

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Cedarwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's representative was notified about the need to alter treatment/new physician's orders for one of nine residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The facility's policy regarding a Change in a Resident's Condition or Status, dated January 25, 2024, indicated that unless otherwise instructed by the resident, a nurse would notify the resident's representative when there was a significant change in the resident's physical, mental or psychosocial status. A significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 3, 2024, indicated that the resident was cognitively impaired, was incontinent of urine, and had diagnoses that included dementia.</p> <p>A nursing note, dated November 29, 2024, at 11:50 a.m., revealed that the resident reported she had an emesis upon arrival to the facility, and the resident's family stated they noticed that the resident's urine had sediment in it and requested another urine test be done. The Certified Registered Nurse Practitioner (CRNP-registered nurse with advanced training) was notified. A CRNP's order, dated November 29, 2024, included an order for a bladder/renal (kidneys) ultrasound.</p> <p>A nursing note, dated December 23, 2024, at 5:54 p.m., revealed that the resident's family was in and asked if another urinalysis was sent on the resident. The nurse explained that the doctor wanted to get an ultrasound on the resident since her urine was described as having sediment in it. The resident's family stated that they were not notified; however, they would like to be notified of the ultrasound results.</p> <p>There was no documented evidence that the resident's family was notified of the new order for a bladder/renal ultrasound.</p> <p>Interview with the Director of Nursing on December 10, 2024, at 4:37 p.m. confirmed that there was no documented evidence that Resident 1's family was notified of the new order for an ultrasound.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>41233</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment for one of nine residents reviewed (Resident 6).</p> <p>Findings include:</p> <p>The facility's policy regarding cleaning and disinfecting, dated January 25, 2024, indicated that housekeeping was to remove visible debris from surfaces and that proper cleaning was necessary to reduce infection.</p> <p>A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated November 18, 2024, revealed that the resident was cognitively intact and had diagnoses that included coronary artery disease, heart failure, and asthma.</p> <p>Observations on December 10, 2024, at 11:02 a.m. revealed that the resident was lying in his bed with a stand-up fan blowing directly on him. The fan was noted to have a very heavy amount of visible dirt and debris accumulated on the blade cover. There were approximately four tendrils of dirt/debris flowing from the fan cover as the fan was blowing toward the resident.</p> <p>Interviews with Housekeeping Aide 2 and the Infection Preventionist on December 10, 2024, at 11:20 a.m. revealed that the fan belonged to the facility. They confirmed that the fan was blowing toward the resident with a large amount of dirt and debris accumulated on the blade cover, and that it should have been clean and it was not.</p> <p>Interview with the Housekeeping Manager on December 10, 2024, at 3:28 p.m. indicated that she would expect the fan to have been cleaned with a damp rag when the room was cleaned. She confirmed that the fan cover should have been clean and it was not.</p> <p>Interview with Director of Nursing on December 10, 2024, at 3:39 p.m. confirmed that Resident 6's fan cover should be clean, and it was not.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p> <p>28 Pa. Code 207.2(a) Administrator's Responsibility.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>48941</p> <p>Based on a review of facility policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents received the appropriate treatment and services to maintain or improve their abilities to ambulate and perform activities of daily living for one of nine residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>A facility policy regarding supporting activities of daily living, dated January 25, 2024, indicated that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. The resident's response to interventions will be monitored, evaluated, and revised as appropriate.</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 11, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to clearly understand others, required substantial assist with care needs, refused transfers chair to bed/chair, refused toileting transfers, refused sit to stand, was not ambulatory, had significant weight loss, received oxygen, and had diagnoses that included pulmonary fibrosis (a lung disease that causing scarring and stiffening of lung tissue, making it harder to breathe), respiratory failure (blood does not have enough oxygen and causes difficulty breathing), asthma, and rheumatoid arthritis (chronic inflammatory disorder that affects the joints and organs).