STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, facility policy, facility investigative reports, and staff interviews, it was determined the facility failed to implement adequate safety measures, including sufficient staff supervision, for a resident identified as at high risk for falls resulting in multiple recurrent falls for one resident (Resident 50) out of 17 sampled Findings include: A review of Resident 50 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing), abnormalities of gait and mobility (refer to any unusual or unexpected patterns of movement or changes in the way an individual walks or moves), repeated falls, hypertensive heart disease (refers to heart conditions caused by high blood pressure), and urinary tract infection (UTI - is an infection in the bladder, kidneys, ureters, or urethra). The resident's person-centered fall care plan initiated on January 13, 2023, identified Resident 50 was at risk for falls due to frequent falls and impulsiveness due to diagnosis and history of self-transfers with ambulation attempts and impulsivity with poor safety awareness. A review of a quarterly Minimum Data Set (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], revealed Resident 50 had severe cognitive impairment. A Fall Risk assessment dated [DATE], confirmed that Resident 50 remained at high risk for falls. Despite this, a clinical record review revealed that Resident 50 experienced 14 falls from July 13, 2024, through February 22, 2025, with 11 of these falls being unwitnessed On July 13, 2024, at 3:58 AM, a progress note documented that Resident 50 was found lying on the floor on his right side. The resident had sustained a 5 cm by 2.5 cm abrasion on the right forehead and a 1 cm by 1.2 cm abrasion on the right shoulder. A clean and dry incontinence brief was found in the bathroom. Following this incident, staff were instructed to check alarms at the beginning of each shift to ensure proper placement and functionality. A therapy consultation was also initiated. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 27, 2024, at 4:43 AM, another progress note indicated that Resident 50 was found on the floor near the foot of the bed with the alarm sounding. The resident stated that he had attempted to get out of bed to use the bathroom but tripped. He sustained a 1.5 cm by 0.5 cm head wound on the back of his head. Orders were received to cleanse the wound and cover it with a bandage. Additional fall prevention measures were implemented, including placing a fall mat on the left side of the bed and ensuring a urinal was available at the bedside. According to a progress note from August 9, 2024, at 8:50 AM, staff responded to an alarm in the East shower room and found Resident 50 sitting on the floor next to the toilet. His red scoot chair was found damaged on the opposite wall. There were no reported injuries. A therapy referral was made to assess whether the red scoot chair remained appropriate or if an alternative seating option was needed. On September 11, 2024, at 5:15 PM, a progress note described an incident in which a registered nurse (RN) responded to a chair alarm sounding from the visitor bathroom. The bathroom door was locked, and when staff gained entry, they found Resident 50 sitting on the floor with his back against the grab bar and his legs extended toward the wall. No injuries were noted. A subsequent urine culture tested positive for a urinary tract infection (UTI), and new antibiotic orders were placed. A progress note from September 23, 2024, at 1:15 AM, stated that Resident 50 was found by his assigned licensed practical nurse (LPN) and nurse aide (NA) sitting on the floor next to an overturned bedside table. The resident was sitting on part of the metal frame of the table and had abrasions on both posterior thighs. He was assisted into his chair, and frequent visual checks were initiated as a preventive measure. On October 3, 2024, at 10:45 PM, a nursing assistant (NA) found Resident 50 lying on the floor on his right side. His walker was positioned against the wall near the bathroom. The resident stated he had attempted to go to the bathroom. A bowel and bladder diary was initiated, and a referral to therapy was sent. This was documented in a progress note dated October 4, 2024, at 12:00 AM. A progress note from October 12, 2024, at 12:00 AM, reported that Resident 50 was found sitting on the floor on the left side of his bed, with his back against the bed. His bed pad was partially off the bed. He was placed in his chair and taken to the nurses' station for close observation. A therapy referral was also placed. On November 18, 2024, at 11:34 AM, a progress note stated that Resident 50's chair alarm was sounding in another resident's bathroom. When staff entered, they found him lying on his right side on the bathroom floor. He stated, I needed to take a crap, and I still need to. After an RN assessment confirmed no injuries, staff assisted him back into his chair and took him to his bathroom. A medication review was ordered, and the physician prescribed