STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: 00 B. WING:	03/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SUNSET RIDGE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **090002**	**3298 RIDGE ROAD** **BLOOMSBURG, PA 17815**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on March 13, 2025, it was determined that Sunset Ridge Rehabilitation and Nursing Center was not in compliance with the following requirements of 42 Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0689 SS=E		F 0689		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689 SS=E	Continued from page 1 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Resident 50 frequent visual checks evaluated and removed from tasks and care plan. Fall interventions reviewed and verified as effective. Facility will continue to implement interventions to assist with prevention of recurrence of falls/injury. Current residents care plans will be reviewed to verify presence of safety interventions to assist in the prevention of falls. Nursing staff will be re-educated on the implementation of effective fall prevention interventions. Audits will be completed on fall incident reports weekly x 4 weeks, then monthly x 2 months to ensure the implementation of fall prevention interventions. Results will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/30/2025**

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F 0689 SS=E	Continued from page 2 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 January 13, 2023, 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	F 0689		

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F 0689 SS=E	Continued from page 3 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 May 13, 2024, revealed Resident 50 had severe cognitive impairment. A Fall Risk Assessment dated July 13, 2024, 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	F 0689		

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F 0689 SS=E	Continued from page 4 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. 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	F 0689		

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F 0689 SS=E	Continued from page 5 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	F 0689		

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F 0689 SS=E	Continued from page 6 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	F 0689		

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F 0689 SS=E	Continued from page 7 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. 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	F 0689		

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F 0689 SS=E	Continued from page 8 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	F 0689		

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F 0689 SS=E	Continued from page 9 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 199. 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	F 0689		

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F 0689 SS=E	Continued from page 10 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	F 0689		

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F 0689 SS=E	Continued from page 11 the facility failed to provide adequate supervision and effective fall prevention interventions. 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.	F 0689		

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F 0689 SS=E	Continued from page 12 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0689		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 13 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	The facility cannot retroactively correct the nonpharmacological intervention documentation presence prior to as needed oxycodone administration for resident 60 for 1/13/25-1/26/25 and 2/13/25. All other administrations have nonpharmacological interventions documented in the Medication Administration Record. Resident 15 has remained free of verbal/nonverbal complaints of pain since 1/13/25, with dates of pain documented only on 1/12-1/13/25. Facility will assess current residents with as needed pain medications to verify presence of nonpharmacological intervention(s) documentation prompt prior to medication administration in the medical record and administer as needed/indicated. Nursing staff will be re-educated on documentation and implementation of nonpharmacological intervention(s) prior to medication administration. Audits will be done on new admissions with as needed pain	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0697 SS=D	Continued from page 14	F 0697	medication to ensure presence of nonpharmacological intervention(s) documentation prior to medication administration in the MAR weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at monthly QAPI meeting.	

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F 0697 SS=D	Continued from page 15 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 January 13, 2025, 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	F 0697		

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F 0697 SS=D	Continued from page 16 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	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: __00_____ B. WING: _____	03/13/2025

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F 0697 SS=D	Continued from page 17 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. 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.	F 0697		

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F 0697 SS=D	Continued from page 18 A clinical record review revealed Resident 15 was admitted to the facility on November 9, 2021, 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	F 0697		

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F 0697 SS=D	Continued from page 19 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.	F 0697		

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F 0697 SS=D	Continued from page 20 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.	F 0697		

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F 0697 SS=D	Continued from page 21 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	F 0697		
F 0744 SS=D		F 0744		

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F 0744 SS=D	Continued from page 22 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 0744	Resident 10 care plan has been updated to reflect specific behavioral symptoms, interventions, resident preferences and interests. Residents with dementia diagnosis will be audited to ensure the presence of personalized interventions related to resident specific behaviors. Nursing staff will be re-educated on resident specific care plans and behaviors related to dementia. Audits will be completed on new admissions with diagnosis of dementia to ensure the presence of resident specific behaviors and interventions in the care plan weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0744 SS=D	Continued from page 23 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 June 26, 2024, 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.	F 0744		

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F 0744 SS=D	Continued from page 24 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.	F 0744		

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F 0744 SS=D	Continued from page 25 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.	F 0744		

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F 0744 SS=D	Continued from page 26 A review of the resident's current care plan revealed it failed to: 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	F 0744		

