

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/23/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, a review of resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide a comfortable and homelike environment for residents, specifically regarding maintaining comfortable ambient temperatures in common areas for four out of four residents interviewed during a group interview (Residents 25, 60, 69, and 76). Findings include: A review of resident council meeting minutes dated December 9, 2025, revealed that residents in attendance raised complaints the dining room was cold. During a resident group interview on January 22, 2026, at 10:00 AM Residents 25, 60, 69, and 76 indicated that they have a concern about the cold temperatures in the facility's dining room. The residents explained that the room is used for dining and activities throughout the day and into the evening. During the group interview Resident 69 indicated that he has been raising concerns about how cold it feels in the dining room for weeks, but no one has addressed the issue. He explained that he was playing bingo in the room yesterday, and the cold made the activity uncomfortable. During the group interview, Resident 25 indicated that he came down to the dining room for a cup of coffee but did not stay in the area because the temperature of the room was too cold. During the group interview, Resident 60 indicated the dining room is often cold and chilly. She explained that she wraps herself up in additional clothing and wears a jacket when she is in the dining room. During the group interview, Resident 76 indicated that she feels cold right now in the dining room. She explained that she could use a sweater to make her feel warmer. During the resident group interview in the facility dining room on January 22, 2026, at 10:30 AM Residents 25, 60, 69, and 76 indicated the room felt cool. During an observation in the facility dining room on January 22, 2026, at 11:02 AM, the Director of Maintenance took temperatures of four walls in the room. The wall temperatures measured 69.7 F, 69.4 F, 65.6 F, and 68.0 F. The room felt cool. The main dining room wall thermostat temperature gauge indicated the room was 70 F. The wall thermostat is positioned on an interior wall opposite the exterior wall. The thermostat is set to heat the room to 73 F. During a follow-up observation in the facility dining room on January 22, 2026, at 12:37 PM, the Director of Maintenance took temperatures of four walls in the room. The wall temperatures measured 70.3 F, 66.4 F, 68.7 F, and 71.1 F. The room continued to feel cool. The Director of Maintenance explained that the heating system in the dining room is old and the system is not able to raise the room temperature higher during cold days. The thermostat in the dining room was set to 73 F, but the wall thermometer continued reading 70 F. During an interview on January 23, 2026, at approximately 11:15 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was unable to provide documented evidence that efforts were made to address residents' concerns about the cold dining room temperatures or that alternative measures were taken to ensure resident comfort. The facility failed to provide a comfortable and homelike environment for residents who raised concerns about the cold dining room temperatures. The facility failed to maintain comfortable temperatures within the required regulatory range of 71 F to 81 F.28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, a review of select facility policies, and staff interviews, it was determined that the facility failed to provide person-centered care and failed to follow professional standards of practice for diabetes management for one of 21 sampled residents (Resident 2). Findings include: A review of the facility policy titled Diabetes Clinical Protocol, last reviewed by the facility on January 5, 2026, indicated it is the policy of the facility that the physician will order appropriate laboratory blood tests (for example, periodic finger sticks or A1C) and adjust treatments based on these results. Further review revealed the resident receiving insulin who is well controlled should monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch, and as necessary) and monitor three to four times a day if on intensive insulin therapy or sliding scale insulin. Adjust monitoring frequency depending on glucose control and resident preference. A review of the facility policy titled Insulin Administration, last reviewed by the facility on January 5, 2026, indicated to check blood glucose per physician order or facility policy before insulin administration. A review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses to include diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of sugar in the blood and urine) and dementia (a progressive syndrome characterized by a decline in cognitive function in memory, language, and problem-solving). A review of the quarterly Minimum Data Set (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) of Resident 2 dated December 23, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 to 7 indicates severe cognitive impairment). A review of Resident 2's clinical record revealed a laboratory report dated December 4, 2025, of a hemoglobin A1C (HgbA1c) result of 12.9% (a blood test that measures the average blood sugar levels over the past two to three months) with an average blood glucose (sugar) of 324 mg/dL, which was significantly elevated and reflected poor blood sugar control over the prior two to three months. A review of physician orders revealed the following changes in diabetes treatment: On December 1, 2025, the resident was ordered Lantus (long-acting insulin) 12 units SC subcutaneous (under the skin injection) once daily at bedtime, which was discontinued on December 15, 2025. On December 15, 2025, the resident was ordered Lantus 16 units subcutaneous once daily at bedtime. On December 1, 2025, the resident was ordered Jardiance (an oral medication that lowers blood sugar by increasing glucose excretion in urine) 10 mg once daily, which was discontinued on December 15, 2025. On December 