Flomax to address benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (LUTS) in an effort to improve his toileting frequency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a November 27, 2024, at 12:00 AM progress note, Resident 50 was found lying on his left side on the floor, with his walker on top of him. He had a small amount of bleeding from his left elbow and a 1/2-inch scratch in the same area. The wound was treated, with orders for daily wound care until healed. Urine was found on the floor, and it was determined that the resident slipped in his own urine. After the incident, he was toileted and placed in a Broda chair (a type of chair or wheelchair that provides comfort, support, and mobility throughout the day and designed for individuals requiring long-term care and allow for safe and comfortable positioning without the use of restraints) at the nurses' station, as he was not sleeping. A therapy referral was also made. On December 10, 2024, at 1:43 AM, a progress note stated that at 12:15 AM, Resident 50's alarm sounded, and staff found him sitting on the floor next to his bed. He reported that he had rolled out of bed. A 4 cm by 2. 5 cm hematoma was noted on the left side of his head. Ice was applied, and the resident was able to move all extremities. After being assisted off the floor, incontinence care was provided, and a body pillow was introduced for positioning support. A therapy referral was sent. On January 14, 2025, at 4:05 AM, Resident 50's alarm alerted staff to another fall. He was found lying on his left side between the foot of his bed and the dresser, with his walker beside him. He was wearing only nonskid socks and a pull-up, and he was incontinent of urine. The resident reported that he had been trying to get up. Staff assisted him into his scoot chair and provided incontinence care. Based on a review of fall incidents, his toileting schedule was adjusted to 3:45 AM to better align with his overnight toileting needs. A therapy referral was also made. A February 22, 2025, at 4:20 PM progress note detailed that at 3:50 PM, an RN was called to the East Hall regarding another fall. Resident 50 was found lying on his left side in the doorway of room [ROOM NUMBER]. He had a 2 cm by 2 cm abrasion/laceration on the left side of his forehead and surrounding bruising measuring 5 cm by 5 cm. A witnessed account from another resident stated that Resident 50 had been standing up, pulling up his pants when he lost his balance, hit the door with his rear, and then struck his head on the door jamb. Staff observed that the resident's speech was significantly delayed, and he was not moving his extremities as usual. Despite this, he denied pain, and there were no visible deformities in his lower or upper extremities. His vital signs remained stable. A neurological assessment revealed significantly delayed speech, reduced movement from baseline, and difficulty following instructions. The resident was found to have a wet brief at the time of the assessment. His head injury was cleaned, and the physician was notified. Orders were received to transfer the resident to the emergency room (ER) for further evaluation. Upon his return, a three-day bowel and bladder evaluation was ordered to determine whether adjustments were needed in his toileting program. Further review of Resident 50's person-centered care plan indicated that frequent visual checks were added as a fall intervention on September 23, 2024. However, there was no documented evidence that these checks were consistently conducted. Despite Resident 50's repeated falls and the documented need for frequent visual checks, a review of the facility's documentation revealed no evidence that these checks were consistently conducted. The resident continued to experience falls in various locations-including the resident's room, bathrooms, and common areas-indicating that the facility failed to provide adequate supervision and effective fall prevention interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on March 13, 2025, at approximately 9:30 AM, the Director of Nursing (DON) confirmed that the facility did not implement the planned intervention of frequent visual checks. The DON also acknowledged that the facility did not provide adequate supervision to prevent the resident's recurrent falls, despite the identified high risk The facility failed to ensure adequate supervision and implement effective fall prevention interventions to protect Resident 50 from recurrent falls, as evidenced by multiple documented falls, injuries, and a lack of follow-through with the planned intervention of frequent visual checks.28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident (Resident 60) and failed to implement interventions to alleviate pain for one resident (Resident 15) out of 17 residents reviewed. Findings include: A review of the clinical record revealed that Resident 60 was admitted to the facility on [DATE], with diagnoses to include multiple rib fractures with routine healing. A review of Resident 60's clinical record revealed