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F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 0755	The facility cannot retroactively correct the absence of the medication disposition on resident 62. Residents discharged home in the last 30 days will be reviewed to determine the presence of medication disposition form. Nursing staff will be re-educated on completion of the medication disposition form upon discharge home. Audits will be completed on residents discharging home from the facility to ensure the presence of the medication disposition form weekly x 4 weeks, then monthly x 2 months. Results will be reviewed in monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0755 SS=D	Continued from page 28	F 0755		

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F 0755 SS=D	Continued from page 29 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	F 0755		

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F 0755 SS=D	Continued from page 30 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 January 23, 2025, 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,	F 0755		

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F 0755 SS=D	Continued from page 31 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. 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	F 0755		

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F 0755 SS=D	Continued from page 32 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	F 0755		
F 0757 SS=D		F 0757		

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F 0757 SS=D	Continued from page 33 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	The facility cannot retroactively correct the ordered administration of the antibiotic to resident 1. Lab culture results will be reviewed on all current resident's receiving antibiotic therapy for a UTI to ensure that the ordered Antibiotic is clinically justified. Nursing staff will be re-educated on medication necessity related to evidence-based infection control and antimicrobial stewardship practices. Audits will be completed on new antibiotics for UTI's to determine the necessity weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: __00_____ B. WING: _____	03/13/2025

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F 0757 SS=D	Continued from page 34 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 January 8, 2024, 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	F 0757		

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F 0757 SS=D	Continued from page 35 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.	F 0757		

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F 0757 SS=D	Continued from page 36 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. 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	F 0757		

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F 0757 SS=D	Continued from page 37 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	F 0757		
F 0803 SS=F		F 0803		

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F 0803 SS=F	Continued from page 38 483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 0803	The facility cannot retroactively correct the menu schedule as observed during survey. Current menu will be reviewed, altered, and updated to reflect variety to assist in deterring menu fatigue and increasing menu satisfaction. Certified dietary manager, Registered Dietician and kitchen staff will be re-educated on meal rotation/variety. Audits will be completed on resident satisfaction of meal variety weekly x 4 weeks, then monthly x 2 months. Audit findings will be reviewed at monthly QAPI meeting, resident council and food committee.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0803 SS=F	Continued from page 39	F 0803		

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F 0803 SS=F	Continued from page 40 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	F 0803		

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F 0803 SS=F	Continued from page 41 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 entrée 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 entrée was turkey and Swiss sandwich and then the planned	F 0803		

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F 0803 SS=F	Continued from page 42 entrée for lunch on Wednesday was roast turkey (poultry) with poultry served for consecutive meals. The planned entrée for Tuesday week 1 dinner was a Sloppy Joe (beef), and the planned entrée for Wednesday lunch was lasagna with meat sauce, and Thursday lunch the planned entrée served was beef and bean chili, with beef served for consecutive meals. Sunday week 2, the planned entrée for lunch was ham steak and then for dinner, the planned entrée was BBQ pork rib with pork served for consecutive meals. The planned entrée for lunch Monday was beef macaroni casserole and then for Monday dinner the planned entrée was a beef hot dog on a bun with beef served for consecutive meals. The planned entrée for dinner Tuesday was baked chicken tenders and then for Tuesday lunch the planned entrée was oven fried chicken, and then for	F 0803		

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F 0803 SS=F	Continued from page 43 Tuesday dinner the planned entrée was a chicken salad sandwich with chicken served for consecutive meals. Further review of week 2 revealed that Friday dinner the planned entrée was Italian sausage sub and then for Saturday lunch the planned entrée served was bratwurst on a bun with pork served for consecutive meals. Saturday week 2 dinner, the planned entrée served was baked ziti with meat sauce, and then Sunday week 3 lunch, the planned entrée served was homestyle meatloaf with beef served for consecutive meals. Sunday week 3 dinner, the planned entrée served was a chicken patty on a bun and then Monday week 3 lunch the planned entrée served was baked chicken with poultry served for consecutive meals. Monday week 3 dinner, the planned entrée served was a hamburger on a bun and then week 3	F 0803		

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F 0803 SS=F	Continued from page 44 Tuesday dinner, the planned entrée served was beef macaroni casserole with beef served for consecutive meals. Tuesday week 4 lunch, the planned entrée 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	F 0803		

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F 0803 SS=F	Continued from page 45 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.	F 0803		