</p> <p>A physical therapy discharge summary for Resident 2, dated July 26, 2024, revealed that the resident performed the bed mobility task and functional transfers with stand by assistance (no physical contact or assistance) and was able to ambulate 60 feet with the use of a front-wheeled walker and stand-by assistance. She was discharged from therapy to nursing care with no program in place to maintain functional mobility.</p> <p>Physical therapy documentation for Resident 2, dated August 24, 2024, through September 16, 2024, revealed that the resident was referred to physical therapy due to an exacerbation of pain and a decrease in functional mobility with a goal to regain transfers and ambulatory ability. A physical therapy discharge summary, dated September 16, 2024, revealed that the resident performed the bed mobility task and functional transfers with moderate assistance (therapy and the resident each put in half the effort) and was unable to ambulate. She was discharged from therapy to nursing care with no program in place to maintain functional mobility.</p> <p>An occupational therapy discharge summary for Resident 2, dated August 1, 2024, revealed that the resident performed toileting task/transfers with contact guard assistance (hand-on assistance with no physical assistance) and upper and lower body dressing with stand-by assistance. She was discharged from therapy with recommendations for an ADL restorative nursing program. There was no documented evidence that a restorative nursing program was developed and implemented.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An occupational therapy discharge summary for Resident 2, dated October 11, 2024, revealed that the resident performed the bed mobility task with maximum assistance (over half of the assistance is provided by the therapist). She was discharged from therapy with recommendations for a restorative nursing program to maintain current level of performance and to prevent decline. Development of and instruction in the restorative nursing programs for transfers and range of motion were completed with the interdisciplinary team; however, there was no documented evidence that a restorative nursing program was developed and implemented.</p> <p>Interview with Physical Therapist 1 on December 10, 2024, at 3:34 p.m. revealed that Resident 2 did well when she was first admitted to the facility, and he thought she would be going home. He indicated that she was performing ADLs and transfers with supervision and was walking 60 feet with supervision. He indicated that after discharge from therapy, they would have released her to nursing to continue with care for maintenance and would have made recommendations to nursing for programs. He revealed that the resident received physical therapy again at the end of August 2024 due to Resident 2's decline and knee pain. He indicated that she was not ambulating and required maximum assistance for transfers.</p> <p>Interview with the Director of Nursing on December 10, 2024, at 4:53 p.m. revealed that the facility did not have restorative nursing programs and did not have a program in place to prevent decline and maintain Resident 2's ability to perform ADLs and ambulation.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>19102</p> <p>Based on review of the facility's investigation documents and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that safe transfer techniques were used in accordance with their care plans for one of nine residents reviewed (Resident 5) resulting in a fall. This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated September 26, 2024, revealed that the resident was cognitively intact and had a diagnosis of a fracture, anxiety, and depression.</p> <p>A Kardex report (a nursing worksheet that includes a summary of patient information, such as devices/interventions, activities of daily living, behaviors/mood, mobility, bathing, bladder/bowel, positioning and toileting) for Resident 5, dated October 14, 2024, revealed the following safety measures for staff to follow: transfer with a stand-up lift (mechanical lift used to transfer resident in a standing position with partial weight bearing) with a medium sling (yellow) and the assistance of two staff members.</p> <p>A nursing note for Resident 5, dated October 16, 2024, at 10:00 a.m. revealed that the nurse aide reported that the resident told her she had been lowered to the floor on Monday evening. The resident reported that while being transferred from the chair to the bed on October 14, 2024, she lost her balance and was lowered to the floor by the nurse aide onto her left knee. The resident reported that she did not sustain any injuries.</p> <p>The facility's investigation, dated October 16, 2024, revealed that Nurse Aide 3 reported that he transferred the resident back to bed and she began to fall, but he was able to maintain the resident's balance and denied that she was on the floor. He reported that he was under the impression that Resident 5 was not safe in the sit-to-stand lift related to a comment previously made by a licensed practical nurse (LPN) charge nurse. He reported that he did not check the resident's care plan.</p> <p>A statement completed by Nurse Aide 3, undated, revealed that on Monday, October 14, 2024, he assisted Resident 5 from her wheelchair to her bed without the sit-to-stand lift because on a previous occasion the LPN said the sit-to-stand lift was too dangerous, as the resident slips from it.