physician orders for as-needed (PRN) pain medication included: Oxycodone HCL 5 mg (narcotic pain medication), one tablet by mouth every four hours as needed for pain rated 5 to 7 (scale used to rate pain, with 0 being no pain and 10 being severe pain), initiated on January 13, 2025, and ending January 26, 2025. Oxycodone HCL 5 mg, two tablets by mouth every four hours as needed for pain rated 8 to 10, initiated on January 13, 2025, and ending January 26, 2025. Oxycodone HCL 5mg one tablet by mouth every 4 hours for pain as needed for pain 4 to 7 and two tablets by mouth every 4 hours for pain as needed for pain 8 to 10 initiated on January 27, 2025, and ending February 15, 2025. Oxycodone HCL 5mg give one tablet by mouth every 4 hours for pain rated 4 to 7 and two tablets by mouth every 4 hours for pain rated 8 to 10 initiated on February 18, 2025, and remains active. In January 2025, staff administered Oxycodone 30 times; of these, 23 instances lacked documented evidence of non-pharmacological interventions attempted prior to administration A review of the resident's January 2025 Medication Administration Record (MAR) revealed staff administered the PRN Oxycodone 30 times; of these, 23 instances lacked documented evidence of non-pharmacological interventions attempted prior to administration A review of the resident's February 2025 MAR revealed staff administered Oxycodone 28 times; of these, 8 instances lacked documented evidence of non-pharmacological interventions attempted prior to administration. A review of the resident's March 2025 MAR revealed staff administered Oxycodone one time with no documented evidence of non-pharmacological interventions attempted prior to administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at approximately 1:15 PM both confirmed there was no evidence that non-pharmacological interventions were consistently attempted and deemed ineffective before administering as-needed narcotic pain medication. A clinical record review revealed Resident 15 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and emphysema (a chronic lung disease characterized damage to the air sacs in the lungs. A review of the resident's plan of care dated November 11, 2021, for pain related to arthritis, identified a potential for pain related to arthritis, with planned interventions to encourage/assist to reposition frequently for comfort and therapy evaluation and treatment per orders. The care plan goal was documented as the resident reporting that pain management was within acceptable limits. A review of physician orders revealed that, beginning August 1, 2023, the resident was prescribed: Acetaminophen 325 mg (Tylenol), two tablets by mouth every six hours as needed for mild pain (rated 1 to 5), with required non-pharmacological interventions including repositioning, back rubs, warm/cool compress application, and diversional activities prior to administration. A review of progress notes indicated: On January 12, 2025, at 5:00 PM, the resident complained of left-sided lower back pain, and a new order was placed for a lidocaine patch to be applied at bedtime. On January 13, 2025, at 10:31 AM, the resident continued to complain of low back pain, and a physician was contacted for an x-ray order. On January 13, 2025, at 10:33 AM, the resident refused the lidocaine patch, and the physician discontinued the order. On January 13, 2025, at 1:00 PM, an x-ray was performed. A nursing progress note dated January 14, 2025, at 1:31AM documented Xray results revealed a compression fracture (a type of broken bone that can cause your vertebrae to collapse, making them shorter) of lumbar vertebrae (bones that make up the lower back) L1, L2, and L3 of an indeterminate age and degenerative disc disease (a condition where the spinal discs, which act as shock absorbers between the vertebrae, wear down and lose their cushioning over time, leading to pain and potentially other issues) of the lumbar vertebrae between L4 and L5. Despite continued complaints of pain, there was no documented evidence that the resident was offered the as-needed acetaminophen or any other alternative pain-relief interventions. During an interview on March 12, 2025, at approximately 11:00 AM, the Director of Nursing (DON) confirmed the facility staff failed to develop and implement appropriate pain management interventions for Resident 15's continued pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure non-pharmacological interventions were attempted prior to administering PRN narcotic pain medication for Resident 60 and failed to implement appropriate interventions to address continued pain for Resident 15. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an effective individualized person-centered plan to address and manage the dementia-related behavioral symptoms of one out of 17 residents reviewed (Resident 10). Findings include: A review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dementia with agitation (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). The resident exhibited recurrent episodes of increased agitation, aggressive and argumentative behaviors, verbal threats toward staff and residents, and delusional ideation, including believing another resident was her daughter and that staff had taken her daughter. A review of a progress note dated August 25, 2024, at 8:37 PM revealed the resident became increasingly agitated making threats of harm, stating if she gets killed, she will throw every penny at somebody to have someone killed. The resident exhibited paranoid behavior and believed that another resident was her daughter and that someone was in another resident's room with a gun. A review of a progress note dated November 14, 2024, at 6:15 PM revealed the resident was observed arguing with another resident and became upset when her husband left mid-dinner. A review of a progress note dated November 15, 2024, at 6:44 PM indicated the resident was aggressive and argumentative with both staff and residents. A review of a progress note dated November 15, 2024, at 7:32 PM indicated the resident exhibited delusional beliefs that staff had taken her daughter and threatened to strike them. A review of a progress note dated November 16, 2024, at 2:08 PM and again at 5:22 PM, the resident demonstrated increased agitation, verbal threats toward staff, and irritability toward her husband. A review of a progress note dated November 18, 2024, at 2:00 AM revealed the resident was awake, restless, and argumentative with staff. A review of a progress note dated November 20, 2024, at 8:57 PM revealed the resident was observed making agitated statements toward other residents during dinner. A review of a progress note dated December 3, 2024, at 8:00 PM indicated the resident attempted to enter another resident's room, became irate when redirected by staff, and insisted she needed to protect the resident whom she believed to be her daughter. A review of the resident's current care plan revealed it failed to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Identify specific behavioral symptoms exhibited by the resident. Include individualized, person-centered interventions tailored to address each behavior. Incorporate the resident's preferences, social and past life history, customary routines, and interests to support behavior management. An interview with the Nursing Home Administrator on March 13, 2025, at approximately 1:15 PM, confirmed the facility was unable to provide evidence of an individualized, person-centered care plan to address and manage the resident's dementia-related behaviors. 28 Pa Code 211.12 (c)(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
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to provide pharmaceutical services to ensure a system of records of receipt and disposition of controlled drugs in sufficient detail to enable accurate accounting of controlled substances when acquiring, receiving, dispensing, and or administering to identify possible diversion for one of three residents reviewed (Resident 62). Findings include: Review of the facility's Discharge Medications policy last reviewed by the facility on January 25, 2025, indicated controlled substances shall not be released upon discharge of the resident unless permitted by current state law governing the release of controlled substances and as authorized (in writing) by the resident's Attending Physician. The nurse will reconcile pre-discharge medications with the resident's post discharge medications and the medication reconciliation will be documented. The nurse shall complete the medication disposition record including the resident's name, the name of the person assisting or administering the medication after discharge, the date of discharge, the name of each medication, the prescription (Rx) number of each medication, the quantity or amount of each medication, the strength of each medication, any special instructions, telephone numbers of the physician, pharmacy, and facility, the signature of the person receiving the medications, and the signature of the nurse releasing the medications. The nursing staff shall forward completed drug disposition records to medical records and the complete list of the resident's medications shall also be provided to the resident upon discharge. A review of Resident 62's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included acute cystitis (inflammation of the bladder) and weakness. A physician's order dated January 23, 2025, at 3:54 PM, included the following controlled medications: Oxycodone 5 mg (opioid analgesic pain medication, a controlled medication) 1 tablet by mouth every 4 hours as needed for severe pain rated 7-10 (scale used to rate pain, with 0 being no pain and 10 being severe pain),) for 14 days and Tramadol 50 mg - 1 tablet by mouth every 6 hours as needed for mild pain rated 1-3. A nursing note dated February 5, 2025, at 6:51 PM, indicated that Resident 62 signed out Against Medical Advice (AMA) at 6:45 PM. The note documented that the attending physician and the Nursing Home Administrator (NHA) were notified. Further review of Resident 62's closed record failed to provide documented evidence of a controlled medication accountability record for the Oxycodone 5 mg tablets or Tramadol 50 mg tablets, as required by facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of nursing (DON) on March 13, 2025, at 10:00 AM, the DON was unable to provide documented evidence that the required accountability record for Resident 62's controlled medications had been completed. The DON confirmed that facility policy requires a controlled medication accountability record for all controlled medications to prevent unauthorized use, misappropriation, and ensure accurate tracking and disposition. 28 Pa. Code 211.9 (j.1)(1)(2)(3)(4)(5) Pharmacy services. 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