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F 0803 SS=F	Continued from page 46	F 0803		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Areas of concern noted during tour on 3/11/25 were cleaned/corrected that same day, 3/11/25. New microwave has been purchased to replace the current microwave noted as a concern during survey. Food prep, storage and hard surface areas will be placed on a routine cleaning schedule to prevent food contamination and food-borne illness. CDM and kitchen staff will be re-educated on new routine cleaning schedules. Audits of food prep, storage and hard surface areas will be completed by NHA/designee weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0812 SS=F	Continued from page 47 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	F 0812		

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F 0812 SS=F	Continued from page 48 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	F 0812		

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F 0812 SS=F	Continued from page 49 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	F 0812		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: 00 B. WING:	03/13/2025

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SUNSET RIDGE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **090002**	**3298 RIDGE ROAD** **BLOOMSBURG, PA 17815**

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F 0842 SS=D	Continued from page 50 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Medical records were updated on resident 8 and resident 44 to include investigation summary and outcome. Last 3 PB22's will be reviewed to ensure the presence of documentation in the medical record. Nursing staff will be re-educated on maintaining accurate and complete clinical records related to PB 22's. Audits will be completed on new PB22's to verify accurate and complete documentation weekly x 4 weeks, then monthly x 2 months. Findings will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0842 SS=D	Continued from page 51 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 52 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 53 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	F 0842		

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F 0842 SS=D	Continued from page 54 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	F 0842		

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F 0842 SS=D	Continued from page 55 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 September 24, 2021, 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),	F 0842		

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STATE LICENSE NUMBER: **090002**	

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F 0842 SS=D	Continued from page 56 A review of clinical record revealed that Resident 44 was admitted to the facility on March 20, 2021, with diagnoses which included multiple sclerosis (nerve damage disrupts communication between the brain and the body causing many different symptoms, including vision loss, pain, fatigue, and impaired coordination). A review of a Quarterly Minimum Data Set Assessment dated November 19, 2024, 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.	F 0842		

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F 0842 SS=D	Continued from page 57 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.	F 0842		

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F 0842 SS=D	Continued from page 58 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.	F 0842		
F 0849 SS=D	483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and	F 0849	Resident 1 care plan has been reviewed and updated to reflect the coordination of care and services between the facility and hospice agency. Current residents on hospice will have care plans reviewed to verify the presence of coordination of care and services between the facility and hospice agency. Nursing staff will be re-educated on the need of care plan coordination of care and services between facility and hospice. Audits will be completed on new hospice admissions to ensure the presence of coordination of care and services between facility and hospice in the care plan weekly x 4 weeks, then monthly x 2 months. Results will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0849 SS=D	Continued from page 59 an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care	F 0849		

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F 0849 SS=D	Continued from page 60 provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a	F 0849		

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F 0849 SS=D	Continued from page 61 member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 0849		

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F 0849 SS=D	Continued from page 62 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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STATE LICENSE NUMBER: **090002**	

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F 0849 SS=D	Continued from page 63 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 January 8, 2024, 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	F 0849		

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F 0849 SS=D	Continued from page 64 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	F 0849		
F 0880 SS=F		F 0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=F	Continued from page 65 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Facility logs for June 2024 were located and are present in the facility. Current system utilized for infection prevention and control will be reviewed. Processes not meeting policy guidelines will be updated and implemented. Nursing staff will be re-educated on facility infection prevention and control program and policies. Audits will be completed on new infections to determine that criteria in facility policies have been followed weekly x 4 weeks, then monthly x 2 months. Results will be reviewed in monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: __00_____ B. WING: _____	03/13/2025

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F 0880 SS=F	Continued from page 66 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=F	Continued from page 67	F 0880		

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F 0880 SS=F	Continued from page 68 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	F 0880		

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F 0880 SS=F	Continued from page 69 following: A. Identifying information including the residents name, age, room number, unit, an attending physician B. Diagnoses C. Admission date, 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.	F 0880		

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F 0880 SS=F	Continued from page 70 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: 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.	F 0880		