</p> <p>Interview with the Director of Nursing on December 10, 2024, at 3:00 p.m. confirmed that Nurse Aide 3 did not follow Resident 5's care plan to transfer the resident using a stand-up lift with the assistance of two staff members.</p> <p>Following the investigation on October 16, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 3 was educated on following the plan of care.</p> <p>Staff education on reporting falls, change in plan, and following the care plan was completed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON or designee would audit resident progress notes weekly for two months to ensure that falls were reported timely.</p> <p>The results of these audits would be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>A review of the facility's corrective actions revealed that they were in compliance with F689 on October 17, 2024.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>48941</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that weekly weights were obtained as recommended by the dietician for one of nine residents reviewed (Resident 2) who had a weight loss.</p> <p>Findings include:</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 11, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to clearly understand others, required substantial assist with care needs, had significant weight loss, and had diagnosis that included protein calorie malnutrition.</p> <p>A care plan for Resident 4, dated July 5, 2024, indicated that the resident had a risk for altered nutrition due to her history of dysphagia (difficulty swallowing), weight loss, and need for a textured diet. A care plan intervention, dated July 5, 2024, indicated to periodically obtain the resident's weight, evaluate, and report to the registered dietician, physician, and family of significant weight changes.</p> <p>A dietician note for Resident 2, dated September 9, 2024, revealed that the resident had a significant weight loss in the last 30 days and indicated that the registered dietician would continue to monitor the resident's weight trends for further nutrition interventions as warranted. A dietician note for Resident 2, dated September 30, 2024, revealed that the resident had a continued weight loss trend and the registered dietician would continue to monitor weight trends.</p> <p>A dietician note for Resident 2, dated October 15, 2024, revealed that the resident's weight had significantly declined over the last one to two months. A mini nutritional assessment (MNA) indicated a malnourished status related to variable meal intakes requiring oral nutrition supplements, recent weight loss, and low body weight. The registered dietician recommended obtaining weekly weights for two weeks to closely monitor weight trends with increased supplementation and would continue to monitor for further nutritional intervention as warranted.</p> <p>Review of clinical records for Resident 2 for October and November 2024 revealed no documented evidence that weekly weights were obtained as recommended, and there was no documented evidence that the dietician had monitored for continued weight loss and further nutritional intervention.</p> <p>Interview with the Director of Nursing on December 10, 2024, at 4:53 p.m. indicated that the dietician did not put physician's orders in to obtain weekly weights as recommended and confirmed that the weights were not obtained and monitored as recommended.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>48941</p> <p>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 nine residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 11, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to clearly understand others, required substantial assist with care needs, had significant weight loss, received oxygen, and had diagnoses that included pulmonary fibrosis (a lung disease that causing scarring and stiffening of lung tissue, making it harder to breathe), respiratory failure (blood does not have enough oxygen and causes difficulty breathing), asthma, rheumatoid arthritis (chronic inflammatory disorder that affects the joints and organs), and protein calorie malnutrition.</p> <p>Physician's orders for Resident 2, dated October 7, 2024, indicated that the resident was ordered to have bloodwork (calcium level, sed rate, CHEM 4, albumin, AST, ALT, Creatinine and a CBC with auto diff) completed on October 7, 2024.</p> <p>A nursing note for Resident 2, dated October 8, 2024, revealed that the resident refused annual labs again and staff would attempt again on October 9, 2024. The medical director and resident representative were updated.</p> <p>A nursing note for Resident 2, dated October 9, 2024, revealed that the physician was aware that the resident refused labs again and staff would attempt again on October 10, 2024. There was no documented evidence in Resident 2's clinical record that the bloodwork was attempted or obtained on October 10, 2024.</p> <p>Interview with the Director of Nursing on December 10, 2024, at 5:08 p.m. confirmed that there was no documented evidence in Resident 2's clinical record that the bloodwork ordered on October 7, 2024, was attempted or obtained on October 10, 2024.