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotics for one out of 17 residents sampled (Residents 1). Findings included: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis to include history of malignant neoplasm (cancer) of the bladder and dementia (a decline in memory, thinking, and other cognitive abilities, significantly impacting daily life). A nursing progress note dated October 16, 2024, at 8:23 AM indicated the resident's white blood count (WBC) was elevated at 15.48 ul (4.000 ul to 1100 ul normal), but the resident did not exhibit any other signs or symptoms of infection at that time. The physician was notified, and an order was obtained for a Urinalysis with Culture and Sensitivity (UA C&S a laboratory test used to detect and identify bacteria or fungi in urine, A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) to assess for possible infection. A progress note dated October 16, 2024, at 10:41 AM documented that the resident was catheterized (rubber tube placed in the bladder) to obtain a urine sample, which was then placed in the specimen refrigerator for pick-up. A review of a nursing progress note dated October 16, 2024, at 11:31 PM revealed the resident's urinalysis results were received, and the physician was made aware. A progress note dated October 17, 2024, at 8:00 AM documented that the physician ordered Bactrim DS (an antibiotic) one tablet every 12 hours for five (5) days, despite the culture and sensitivity results not yet being available to determine the type of infection and appropriate antibiotic treatment. A review of the resident's laboratory report dated October 19, 2024, at 1:34 PM, revealed that the urine culture identified Escherichia coli ESBL (extended-spectrum beta-lactamase-producing E. coli. These enzymes break down certain antibiotics making the bacteria resistant to these medications) with bacterial growth exceeding 100,000 CFU/ml. The report further indicated that the prescribed antibiotic (Bactrim DS) was resistant to the bacteria found in the resident's urine, rendering the treatment ineffective. A review of Resident 1's Medication Administration Record (MAR) for October 2024 revealed that the resident received five (5) doses of Bactrim DS, an unnecessary antibiotic, before the culture and sensitivity results confirmed that the prescribed medication was ineffective. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on March 13, 2025, at approximately 1:15 PM, the DON confirmed that the administration of Bactrim DS was not clinically justified, as the prescribed antibiotic was ineffective against the identified organism. The DON acknowledged that the resident received an unnecessary medication, which did not align with evidence-based infection control and antimicrobial stewardship practices. Refer 881 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(d)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of the facility's planned 4-week menu cycle and menu extensions, resident interviews, and staff interviews, it was determined the facility failed to ensure the planned menu was sufficiently reviewed and updated to ensure that the menu offered variety and avoid repetitive meal selections. Findings included: During a Resident Council meeting conducted on March 12, 2025, at 10:35 AM, with Residents 40, 45, 48, and 264, concerns were raised regarding the lack of variety in the facility's menu. Resident 48 reported that the menu was repetitive, and they get the same meats for days in a row and that the meals offered on the facility's always available menu were the same items rotated throughout the standard regular menu. Residents 40, 45, and 264 also confirmed that meals, especially meats, were frequently repeated over consecutive days. Resident 264, the elected Resident Council President, stated that concerns had been raised in food committee meetings with the Certified Dietary Manager (CDM) but were not addressed, as the facility's menu was provided by a contracted vendor and reportedly could not be modified. A review of the Fall/Winter 2024-2025 menu, signed by the Registered Dietitian on January 16, 2025, and implemented by the facility on February 9, 2025, revealed multiple instances of repetitive meal patterns over the 4-week menu cycle: A review of week 1, revealed Sunday the planned entree for dinner was a cheeseburger on a bun and then for lunch on Monday, the planned lunch was Salisbury steak (beef) with beef served for consecutive meals. Monday week 1 dinner, the planned entree was turkey and Swiss sandwich and then the planned entree for lunch on Wednesday was roast turkey (poultry) with poultry served for consecutive meals. The planned entree for Tuesday week 1 dinner was a Sloppy [NAME] (beef), and the planned entree for Wednesday lunch was lasagna with meat sauce, and Thursday lunch the planned entree served was beef and bean chili, with beef served for consecutive meals. Sunday week 2, the planned entree for lunch was ham steak and then for dinner, the planned entree was BBQ pork rib with pork served for consecutive meals. The planned entree for lunch Monday was beef macaroni casserole and then for Monday dinner the planned entree was a beef hot dog on a bun with beef served for consecutive meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The planned entree for dinner Tuesday was baked chicken tenders and then for Tuesday lunch the planned entree was oven fried chicken, and then for Tuesday dinner the planned entree was a chicken salad sandwich with chicken served for consecutive meals. Further review of week 2 revealed that Friday dinner the planned entree was Italian sausage sub and then for Saturday lunch the planned entree served was bratwurst on a bun with pork served for consecutive meals. Saturday week 2 dinner, the planned entree served was baked ziti with meat sauce, and then Sunday week 3 lunch, the planned entree served was homestyle meatloaf with beef served for consecutive meals. Sunday week 3 dinner, the planned entree served was a chicken patty on a bun and then Monday week 3 lunch the planned entree served was baked chicken with poultry served for consecutive meals. Monday week 3 dinner, the planned entree served was a hamburger on a bun and then week 3 Tuesday dinner, the planned entree served was beef macaroni casserole with beef served for consecutive meals. Tuesday week 4 lunch, the planned entree served was a Philly cheese steak sandwich, and then week 4 Wednesday lunch, the planned meal served was BBQ beef on a bun, and then Wednesday dinner, the planned meal served was a cheeseburger on a bun with beef served for consecutive meals. The repetitive meal patterns demonstrated that the facility failed to provide a varied menu that met resident preferences and nutritional needs, leading to menu fatigue and reduced meal satisfaction. During an interview with Employee 2, facility's contracted dietary food/menu representative, on March 12, 2025, at 1:05 PM, stated that his company was responsible for proving the facility with a 4-week seasonal menu that was reviewed by the facility's Registered Dietitian. Also, Employee 2 indicated the facility could alter the meals and items offered on the menu to best meet the needs and preferences of the residents. An interview with the facility's Nursing Home Administrator (NHA) on March 13, 2025, at 10:00 AM, confirmed that similar foods were served for consecutive meals and that similar or the same foods/meals were also offered on the resident's always available menu. The NHA confirmed the facility's menu was repetitive and didn't offer variety to deter menu fatigue. The facility failed to ensure the planned menus were reviewed and modified to provide variety, leading to repetitive meal patterns that did not meet the satisfaction of the residents. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.6 (a) Dietary services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, increasing the risk of contamination and foodborne illness in the dietary department Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). During an initial tour of the dietary department on March 11, 2025, at 9:10 AM, conducted with the Food Service Director (FSD) and Employee 1, a food service worker (FSW), the following unsanitary conditions were observed: In the cook's area, a metal wire rack used to store clean cooking equipment, felt greasy had a significant buildup of grease and debris, indicating inadequate cleaning practices. The windowsill above the microwave and open bread loaves was cluttered and covered in dust and debris, creating a potential source of contamination. A storage container of butter was placed on top of the microwave with a dirty, uncovered butter spreader resting on it. The butter was discolored, had crumbs adhered to its surface, and appeared soft and melting, indicating improper food handling and storage. The interior of the microwave contained food splatter and peeling surfaces, presenting a potential source of cross-contamination. A food prep station contained an industrial can opener with a sticky blade. Employee 1 stated that it was used earlier to open cans of tuna fish and had not been cleaned afterward, failing to meet sanitary standards for food preparation equipment, The above findings were reviewed with the facility's Nursing Home Administrator (NHA) on March 11, 2025, at 1:30 PM, and it was confirmed that the dietary department should be maintained in a sanitary manner to prevent the potential for food contamination and foodborne illness. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, facility investigative reports, and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, in accordance with professional standards of practice for two of 17 sampled residents (Resident 8 and 44). Findings include: 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. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register 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. 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. A review of clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses which included hypertensive (high blood pressure) heart disease. A review of a Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 19, 2024, revealed the resident was cognitively intact with a BIMs score of 13 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact), A review of clinical record revealed that Resident 44 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). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired with a BIMs score of 5 (0-7 indicating severe cognitive impairment). A review of a facility investigative report dated November 28, 2024, at 11:50 AM revealed at 11:00 AM staff observed Resident 8 and Resident 44 holding hands in the hallway. Resident 44 tapped her lips, leaned in, and kissed Resident 8. Staff separated the residents. Resident 44 stated, It was not a big deal; I just gave him a little peck. Resident 8 expressed no concerns regarding the incident. Despite this event a review of Resident 8's clinical record contained no documentation of the interaction, staff intervention, or follow-up assessments to determine any emotional or psychological effects on the resident. Additionally, Resident 44's clinical record lacked documentation of the inappropriate behavior, assessments following the event, or any interventions to prevent recurrence. The failure to document this incident and any follow-up actions resulted in incomplete and inaccurate clinical records, which did not reflect the residents' conditions, behaviors, or staff interventions. An interview conducted on March 13, 2025, at approximately 1:15 PM, the Nursing Home Administrator and Director of Nursing confirmed that nursing staff failed to consistently and accurately document residents' interactions and behaviors in the clinical records. 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interviews it was determined the facility failed to ensure coordination of care and services between the facility and the Hospice Agency for one resident out of 17 sampled residents (Resident 1). Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis to include history of malignant neoplasm (cancer) of the bladder and dementia (a decline in memory, thinking, and other cognitive abilities, significantly impacting daily life). A review of physician's orders dated February 18, 2025, revealed the resident was admitted into hospice services. A review of the resident's care plan, initially dated January 27, 2024, revealed that the care plan failed to reflect coordination of services between the facility and the hospice agency. Specifically, the care plan lacked documented evidence of collaboration in addressing the resident's daily care needs and specific care and services related to the resident's terminal diagnosis. An interview with the Nursing Home Administrator on March 13, 2025, at approximately 1:15 PM, confirmed the resident's care plan was not coordinated with hospice services. 28 Pa. Code 211.12 (c)(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
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41581 Based on review of select facility policies, the facility's infection control log and staff interview, it was determined the facility failed to maintain and implement a comprehensive infection prevention and control program. Findings included: A review of a select facility policy entitled, Infection Prevention and Control Program last reviewed by the facility January 2025 revealed the facility must establish an infection prevention and control program under which it identifies, investigates, controls, and prevents infections in the facility. Further it is indicated the objectives of the infection control policies and procedures are to prevent, detect, investigate, and control infections in the facility. A review of facility policy entitled Surveillance for Infections last reviewed January 2025 revealed for residents with infections that meet the criteria for definition of infection the facility will collect the following: A. Identifying information including the residents name, age, room number, unit, an attending physician B. Diagnoses C. admitted , date of onset of infection (may list onset of symptoms) D. Infection site E. Pathogens F. Invasive procedures or risk factors such as surgery, indwelling tubes, or Foley catheter G. Pertinent remarks (symptoms) and record if the resident is admitted to the hospital or expires H. Treatment measures A