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F 0880 SS=F	Continued from page 71 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.	F 0880		
F 0881 SS=F	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	The facility cannot retroactively correct the administration of antibiotic to resident 1. Current residents on antibiotic therapy for a UTI will be reviewed to determine antibiotic necessity and verification of MD notification. Nursing staff and in-house physicians will be re-educated on antibiotic stewardship policy. Audits will be completed on residents who are ordered a UA C&S to determine the necessity of antibiotic and verification of MD notification weekly x 4 weeks, then monthly x 2 months. Findings will be reviewed in monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/27/2025**

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F 0881 SS=F	Continued from page 72 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	F 0881		

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F 0881 SS=F	Continued from page 73 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	F 0881		

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F 0881 SS=F	Continued from page 74 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 January 8, 2024, 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	F 0881		

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F 0881 SS=F	Continued from page 75 confirm an infection or guide appropriate treatment, the physician ordered Bactrim DS (antibiotic) for five (5) days. 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	F 0881		

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F 0881 SS=F	Continued from page 76 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	F 0881		

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P 4880	Medical records. (f) In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a resident ' s medical record shall include at a minimum: (i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death. This REGULATION is not met as evidenced by:	P 4880	The facility cannot retroactively correct the presence of a physician discharge summary on resident 63. Residents who discharged in the last 30 days will be reviewed to determine the presence of a physician discharge summary. Nursing staff and physicians will be re-educated on completion of a discharge summary. Audits will be completed on residents who discharge to ensure completion of a discharge summary by the physician weekly x 4 weeks, then monthly x 2 months. Findings will be reviewed at monthly QAPI meeting.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/30/2025**

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

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P 4880	Continued from page 1 Based on a review of clinical records and interview with facility staff, it was determined the facility failed to ensure that a discharge summary was completed by the physician for one out of three residents reviewed (Resident 63) Findings include: A review of the clinical record of Resident 63 revealed the resident was admitted to the facility on December 12, 2021, and expired, and was discharged from the facility on December 18, 2024. There was no documented evidence in the resident's clinical record at the time of the survey ending March 13, 2025, the physician completed a discharge summary upon the resident's death and discharge from the facility. An interview with the Director of Nursing on March 13, 2025, at approximately 1:15 PM confirmed the facility could not provide documentation a discharge summary was completed by the physician upon the	P 4880		

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P 4880	Continued from page 2 resident's discharge.	P 4880		
P 5520		P 5520		

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P 5520	Continued from page 3 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot retroactively correct past Nursing Aide ratios The facility will continue to take measures to adequately provide nurse-aide staff to ensure the needs of the residents are met. Measures will be put in place to adequately provide staff with the required nurse aide to resident ratios. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will continue to educate minimum staffing ratios to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The Director of Nursing/designee will audit the daily schedules to ensure that the minimum number of nurse aide staff to resident ratios have been scheduled. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/30/2025**

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P 5520	Continued from page 4 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 2 shifts out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. September 4, 2024- 3.67 nurse aides on the night shift versus the required 4.27 for a census of 64. December 29, 2024- 6.17 nurse aides on the day shift versus the required 6.40 for a census of 64. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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SUNSET RIDGE REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **090002**	**3298 RIDGE ROAD BLOOMSBURG, PA 17815**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 5 An interview with the Nursing Home Administrator on March 13, 2025, at approximately 12:00PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: 00 B. WING:	03/13/2025

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P 5530	Continued from page 6 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility cannot retroactively correct past LPN ratios The facility will continue to take measures to adequately provide LPN staff to ensure the needs of the residents are met. Measures will be put in place to adequately provide staff with the required LPN to resident ratios. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will continue to educate minimum staffing ratios to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The Director of Nursing/designee will audit the daily schedules to ensure that the minimum number of nurse aide staff to resident ratios have been scheduled. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **04/15/2025** Status: **APPROVED** Date: **03/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: __00_____ B. WING: _____	03/13/2025

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P 5530	Continued from page 7 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staffing ratio to resident ratio was provided on each shift for 1 shift out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:30 on the evening shift based on the facility's census. Findings include: December 25, 2024- 2.03 licensed practical nurse staff versus the required 2.10 for a census of 63. On the above date mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395953	A. BLDG: __00_____ B. WING: _____	03/13/2025

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P 5530	Continued from page 8 An interview with the Director of Nursing, on March 13, 2025, at approximately 12:00:PM, confirmed the facility had not met the required LPN to resident ratio on the above date.	P 5530		

Certified End Page

SUNSET RIDGE REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 090002

SURVEY EXIT DATE: 03/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY