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>A review of Resident 7's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>A review of Resident 59's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE]. The resident was again transferred to the hospital [DATE] and returned to the facility on [DATE].</p> <p>A review of Resident 66's clinical record revealed that the resident was transferred to the hospital on February 24, 2024, and expired at the hospital on February 28, 2024.</p> <p>A review of Resident 29's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>Clinical record reviewd revealed no documented evidence that the facility provided written notices to these residents and their representatives upon each facility initiated transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred to, contact and address information for the Office of the State Long-Term Care Ombudsman, and, if applicable, information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>Interview with the Nursing Home Administrator on [DATE] at approximately 1:45 PM, confirmed that there was no evidence that written notifications of the facility initiated transfers were provided to the residents and their representatives.</p> <p>28 Pa. Code 201.29 (c.3)(2) Resident rights</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of clinical records and staff interview it was determined that the facility failed to provide residents or their representatives with written information of the facility's bed hold policy upon transfer to the hospital of five residents out of 19 residents sampled (Resident 27, 7, 59, 66, and 29).</p> <p>Findings include:</p> <p>A review of Resident 27's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>A review of Resident 7's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>A review of Resident 59's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE]. The resident was again transferred to the hospital [DATE] and returned to the facility on [DATE].</p> <p>A review of Resident 66's clinical record revealed that the resident was transferred to the hospital on February 24, 2024, and expired at the hospital on February 28, 2024.</p> <p>A review of Resident 29's clinical record revealed that the resident was transferred to the hospital on [DATE], and returned to the facility on [DATE].</p> <p>There was no documented evidence that the facility provided these residents and/or their representatives written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of transfer.</p> <p>Interview with the Director of Nursing (DON) on [DATE], at approximately 1:45 PM confirmed that the facility was unable to provide documented evidence of the provision of written notice of the facility's bed hold policy upon hospital transfer.</p> <p>28 Pa Code 201.18 (e)(1) Management</p> <p>28 Pa Code 201.29 (b) Resident rights</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and/or implement a person-centered comprehensive care plan for five residents out of 19 sampled (Residents 2, 6, 60, 61 and 14).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included constipation.</p> <p>A review of Resident 2's current physician orders revealed the following orders:</p> <p>Senna-S tablet 8.6-50mg give one tablet by mouth for chronic constipation and chronic ileus (Inability of the intestine to contract normally and move waste out of the body)</p> <p>Miralax 17 grams by mouth every 12 hours for constipation and chronic ileus.</p> <p>Milk of Magnesia 400 mg/5ml give 30 mls by mouth as needed for constipation. Administer if no BM by the third day/9 shifts.</p> <p>Dulcolax Suppository insert on suppository rectally as needed for constipation for no bowel movement with 24 hours after of the administration of Milk of Magnesia.</p> <p>Fleet Enema 7-19 gm/118 ml insert one applicator rectally as needed for constipation for no bowel movement by the end of the following shift after administration of suppository.</p> <p>A review of Resident 2's current comprehensive plan of care revealed that the resident's care plan failed to include the resident's diagnosed constipation and planned interventions and prescribed bowel regimen to prevent, treat and manage the resident's bowel activity.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>A review of a social services note dated November 20, 2023, at 4:41 PM revealed that the Social Services Director spoke with Resident 6 about his interactions with female residents and told Resident 6 he will need to refrain from touching female residents.</p> <p>A review of a nursing note dated January 6, 2024, at 5:12 PM revealed Resident 6 was inappropriate with a peer.</p> <p>A review of a nursing note dated January 8, 2024, at 8:16 AM revealed a new order was obtained to monitor the resident for socially inappropriate behavior, sexual acts towards residents or staff every shift for inappropriate sexual behaviors and provide additional details in the progress notes.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a progress note dated January 15, 2024, at 4:57 PM indicated Resident 6 was in the dining room when he wheeled himself over to another resident who was sitting at a table by herself. Resident 6 was witnessed touching the other female resident under her nightgown in the upper thigh area.