STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395393	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Rehabilitation & Healthcare Center	951 Washington Avenue Tyrone, PA 16686

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that admission orders were followed for one of five residents reviewed (Resident 2). Findings include: Resident 2's clinical record indicated that she was admitted to the facility on [DATE], with diagnoses that included frequent falls and congestive heart failure. Admission orders for Resident 2, dated June 12, 2024, included orders for the resident to be weighed daily and to notify the physician of a weight gain of 1 to 2 pounds in one day or 5 pounds in one week. Admission orders also included for the resident to receive 20 milligrams (mg) Lasix (diuretic) daily. A review of Resident 2's Treatment Administration Record (TAR), dated June 2024, revealed that the resident did not receive the Lasix. Further review revealed that the resident was weighed June 13 at 121.4 pounds, June 14 at 122.4 pounds, and June 20 at 122.4 pounds. She was not weighed daily per the order, and the physician was not notified of the 1 pound weight gain on June 14, 2024. Interview with the Director of Nursing on July 22, 2024, at 1:02 p.m. confirmed that Resident 2 did not receive Lasix as ordered and was not weighed daily as ordered. She stated that the resident's admission orders were not written in the typical fashion and therefore the orders were missed. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395393	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Rehabilitation & Healthcare Center	951 Washington Avenue Tyrone, PA 16686

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that laboratory specimens were obtained as ordered for one of five residents reviewed (Resident 2). Findings include: According to Resident 2's clinical record she was admitted to the facility on [DATE], after being admitted to the hospital for multiple falls and congestive heart failure. Hospital discharge instructions for Resident 2, dated June 12, 2024, included orders for the resident to have repeat lab work in one to two days after discharge from the hospital. There were no labs ordered or obtained for Resident 2 during her stay at the facility. Interview with the Director of Nursing on July 22, 2024, at 1:02 p.m. revealed that the admitting nurse and the nurse that reviewed the admission orders missed the lab order because it was in the narrative of the discharge summary and not included among the discharge orders. She confirmed that the labs should have been obtained and were not. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.