15, 2025, the resident was ordered Jardiance 25 mg once daily. On December 1, 2025, the resident was ordered Novolog (short-acting insulin) before meals based on sliding scale (insulin dose dependent on blood sugar result at the time of testing) blood sugar results, which were discontinued on December 8, 2025. On December 8, 2025, the resident was ordered Novolog 4 units subcutaneous before meals, which was discontinued on December 15, 2025. On December 15, 2025, the resident was ordered Novolog 6 units subcutaneous before meals. A review of physician orders revealed that no blood glucose monitoring was ordered by the attending physician despite increases in all three diabetes medications. A review of a physician progress note dated December 8, 2025, indicated the plan was to continue to monitor glucose. Further review of the clinical record revealed that the last documented blood glucose level for Resident 2 was on December 8, 2025, at 12:42 PM, with no subsequent blood glucose monitoring documented after that date. A review of Resident 2's care plan for endocrine system management dated December 30, 2025, indicated the resident used insulin glargine (long-acting insulin), insulin aspart (short-acting insulin), and Jardiance for diabetes management, with interventions to obtain blood glucose readings and report abnormal values as ordered. During an interview, Employee 6, Licensed Practical Nurse, stated (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was not currently on blood glucose monitoring despite receiving insulin multiple times daily. Employee 6 stated this could be related to the resident complaining of finger pain from blood sugar testing; however, review of the clinical record revealed no documented evidence of such complaints or of an alternative monitoring plan. During an interview with the Director of Nursing on January 23, 2026, at 11:50 AM, Resident 2's diabetes management and review of the information did not reveal evidence of a documented person-centered care plan addressing blood glucose monitoring and individualized diabetes management for Resident 2. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, a review of the facility's planned menus, a review of resident group meeting minutes, and resident and staff interviews, it was determined that the facility failed to accommodate individual food preferences, to the extent possible, to increase resident satisfaction with meals for residents, which included four out of the 21 residents sampled (Residents 4, 25, 33, and 69), and as expressed by four out of four residents during a resident group interview (Residents 25, 60, 69, and 76). Findings include: A review of resident group meeting minutes dated November 18, 2025, revealed residents in attendance raised concerns that they would like more soup added to the facility menu. A review of a Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 19, 2025, revealed that Resident 4 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). During an interview with Resident 4 on January 21, 2026, at 1:30 PM, they stated that soup would be nice, and that the request for soup had come up during food committee meetings and was never resolved. A quarterly MDS of Resident 33 dated November 02, 2025, revealed the resident was severely cognitively impaired and was unable to attempt the BIMS score. An interview with Resident 33 and their resident representative (RP) on January 21, 2026, at 2:00 PM, revealed the request for soup had been discussed with the kitchen and management, and there has not been any resolution. Resident 33's RP stated that she often brings in soup for Resident 33. During a resident group interview on January 22, 2026, at 10:00 AM Residents 25, 60, 69, and 76 indicated that they have a concern about the facility dietary menu. Specifically, residents in attendance indicated that they have requested to have soup added to the menu, but the facility has not addressed their preference. During the group interview, Resident 69 indicated that he has brought up soup every meeting for the last few months. He explained he is frustrated and about to give up asking because no one addresses the concerns. Resident 69 indicated that it is winter now and a bowl of soup would be great. He reported that he has asked for vegetable soup, tomato soup and chicken noodle soup, but none of those options were incorporated into the menu. During the group interview, Resident 25 indicated that he would like to see tomato soup on the menu but hasn't had soup for a while. During the group interview, Resident 60 indicated that residents have been asking for soup for more than a few months. She explained that it has been over a year since the facility served soup. Resident 60 indicated she would like the menu to include soup options. During the group interview Resident 76 indicated that she has only been at the facility for a week, but was told by facility staff that soup is not available. She explained that she would enjoy a bowl of soup, especially with the cold weather. A review of the current facility menu, weeks 1 through 5, revealed the menu rotation did not include soup. Also, a review of the facility's always available food list revealed no options for soup were available. During an interview on January 23, 2026, at 10:00 AM, the Registered Dietician (RD) confirmed that residents have requested soup be added to the menu in the past. The RD was unable to provide documented evidence the facility incorporated residents' requests for soup into the menu or as an always-available option. An interview with the foodservice director (FSD) on January 23, 2026, at 11:00 AM revealed that menus are planned at the corporate level. The FSD confirmed the corporation was aware that the residents have been requesting for soup to be added to the menu but that menus have not yet been adjusted to incorporate soup. The FSD confirmed that soup is also not being offered as a choice on the alternate menu. During an interview on January 23, 2026, at approximately 11:15 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was unable to provide documented evidence that efforts were made to accommodate individual food preferences to the extent possible, including for residents 4, 25, 33, 60, 69, and 76, in order to enhance resident (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	satisfaction with meals. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 201.29(a) Resident rights		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, grievances filed with the facility, facility documentation, and staff and resident interviews, it was determined the facility failed to ensure a resident's right to privacy and failed to prevent intrusion by another resident (Resident 29) during personal care for one out of 21 residents sampled (Resident 37). Findings include: A clinical record review revealed Resident 37 was admitted to the facility on [DATE], with diagnoses that include muscular dystrophy (a group of diseases characterized by progressive weakness and degeneration of skeletal muscles that control movement). A review of an annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 30, 2025, revealed that Resident 37 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). A care plan revealed Resident 37 had activities of daily living deficits (fundamental, routine self-care tasks necessary for independent living and personal health) related to progressive weakness and inability to move extremities due to muscular dystrophy (an inherited condition that causes muscles to become weaker over time because the muscles do not work properly) initiated November 18, 2018. The care plan indicated Resident 37 required extensive staff assistance with showers, moving in bed, dressing, bathing, and toileting. A clinical record review revealed Resident 29 was admitted to the facility on [DATE], with diagnoses that include vascular dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of an annual MDS dated [DATE], Sections C0700 and C0800, revealed that Resident 29 had problems with his short-term (recall after 5 minutes) and long-term memory (recall past events). Section C1000 revealed Resident 29's cognitive skills for daily decision-making were severely impaired. Section C1310 indicated the resident had fluctuating behavior (comes and goes, changes in severity) in his ability to focus attention, being easily distractible, or having difficulty keeping track of what is said. A grievance (documentation of a complaint or concern that can be filed by residents or on behalf of residents in a long-term care facility) filed with the facility dated September 13, 2025, revealed that Resident 29 entered Resident 37's room during care. The document indicated that around 4:30 PM on September 13, 2025, Resident 29 came into Resident 37's doorway. Resident 37's legs were exposed to her belly while she was receiving a bed bath. Resident 37 stated she was extremely upset and angry because Resident 29 came in again while she was on the bedpan and was embarrassed by the incident. During an interview on January 21, 2026, at 10:30 AM, Resident 37 explained that she is very upset about Resident 29 (a male resident) entering her room. She explained it keeps happening and staff reported that there is nothing they can do. She explained that staff need to remove Resident 29 from her room and that it sometimes happens multiple times a day. Resident 37 indicated that last week she was using the toilet in the shower room, and Resident 29 entered the shower room while she was on the toilet. She explained that he continues to come into her room, and she is embarrassed, frustrated, and angry about the situation. During an observation on January 21, 2026, at 10:40 AM Resident 29 was observed sitting in his wheelchair outside of Resident 37's room. During an interview on January 22, 2026, at 11:00 AM, Employee 4, Nurse Aide, indicated the staff try to redirect Resident 29, but he wanders throughout the facility. She explained that she did not have to redirect Resident 29 from Resident 37's room for a few weeks but confirmed that he does go into her room. During an interview on January 22, 2026, at 11:15 AM, Employee 5, Licensed Practical Nurse (LPN), confirmed Resident 29 needs to be redirected multiple times a day. She indicated the facility has attempted to use alarms and stop signs to prevent Resident 29 from entering Resident 37's room, but he still wanders into her room. During an interview on January 23, 2026, at (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:45 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA confirmed that Resident 37 has brought up concerns about Resident 29 entering her room and shower room. The NHA was unable to provide evidence that the facility ensured Resident 37's right to privacy, including the right to privacy during personal care. The NHA was unable to provide documented evidence that the facility sustained corrective action after Resident 37 submitted a grievance on September 13, 2025, regarding Resident 29 intruding on her privacy during personal care. 28 Pa. Code 201.18 (b)(2)(e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on a review of employee personnel files, select facility policy, and staff interviews, it was determined the facility failed to fully implement its abuse prohibition procedures and ensure a criminal history record check was requested or obtained prior to employment for one out of five employees reviewed (Employee 2). Findings include: A review of the facility policy titled Abuse Prevention Program, last reviewed by the facility on January 5, 2026, revealed it is the facility policy to protect residents from abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will conduct employee background checks and will not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. A review of personnel files revealed Employee 2, Licensed Practical Nurse (LPN), start date with the facility was October 21, 2025. A Pennsylvania State Police Response for Criminal Record Check (an official document often called a clearance, detailing an individual's criminal history such as felony and misdemeanor convictions, or arrests within Pennsylvania) with a date of request indicated January 21, 2026. During an interview on January 23, 2026, at 11:15 AM, Employee 3, Human Resources (HR), confirmed that Employee 2, LPN, worked at the facility from October 21, 2025, through January 21, 2026, without a Pennsylvania State Police Response for Criminal Record Check completed. Employee 3, HR, was unable to provide documented evidence that the facility implemented the abuse prevention program policy to ensure the facility did not employ or engage with individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. During an interview on January 23, 2026, at 11:30 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was not able to provide evidence the facility implemented the resident abuse prevention policy by screening Employee 2, LPN, to ensure she had not been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law until three months after working with residents at the facility. The facility failed to ensure a criminal history record check was requested or obtained prior to employing Employee 2, LPN. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(8) Personnel records.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement a comprehensive care plan that reflected the resident's current medical status and required interventions for one of one sampled residents (Resident 7). Findings include: A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses to 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 diagnosed with a subdural hemorrhage (brain bleed) after sustaining a fall on September 5, 2025, and diagnosed with a deep vein thrombosis (a blood clot) in the left leg on November 17, 2025. A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) of Resident 7 dated December 28, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 07 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 to 7 indicates severe cognitive impairment). A physician's order dated November 12, 2025, at 7:23 AM, directed oxygen administration at 2 liters (L) via nasal cannula continuously. A physician's order dated November 18, 2025, at 10:41 AM, prescribed Eliquis 5 mg (blood thinner) every twelve hours for deep vein thrombosis (blood clot). A review of Resident 7's comprehensive plan of care, initiated on December 4, 2024, and most recently revised on December 30, 2025, failed to include updated goals, interventions, or monitoring related to the resident's continuous oxygen therapy or anticoagulant therapy for deep vein thrombosis. During an interview conducted on January 22, 2026, at 12:00 p.m., the Director of Nursing confirmed the facility failed to review and revise Resident 7's care plan to accurately reflect the resident's current medical condition, risks, and required treatments.28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on a review of clinical records, facility policy, observation, and resident and staff interview it was determined the facility failed to ensure the resident environment was free from potential accident hazards for one of 21 sampled residents (Resident 15). Findings include: A review of a facility policy titled 'Storage of Medications', last reviewed on January 5, 2026, indicated the facility will ensure all medications will be stored in the pharmacy and/ or medication rooms according to manufacturer's recommendations. The general guidelines in the policy interpretation direct staff that all drugs and biologicals are to be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature control. A clinical record review revealed Resident 15 was admitted to the facility on [DATE], with diagnoses that included acute kidney failure (condition in which one or both of the kidneys no longer work on its own). According to the Brief Interview for Mental Status (BIMS, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information) Resident 15 had a BIMS score of 9 according to the quarterly Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 4, 2026. A BIMS score of 9 indicates moderate cognitive impairment, suggesting Resident 15 may need extra assistance with daily activities and could be experiencing cognitive decline. During an observation on January 21, 2026, at 10:49 AM, in the resident room of Resident 15 (window side), two clear, 30-milliliter plastic cups containing a white, thick substance were observed on the windowsill. One of the plastic cups contained a wooden tongue depressor (a thin piece of wood rounded at both ends) immersed in the substance. Resident 15 was observed resting in bed at the time of the observation. Upon interview, Resident 15 was unaware of the plastic cups on the windowsill and was unable to identify the purpose of the cups or the substance contained within them. The Registered Nurse Assessment Coordinator (RNAC) entered the resident room during the observation and removed the two plastic cups from the windowsill. The RNAC stated the substance in the plastic cups was cream used for Resident 15's skin to prevent skin breakdown. A review of Resident 15's clinical record revealed no documented evidence that the resident had been assessed or determined safe and appropriate to self-administer medications and or treatments. Review of the physician orders revealed an active order for preventive skin care for Resident 15. The order was last revised on January 7, 2026, and remained in effect for an indefinite duration. During an interview on January 21, 2026, at 2:00 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed there was no documented evidence that Resident 15 had been assessed or determined safe and appropriate to self-administer medications and or treatments. The DON and NHA further confirmed it is the responsibility of the facility to ensure the resident environment is maintained free from potential accident hazards. The facility failed to maintain the resident's environment free of potential accident hazards by leaving topical medication accessible on the windowsill in Resident 15's room without evidence the resident had been assessed and determined safe to self-administer treatment, thereby creating the potential for accidental ingestion or misuse by the resident or others entering the room. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3) Nursing services.		