</p> <p>A review of Resident 6's current comprehensive plan of care in effect at the time of the survey ending revealed that the facility failed to address the resident's sexually inappropriate behaviors on the resident's care plan and develop specific person centered interventions to manage the resident's behaviors and protect other residents from sexual abuse.</p> <p>A review of clinical record revealed that Resident 60 was admitted to the facility on [DATE], with diagnoses which included hypertensive heart disease type 2 diabetes and orthopedic after care.</p> <p>A review of the resident's Bowel and Bladder assessment dated [DATE] revealed the resident had functional incontinence and was placed on a prompted voiding program. The resident was to be prompted to toilet upon arising, before and after meals, and at bedtime.</p> <p>A review of Resident 60's current comprehensive plan of care revealed that the facility failed to address the resident's functional incontinence on the resident's care plan, and the interventions which included the resident's prompted voiding program to treat and manage the resident's incontinence.</p> <p>Review of Resident 61's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include pancreatic cancer, ischemic cardiomyopathy (the hearts decreased ability to pump blood properly due to heart damage), atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow), and the presence of an automatic implantable cardiac defibrillator (AICD- is a microcomputer that is implanted under the skin of the upper chest area. It monitors heart rate and delivers therapy in the form of small electrical pulses. An AICD is a permanent device inserted into the right ventricle and typically placed near the collarbone under the skin of the chest).</p> <p>Continued review revealed that the resident had a Mediport (port-a-cath; an implanted device designed to permit repeated access to the venous system for the delivery of medications, fluids, and nutritional solution and for the sampling of venous blood) in his right chest.</p> <p>A review of Resident 61's current comprehensive plan of care revealed that the facility failed to address the resident's care needs related to potential complications and the emergency care of the Mediport on the resident's care plan. There was no documented evidence that the facility identified and addressed the resident's care needs related to the AICD device as an area of focus with interventions to provide AICD checks as ordered or to monitor for signs and symptoms of AICD complications. The facility failed to address the emergency care of the AICD device and actions to be taken if the AICD was activated (i.e., consulting the physician, obtaining vital signs [clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] and keeping the resident and staff safe from the electrical shock. The resident should notify staff if a shock is felt, and staff should be aware not to touch resident is being shocked since the shock can be felt)</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 14's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include obstructive sleep apnea (intermittent airflow blockage during sleep), and congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues).</p> <p>Review of physician orders dated January 29, 2024, revealed an order for BiPAP (Bilevel Positive Airway Pressure-a mechanical breathing device with a mask that delivers air pressure to ensure breathing airways stay open during sleep) apply during HS (hours of sleep) and remove in the AM (morning).</p> <p>A physician order dated February 12, 2024, was noted for oxygen administration at two liters per minute via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen).</p> <p>A review of Resident 14's current comprehensive plan of care revealed that the facility failed to address the resident's care needs related to the use of oxygen therapy and the use of the BiPAP machine during hours of sleep on the resident's care plan.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 1:45 PM confirmed the facility failed to ensure that comprehensive care plans addressed each resident's individualized care needs and necessary services.</p> <p>28 Pa Code 211.12 (c)(d)(3)(5) Nursing Services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of select facility policies and clinical records, and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed and professional nurses promptly assessed residents following instances of sexual abuse for two residents (Residents 45 and 42) and failed to follow physician's orders for administration of a bowel protocol to promote bowel activity for two residents (Resident 2 and 61) out of 19 sampled.</p> <p>Findings include:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient ' s EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding</p> <p>the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>A review of facility policy entitled Investigation of Allegations of Abuse, Neglect, or Misappropriation of Resident Property last reviewed January 2024 revealed in any resident to resident abuse the residents will be separated and assessed for injury.