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41233</p> <p>Based on review of facility policy, written menus, observations, and staff interviews, it was determined that the facility failed to follow their planned menu.</p> <p>Findings include:</p> <p>The facility's policy for menus, dated January 25, 2024, revealed that menus are served as written unless changed in response to preference, unavailability of an item, or a special meal. In addition, deviations from the posted menus are recorded, including the reason for the substitution or deviation.</p> <p>The written lunch menu for the day of December 10, 2024, revealed that there was to be chunky cheeseburger casserole, glazed sweet carrots, garlic bread, and lemon brownies.</p> <p>Observations on Tuesday, December 10, 2024, at 12:35 p.m. of Resident 4's lunch tray revealed that the lunch meal consisted of chunky cheeseburger casserole, glazed sweet carrots, a half of a hot dog bun broken in half with butter, and a chocolate brownie. There was no garlic bread or lemon brownie.</p> <p>Interview with Resident 4 on December 10, 2024, at that time revealed that the bread served was not garlic bread and that she never heard of a lemon brownie. She stated that the menu does not usually match what is served. She continued by showing the surveyor her December menu, of which she had scratched out in pencil what was on the menu and replaced it with what she had actually received on her tray.</p> <p>Interview with the Dietary Manager on December 10, 2024, at 13:15 p.m. confirmed that the residents were not notified that the lunch meal on December 10, 2024, had changed and that the residents would not be receiving lemon brownies or garlic bread as was advertised on the menu for that day. She stated that she does not notify the residents of the change. She stated that she is relatively new to the facility, but not to dietary services, and that she is working on improving all aspects of the dietary experience.</p> <p>28 Pa. Code 211.6(a) Dietary Services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>41233</p> <p>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to serve food in accordance with professional standards for food safety by ensuring the food was served at the appropriate temperatures.</p> <p>Findings include:</p> <p>The facility's policy regarding food preparation and service, dated January 25, 2024, revealed that the facility was to serve food in a manner that complies with safe food handling practices.</p> <p>A test tray was done during the lunch meal on December 10, 2024. The food cart carrying the test tray left the kitchen at 12:49 p.m., arrived on the second floor at 12:50 p.m., and the last resident tray was delivered and the test tray was tested at 1:02 p.m. The test tray consisted of chunky cheeseburger casserole, glazed sweet carrots, bread, brownies, milk, pink lemonade, and coffee. The food was then tasted and the following temperatures were obtained by the Dietary Manager and visualized by the surveyor. The cheeseburger casserole was 129.7 degrees Fahrenheit (F), glazed sweet carrots were 116.1 degrees F, coffee was 140 degrees F, milk was 49.1 degrees F, and the pink lemonade was 60 degrees F. The food was cool and tasted fair. Interview with the Dietary Manager at that time revealed that she would expect the food to taste good, that hot foods such as the casserole and carrots would be at least 135 degrees F or higher, and the cold foods would be at 41 degrees F or lower. She indicated that at this time they do not have hot plates to keep the food warm. The future plan is to have the meals served from steamers in the dining areas on the units and she was confident that would provide hot food for the residents.</p> <p>Interview with the Dietary Manager on December 10, 2024, at 1:15 p.m. confirmed that the food should have been served at safe and appropriate temperatures that complied with safe food handling practices.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41233</p> <p>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety by failing to ensure that dietary staff wore appropriate hair coverings.</p> <p>Findings include:</p> <p>The facility's policy regarding hair restraints, dated January 25, 2024, revealed that all kitchen employees prepping or preparing food must wear hair restraints that are designed to effectively keep hair properly restrained.</p> <p>Observations in the kitchen on December 10, 2024, at 11:35 a.m. revealed that the Dietary Manager was stirring, temping, and plating food for residents. It was noted that the she had two to three inches of hair at the back of her head at her hairline and approximately one inch of hair on the side of her face that was not covered.</p> <p>Observations in the main kitchen on December 10, 2024, at 11:50 a.m. revealed that Dietary Worker 4 was placing desserts and lids onto the residents' meal trays, which already contained prepared plates of food. Dietary Worker 4 had a beard and sideburns, and the sideburns were not completely covered.</p> <p>Interview with the Dietary Manager on December 10, 2024, at 3:35 p.m. confirmed that she and Dietary Worker 4 should have had their hair completely covered when plating/preparing food for the residents, and they did not.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>