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 01/23/2026
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)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure the attending physician documented a clinical rationale for declining a consultant pharmacist's recommendation to reduce a psychoactive medication for one of five sampled residents reviewed for unnecessary medications (Resident 66). Findings include: A review of the clinical record revealed that Resident 66 was admitted to the facility on [DATE], with diagnoses that included diastolic congestive heart failure (a long-term condition in which the heart cannot pump blood efficiently to meet the body's needs), dysphagia, oropharyngeal phase (difficulty swallowing), and chronic respiratory failure with hypoxia (a condition in which the body does not receive enough oxygen). A review of a consultation report completed by the facility's consultant pharmacist dated December 12, 2025, revealed Resident 66 was receiving Duloxetine Hydrochloride 30 mg one capsule daily, an antidepressant in the class of Serotonin and norepinephrine reuptake inhibitors (SSNRI) a type of medication used to treat depression and nerve pain. The medication order indicated Duloxetine was prescribed to treat depression. The consultant pharmacist's review recommended that the attending physician consider a gradual dose reduction (GDR) of Duloxetine 30mg to achieve maintenance at the lowest dose possible. A gradual dose reduction, or GDR, refers to the stepwise tapering of a medication dosage to determine whether symptoms, conditions, or risks can be managed with a lower dose or discontinued altogether. A review of the physician's response dated December 15, 2025, revealed the attending physician declined the pharmacist's recommendation for a GDR and deferred the decision to psychiatry, stating the medication was also used for pain management. The physician's response did not include documentation of a clinical assessment, monitoring plan, or risk-benefit analysis explaining why the recommended GDR was not appropriate for the resident at that time. Further review of the clinical record, including a document titled Psychiatric Evaluation & Consultation dated December 17, 2025, revealed that Resident 66 continued to receive Duloxetine 30 mg daily for depression. The psychiatric consultation documented that the resident had no mood or behavioral concerns, with mood described as good and sleep and appetite reported as stable. The resident denied depression, anxiety, mood swings, irritability, lack of motivation, and feelings of hopelessness or worthlessness. The consultation further documented there was no evidence of hallucinations (seeing or hearing things that are not present) or delusions (fixed false beliefs). A review of the nurse practitioner's evaluation dated December 17, 2025, revealed no acknowledgment of the consultant pharmacist's recommendation for a GDR and no documented clinical justification for continuing Duloxetine at the same dose. The evaluation did not include a rationale for why a dose reduction was not clinically appropriate despite the pharmacist's recommendation. The above was reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 23, 2026, at 1:45 PM. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director.		

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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** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure a resident's medication regimen was free from unnecessary medications and failed to ensure nonpharmacological interventions were implemented prior to the initiation of an anticonvulsant medication used as a psychotropic medication (a drug that affects brain activity related to thinking, emotions, and behavior) for the treatment of a mood disorder (a category of mental illnesses in which the primary problem affects a person's emotional state) for one of five residents reviewed for unnecessary medications (Resident 52). Findings included: A review of the facility Psychoactive Medication Use Policy last reviewed January 5, 2026, indicated psychoactive medications may be used when necessary to treat specific conditions or diagnoses for which they are clinically indicated and effective. The psychoactive medication regimen will be regularly reviewed by the physician, and gradual dose reductions will be initiated at routine intervals unless contraindicated. Psychoactive medications may be considered for 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 disease of the brain) but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of psychoactive medications. A review of the facility Behavior Assessment, Intervention, and Monitoring Policy last reviewed January 6, 2026, indicated that behavioral symptoms will be identified using facility approved behavioral screening tools. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. Appropriate assessment and treatment of behavioral symptoms require differentiation between behavioral symptoms that can be managed by treating underlying factors, and those that cannot. Current guidelines recommend the use of nonpharmacological interventions (individualized approaches aimed at decreasing behaviors without a medication) before reaching pharmacological means. A review of the clinical record revealed that Resident 52 was admitted to the facility on [DATE], with diagnoses that include congestive heart failure (chronic condition where the heart muscle becomes too weak to pump blood efficiently) and depression. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 29, 2025, revealed that Resident 52 was moderately cognitively impaired with a BIMS score of 9 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8-12 indicates moderately cognitively impaired), a mood disorder score of 6 (a score of 5 to 9 indicates mild depression), and had no behavioral symptoms during the assessment seven day look back period. A review of a nursing note dated September 20, 2025, at 6:18 AM revealed that that Resident 52 was sitting in a wheelchair in the hallway, removed the alarm, and was walking around the dining room rearranging furniture. The note stated the resident was educated on asking for help and responded, I know. A review of a nursing note dated September 25, 2025, at 8:56 PM documented the resident had increasingly aggressive behaviors toward staff and peers and was difficult to redirect; however, no description of the specific aggressive behaviors was documented. The physician was made aware. A review of a consultant psychiatric evaluation and consultation note dated October 1, 2025, revealed nursing requested a follow-up visit due to behavioral disturbance. During the visit, the resident was calm and cooperative. The psychiatric history included adjustment disorder with depressed mood and insomnia (difficulty sleeping or falling (continued on next page)		

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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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asleep). Staff reported the resident sometimes had increased behaviors and agitation with recent verbal aggression toward staff and other residents. The psychiatrist reviewed current medications and diagnosed adjustment disorder with depressed mood, moderate severity and chronic illness with progression of symptoms. The psychiatrist recommended Depakote 125 mg by mouth twice daily for mood disorder. Depakote (divalproex sodium) is an anticonvulsant medication primarily used to treat seizures and may be used off label as a psychotropic medication for mood stabilization. A nursing note dated October 3, 2025, at 3:49 PM indicated the physician was aware of the psychiatric recommendation and agreed. The note stated the resident representative was to be notified to determine if in agreement. A review of the resident's Psychoactive Medication Therapy Informed Consent Form revealed verbal consent was obtained from the resident representative on October 12, 2025, for Depakote 125 mg twice daily for mood disorder to improve functional ability and reduce behaviors. A physician order dated October 12, 2025, at 11:23 AM documented Depakote 125 mg by mouth twice daily for mood disorder. A nursing note dated October 12, 2025, at 10:02 PM documented that the resident was aggressive toward staff, attempting to transfer independently, and verbally aggressive; however, no specific behaviors were described, and redirection was documented as ineffective. A review of the resident's care plan, initially dated December 18, 2024, identified occasional verbal aggression and periodic attempts to transfer and ambulate independently. Planned interventions included offering a stuffed bear or cat, providing conversation and one-on-one interaction, changing the environment, and offering food and fluids when behaviors occurred. A review of the clinical record revealed no documented evidence that individualized nonpharmacological interventions, other than redirection, were implemented and evaluated prior to initiating Depakote for treatment of the resident's mood disorder. There was no documentation demonstrating that behavioral triggers were identified that alternative approaches were attempted, or that those approaches were ineffective prior to starting Depakote 125 mg by mouth twice daily. An interview with the Director of Nursing on January 23, 2026, at 11:30 AM failed to provide documented evidence that Resident 52 was free from unnecessary use of an anticonvulsant medication being used as a psychotropic medication for mood disorder. The Director of Nursing acknowledged that documentation of behavioral monitoring and attempted nonpharmacological interventions prior to initiation of Depakote was not consistently present in the clinical record as required by facility policy and federal regulation to justify the clinical indication for the use of the medication. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of two medication storage rooms (East wing medication room). Findings include: A review of the facility policy titled Administering Medications, last reviewed by the facility January 5, 2026, indicated that when opening a multi-dose container, (medication vial that can be punctured with a needle multiple times for more than one dose of the same medication) the date opened for use will be recorded on the container. A review of the facility policy titled Storage of Medications, last reviewed by the facility January 5, 2026, indicated that it is the policy of the facility to ensure all medications housed on premises will be stored in medication rooms according to the manufacturer's recommendations and sufficiently to ensure proper sanitation, temperature, light, moisture control, segregation, and security. An observation of the East wing medication room on January 22, 2026, at 8:37 AM, in the presence of Employee 1, licensed practical nurse (LPN), of medication stored in the medication refrigerator, revealed two multi-dose vials of Aplisol (solution used for screening tuberculosis) that had been opened and available for use but not dated when initially opened. A review of the manufacturer's dosage and administration recommendation for Aplisol revealed that vials in use for more than 30 days should be discarded. An interview with Employee 1 at the time of the observation on January 22, 2026, at 8:37 AM, confirmed the Aplisol had been opened and not dated, and the medications should have been removed from the medication refrigerator and discarded. An interview with the Director of Nursing on January 22, 2026, at 12:00 PM, confirmed that the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services		