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>A review of an Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated January 3, 2024, revealed that the resident was moderately cognitively impaired.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired.</p> <p>A review of Resident 6's clinical record revealed a progress note dated January 15, 2024, at 4:57 PM which indicated Resident 6 was in the dining room when he wheeled himself over to another resident, Resident 45, who was sitting at a table by herself. Staff observed Resident 6 touching Resident 45 under her nightgown in the upper thigh area. The RN (Registered Nurse) was made aware according to the entry.</p> <p>An interview with Employee 3, nurse aide, on April 24, 2024, at 2:19 PM revealed that this employee had witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area, near her private area.</p> <p>An interview with Employee 4, LPN (license practical nurse), on April 25, 2024, at 9:47 AM revealed that Employee 4 was coming down the hall with her medication cart and witnessed Resident 6 and Resident 45 sitting at a dining room table. Employee 4 saw Resident 6's hand up Resident 45's nightgown on her upper thigh area by Resident 45's private area. The employee stated she made Employee 6, RN Supervisor, aware of the incident.</p> <p>A review of Resident 45's clinical record revealed that nursing staff failed to document that Resident 45 was victim of sexual abuse perpetrated by Resident 6. Further review of the clinical record revealed the no documented nursing assessment after the resident was sexually touched by Resident 6 to identify if the resident had any trauma, skin injuries, bruising to her inner thighs, vaginal bleeding, or pain in the genital area.</p> <p>A review of clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination).</p> <p>An interview with Employee 3, a nurse aide, on April 24, 2024, at 2:19 PM revealed that employee witnessed Resident 6 grab Resident 42's breast, but could not remember the exact date the sexual abuse occurred.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Employee 5, a nurse aide, on April 24, 2024, at 2:26 PM revealed that she was aware and had witnessed Resident 6 grope Resident 42's breast. She stated she was not sure of the date that this sexual abuse occurred, but stated that other nursing staff were aware this happened.</p> <p>An interview with Employee 4, LPN, on April 25, 2024, at 9:47 AM revealed that this nurse stated that she, and other employees, had witnessed Resident 6 groping Resident 42's breasts. The employee stated that she documented this behavior in Resident 6's behavior tracking and made the RN supervisor aware. A review of Resident 6's Behavior Tracking for February 2024 revealed that Employee 4 documented Resident 6 was sexually inappropriate on February 4, 2024, during the evening shift.</p> <p>A review of Resident 42's clinical record revealed that nursing staff failed to document that Resident 42 had been sexually abused by Resident 6. Further review of the clinical record revealed the no documented professional nursing assessment following the incident of sexual abuse by Resident 6. There was no documented nursing assessment of the resident's breasts for potential skin injuries, swelling, bruising or pain in her breast area.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 1:45 PM confirmed the facility failed to promptly assess residents after instances of sexual abuse.</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included constipation.</p> <p>A review of physician's orders initially dated December 30, 2022, revealed the following bowel regimen:</p> <p>Milk of Magnesia 400 mg/5ml give 30 mls by mouth as needed for constipation. Administer if no BM by the third day/9 shifts.</p> <p>Dulcolax Suppository insert on suppository rectally as needed for constipation for no bowel movement with 24 hours after of the administration of Milk of Magnesia.</p> <p>Fleet Enema 7-19 gm/118 ml insert one applicator rectally as needed for constipation for no bowel movement by the end of the following shift after administration of suppository.</p> <p>Review of Resident 2 's report of bowel activity from the Documentation Survey Report v2 for the month of April 2024, revealed that the resident did not have a bowel movement on April 14, 15, 16, 2024 (9 shifts).</p> <p>Review of Resident 2's Medication Administration Record for April 2024 revealed no documented evidence that nursing administered the prescribed bowel protocol during the period without a bowel movement to promote bowel activity.</p> <p>A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses to include malignant neoplasm of the pancreas (pancreatic cancer), muscle weakness and need for assistance with personal care.</p> <p>The resident had physician orders dated April 12, 2024, for the following bowel regimen:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Milk of Magnesia 400 MG/5ML. Give 30 ml by mouth as needed for constipation. Administer if no BM by the third day/9 shifts. Document effectiveness.</p> <p>Dulcolax Suppository. Insert 1 suppository rectally as needed for constipation for no bowel movement by the end of the following shift after administration of Milk of Magnesia. Notify MD if ineffective.</p> <p>Fleet Enema 7-19 GM/118 ML (Sodium Phosphates). Insert 1 applicatorful rectally as needed for constipation for no bowel movement by the end of the following shift after administration of suppository. Notify MD if ineffective.</p> <p>Review of Resident 61 's report of bowel activity from the Tasks for the month of April 2024, and the Medication Administration Record (MAR) for April 2024, revealed the that the resident did not have a bowel movement on:</p> <ul style="list-style-type: none"> - April 16, 2024 - day one without a bowel movement - April 17, 2024 - day two without a bowel movement - April 18, 2024 - day three (9 shifts) without a bowel movement, 30 ml of Milk of Magnesia was ordered but no evidence that it was administered to the resident. - April 19, 2024 - day four without a bowel movement, Dulcolax suppository was ordered but no evidence that it was administered. <p>There was no documented evidence that the staff had notified the physician that the resident went four consecutive days, April 16, 17, 18, 19, 2024, without a bowel movement.</p> <p>An interview with the Director of Nursing (DON) on April 25, 2024, at approximately 1:45 PM, confirmed the physician orders were followed to promote normal bowel activity.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>

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NAME OF PROVIDER OR SUPPLIER Sunset Ridge Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Ridge Road Bloomsburg, PA 17815	
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>48277</p> <p>Based on observation, review of facility scheduled meal times and select facility policy, and resident and staff interviews the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack when greater than 14 hours elapsed from the supper meal to breakfast the next day for residents including seven residents of 19 sampled (Residents 56, 27, 62, 6, 26, 21, and 28).</p> <p>Findings include:</p> <p>Review of the facility's Snacks Policy last reviewed January 2024, indicated that it is the facility policy to provide bulk snacks and beverages to each resident care area for availability upon request, snacks as identified in the individual plan of care, and bedtime (HS-hour of sleep) snacks to all residents.</p> <p>Review of the facility's scheduled (not exact times may fluctuate +/- 15 minutes) meal times revealed 14 hours between the evening meal and the next day's breakfast meal.</p> <p>During an interview on April 23, 2024, at 11:30 AM Resident 56 stated that he would like milk or coffee before bed at times, and that evening snacks are not always offered.</p> <p>During a group interview with six alert and oriented residents on April 24, 2024, at 11:00 AM, all six residents (Residents 27, 62, 6, 26, 21, and 28) in attendance stated that snacks are not routinely offered to them in the evenings. The residents stated they would like to receive an evening/bedtime snack. Resident 27 reported that when he has requested a snack, one is provided for him but if he does not ask, then none is offered or received.</p> <p>Observation of the resident pantry on the [NAME] Unit on April 25, 2024, at approximately 10:00 AM revealed that snacks and beverages such as milk and juice were not available as reflected in the facility policy which indicated that bulk snacks and beverages would be provided to each resident care area.</p> <p>Interview with the foodservice director (FSD) on April 25, 2024, at 10:30 AM confirmed that due to the close location of the kitchen to the nursing units that staff call or come to the kitchen when a snack is requested during the day. The FSD confirmed that snacks are sent each evening for nursing staff to offer to each resident.</p> <p>During an interview on April 25, 2024, at approximately 9:00 AM the administrator failed to provide documented evidence that residents were routinely offered and provided with a bedtime/evening snack.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for three of 19 sampled residents (Resident 6, 45, 42).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place.</p> <p>A review of clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease.</p> <p>A review of a social services note dated November 20, 2023, at 4:41 PM revealed the Social Services Director spoke with Resident 6 about his interactions with female residents and told Resident 6 he will need to refrain from touching female residents.</p> <p>There was no documentation in Resident 6's clinical record as to which residents Resident 6 was touching noted by some identifier, how many residents or the number of interactions Resident 6 had with other female resident, nor was there any indication what dates these interactions occurred.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a nursing note dated January 6, 2024, at 5:12 PM revealed Resident 6 was inappropriate with a peer. There was no further documentation to describe these inappropriate behaviors that were witnessed by staff or identification of the peer by some identifier.</p> <p>A review of a nursing note dated January 8, 2024, at 8:16 AM revealed a new order was obtained to monitor the resident for socially inappropriate behavior, sexual acts towards residents or staff every shift for inappropriate sexual behaviors and provide additional details in the progress notes.</p> <p>There was no documentation of the precipitating factors or events which led to nursing staff contacting the physician and obtaining on order on January 8, 2024 to monitor the resident for sexually inappropriate behaviors.</p> <p>A review of behavior tracking for January 2024 revealed that on January 15, 2024, during the night shift and January 16, 2024, during the day shift, staff noted that Resident 6 displayed sexually inappropriate behaviors. There was no documentation in the resident's clinical record detailing these sexually inappropriate behaviors and to whom they had been directed.</p> <p>A review of behavior tracking for February 2024 revealed on February 4, 2024, during the evening shift the resident was documented as having sexually inappropriate behaviors. There was no documentation in the resident's clinical record describing these behaviors and to whom they had been directed.</p> <p>A review of clinical record revealed that Resident 45 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>A review of Resident 6's clinical record revealed a progress note dated January 15, 2024, at 4:57 PM, which indicated that Resident 6 was in the dining room when he wheeled himself over to another resident, (subsequently identified as Resident 45), who was sitting at a table by herself. Staff observed Resident 6 touching the other female resident under her nightgown in the upper thigh area. Resident 6's clinical record did not identify the female resident by any form of identification.</p> <p>An interview with Employee 3 NA (nurse aide) on April 24, 2024, at 2:19 PM revealed the employee witnessed Resident 6 with his hand up under Resident 45's nightgown and touching her in the upper thigh area near her private area.</p> <p>An interview with Employee 4 LPN (license practical nurse) on April 25, 2024, at 9:47 AM revealed the employee was coming down the hall with her medication cart and witnessed Resident 6 and Resident 45 sitting at a dining room table. The employee indicated she saw Resident 6's hand up Resident 45's nightgown in her upper thigh area by Resident 45's private area.</p> <p>A review of Resident 45's clinical record revealed the facility failed to document that Resident 45 was victim of sexual abuse by Resident 6. Resident 45's clinical record contained no documented nursing assessment of Resident 45 for physical signs of injury after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination).</p> <p>An interview with Employee 3 NA on April 24, 2024, at 2:19 PM revealed the employee witnessed Resident 6 grab Resident 42's breast. The employee could not remember the exact date but stated that the Resident 6 is known for targeting and being inappropriate with Resident 42 and Resident 45.</p> <p>An interview with Employee 5 NA on April 24, 2024, at 2:26 PM revealed that she was aware and has witnessed Resident 6 grope Resident 42's breast. She stated she was not sure of the date that this occurred, but staff were aware this happened.</p> <p>An interview with Employee 4 LPN on April 25, 2024, at 9:47 AM revealed the employee stated she and other employees had witnessed Resident 6 groping Resident 42's breasts. The employee indicated that she documented this behavior in Resident 6's behavior tracking and made the RN(registered nurse) supervisor aware. A review of Resident 6's Behavior Tracking For February 2024 revealed the employee documented the resident being sexually inappropriate on February 4, 2024 during the evening shift.</p> <p>A review of Resident 42's clinical record revealed that nursing staff did not document that Resident 42 had been the victim of sexual abuse perpetrated by Resident 6. Resident 45's clinical record contained no nursing assessment of Resident 45 for injuries after the incident of sexual abuse.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on April 25, 2024, at approximately 2:45 PM confirmed that the facility's licensed and professional nursing staff failed to document complete and accurate information in residents' clinical records and these records did not contain an accurate representative of the actual experiences of the residents.</p> <p>28 Pa. Code 211.5 (f)(iii) Medical records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observation, review of clinical records and select facility policy, and staff interview, it was determined that the facility failed to maintain infection control practices to prevent spread of infection for three of 19 sampled residents (Residents 56, 1, and 59)</p> <p>Findings include:</p> <p>According to the Centers for Disease Control (CDC) Enhanced Barrier Precautions (EBP) guidance focus on gown and glove use and not other important infection control measures for prevention of multi-drug resistant organisms (MDRO). EBP are recommended for residents with any of the following: infection or colonization with a MDRO, a wound, or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Review of the facility Enhanced Barrier Precautions last reviewed/revised March 2024 indicated that to minimize the transmission of germs transferring from residents to staff hands and clothing, staff will wear a gown and gloves when providing care to residents that require significant physical contact and are at high risk of acquiring or spreading Multidrug Resistance Organisms (MDRO). Enhanced barrier precautions will be applied to residents known to be colonized with a targeted MDRO, per CDC guidelines, residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube (PEG tube), tracheostomy/ventilator regardless of their MDRO status, and residents with a chronic wound, regardless of their MDRO status. Chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. The procedure to implement indicated signage will be displayed outside of resident rooms specifying the type of PPE (personal protective equipment) needed and will clarify high-contact activities, PPE, including gowns and gloves, will be made available immediately outside resident rooms, alcohol-based hand rub will be accessible for use in or in close proximity to the resident's room, and staff will remove and discard gown and gloves after each resident care encounter and perform hand hygiene upon exiting the room.</p> <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses which include dementia and cerebral infarction (stroke).</p> <p>A physician order dated November 17, 2022, at 6:10 PM was noted for a Foley catheter (closed sterile system with a catheter and retention balloon that is inserted into the urethra to allow for bladder drainage) 16 Fr (French size, which is based upon measurement of the external diameter of the catheter tube) 10 cc (cubic centimeter, milliliter (ml) a measurement of volume in the metric system) balloon to straight bag gravity drainage for a diagnosis of urinary retention.</p> <p>Review of a Wound Assessment Report dated April 23, 2024, revealed Resident 1 had a stage 3 pressure ulcer [characterized by full-thickness skin loss, subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough (yellow, tan, gray, green, or brown tissue) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling] to the left butt which measured 2.30 cm x 2.10 cm x 0.30 cm with slough and serosanguineous exudate (thin, often slightly yellow drainage).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on April 23, 2024, at 10:30 AM and April 25, 2024, at 9:00 AM revealed no evidence that EBP were implemented for Resident 1 based on the presence of the pressure ulcer and Foley catheter.</p> <p>A review of the clinical record revealed that Resident 56 was admitted to the facility on [DATE], with diagnoses which include diabetes mellitus and venous insufficiency (failure of the veins to adequately circulate the blood especially from the lower extremities), venous ulcer, and diabetic foot ulcers.</p> <p>Review of a Wound Assessment Report dated April 23, 2024, revealed Resident 56 had two venous ulcers on the right leg with heavy exudate (drainage) and diabetic ulcers on the third, fourth, and fifth toes of the right foot.</p> <p>Observations on April 23, 2024, at 11:00 AM and April 24, 2024, at 9:30 AM revealed no evidence that EBP were implemented for Resident 56 based on the presence of the venous ulcers on the resident's right leg and diabetic ulcers on the third, fourth, and fifth toes of the right foot.</p> <p>A review of clinical record revealed the Resident 59 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the tongue and larynx.</p> <p>A review of physician order's dated January 16, 2024, revealed the resident has a tracheal stoma (a hole made in the skin in front of your neck to allow you to breathe) and was to receive humidified oxygen at 5 L/min via a trach collar as needed.</p> <p>Observations on April 23, 2024, at 1:00 PM and April 25, 2024, at approximately 9:30 AM revealed no evidence that EBP were implemented for Resident 59 based on the presence of the resident's tracheal stoma.</p> <p>Interview with the infection preventionist on April 25, 2024, at 11:30 AM confirmed that the facility failed to implement EBP as required for residents at higher risk for the development of infections based on facility policy and CDC Enhanced Barrier Protection guidance.</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>41581</p> <p>Based on staff interviews it was determined that the facility failed to timely train one agency employees out of eight employees reviewed on the facility's abuse prohibition policy and procedures.</p> <p>Findings include:</p> <p>An interview with Employee 1 Agency NA (nurse aide) on April 23, 2024, at approximately 1:00 PM revealed the employee stated it was her first day working in the facility and she was not given an orientation or trained on the facility's abuse policy prior to working on the nursing unit with the residents.</p> <p>A review of the resident's employee file revealed no documented evidence was provided that the facility provided abuse training on the facility's abuse policy prior to working on the nursing units with residents.</p> <p>An interview with Nursing Home Administrator on April 25, 2024, at approximately 1:45 PM confirmed there was no documentation that Employee 1 was trained on the facility's abuse prohibition policy and procedures prior to assuming their job duties.</p> <p>28 Pa. Code 201.20(b) Staff development</p> <p>28 Pa Code 201.18 (e)(1) Management</p>		