review of the facility's infection control data revealed the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. Specifically, the facility lacked an effective system which enabled the facility to analyze clusters, track changes in prevalent organisms, or identify increases in the rate of infection in a timely manner. A review of facility infection control logs for May 2024 through March 2025 revealed the facility did not have any tracking of infections for the month of June 2024. Additionally, review of the logs indicated that the facility failed to consistently document critical infection-related details such as: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Location of infections Whether infections were community-acquired or facility-acquired Symptoms experienced by residents Onset date of infections An interview with the Assistant Director of Nursing (ADON) who also serves as the facility's Infection Preventionist, conducted on March 13, 2025, at approximately 10:15 AM, the ADON confirmed that no infection control tracking log could be located for June 2024. The ADON further acknowledged that the facility's infection control logs were incomplete and failed to support a comprehensive infection prevention and control program. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interview it was determined the facility failed to maintain a system to effectively monitor antibiotic usage in accordance with its antibiotic stewardship program for one of 17 sampled residents (Resident 1). Findings include: A review of select facility policy entitled, Antibiotic Stewardship last reviewed January 2025 revealed antibiotics will be prescribed and administered to residents under the guidance of the facilities antibiotic stewardship program. The purpose of the antibiotic stewardship program is to monitor the use of antibiotics. A review of select facility policy entitled, Antibiotic Stewardship Orders for Antibiotics Last review January 2025 revealed appropriate indications for use of antibiotics stated that appropriate indications for antibiotic use include meeting the clinical definition of active infection or suspected sepsis and confirming pathogen susceptibility based on culture and sensitivity results. A review of select facility policy entitled, Antibiotic Stewardship Review and Surveillance of Antibiotic Use and Outcomes last reviewed January 2025, revealed antibiotic usage and outcome data will be collected and documented using the facility approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility antibiotic stewardship. Further it is indicated the infection preventionist will review antibiotic utilization as part of the antibiotic stewardship program and at the conclusion of the review the provider will be notified of any review findings. At the time of the survey ending March 13, 2025, the facility failed to demonstrate their actions designed to optimize the treatment of infections through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use Additionally, the facility failed to provide documented evidence that prescribing practitioners were made aware of their prescribing practices. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis to include history of malignant neoplasm (cancer) of the bladder and dementia (a decline in memory, thinking, and other cognitive abilities, significantly impacting daily life). On October 16, 2024, at 8:23 AM, a nursing progress note indicated that Resident 1 had an elevated white blood cell count (WBC) of 15.48 ul but no other symptoms. Despite the absence of multiple clinical symptoms necessary to justify antibiotic use, the physician was notified, and a urinalysis with culture and sensitivity (UA C&S) was ordered. On October 17, 2024, at 8:00 AM, before the culture and sensitivity results were available to confirm an infection or guide appropriate treatment, the physician ordered Bactrim DS (antibiotic) for five (5) days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395953	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Ridge Rehabilitation and Nursing Center	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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On October 19, 2024, at 1:34 PM, the urine culture results confirmed the presence of Escherichia coli ESBL (extended-spectrum beta-lactamase-producing E. coli. These enzymes break down certain antibiotics making the bacteria resistant to these medications), which was resistant to Bactrim DS. A review of the October 2024 Medication Administration Record (MAR) showed that the resident received five (5) doses of an unnecessary and ineffective antibiotic, demonstrating a failure in antibiotic stewardship. An interview with the Director of Nursing on March 13, 2025, at approximately 1:15 PM confirmed the facility failed to have a functioning antibiotic stewardship program. The facility's failure to ensure adherence to its antibiotic stewardship policies resulted in the administration of an inappropriate antibiotic. Refer F757 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services