

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 04/17/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012</p> <p>Based on review of policies, investigation reports, clinical records, and staff education records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of four residents reviewed (Resident 2), resulting in harm due to a fall with fractures. This deficiency is being cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's policy regarding abuse, neglect, exploitation, and misappropriation dated January 30, 2025, indicated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The nursing facility will implement measures to address factors that may lead to abusive situations by adequately preparing staff for caregiving responsibilities.</p> <p>Admission paperwork for Resident 2, dated April 4, 2025, revealed that the resident was admitted to the facility on [DATE], after having fallen at home and suffering a hip fracture, which required surgery on March 30, 2025. The resident was alert with slight confusion and required extensive assistance from two staff members for care, including bed mobility. The resident's care plan, initiated April 4, 2025, revealed that the resident required two staff members for bed mobility.</p> <p>An incident note for Resident 2, dated April 7, 2025 revealed that the resident was receiving care from Nurse Aide 1 while in bed. Nurse Aide 1 rolled the resident to do a complete bed change when the resident rolled out of bed and landed face down on the floor. Nurse Aide 1 was the only nurse aide providing care for the resident at the time of her fall out of bed.</p> <p>X-ray reports, dated April 7, 2025, confirmed that Resident 2 had a nasal bone fracture, an acute nondisplaced fracture through the base of the odontoid process (also known as the dens, a bony projection of the second cervical vertebra), and a left frontal scalp laceration requiring sutures.</p> <p>Education records for Nurse Aide 1 revealed that he signed that he received education regarding the facility's abuse policy on August 12, 2024, and again on February 5, 2025, and education regarding the facility's policy for reviewing the resident's Kardex (a documentation system that helps nursing staff access key patient information from their care plan) on February 14, 2025.</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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A written statement by Nurse Aide 1, dated April 7, 2025, revealed that he did not review the resident's Kardex prior to providing care for her and therefore, he did not know that she required two staff for care. He stated that while she was on her side she was holding onto the nightstand; however, she fell to the floor.</p> <p>An interview with the Director of Nursing on April 17, 2025, at 10:21 a.m. confirmed that Nurse Aide 1 failed to follow Resident 2's care plan for bed mobility resulting in her falling out of bed and sustaining facial and neck fractures.</p> <p>Following the incident on April 7, 2025, the facility's corrective actions included:</p> <p>On April 7, 2025, the resident was immediately assessed and transferred to the hospital for further assessment. Nurse Aide 1 was immediately removed from care, interviewed, and suspended. He was then terminated for admitted ly not following the resident's care plan regarding the need for two persons to assist with bed mobility.</p> <p>The alert and oriented residents of the facility were interviewed to determine if they were transferred and received care according to their care plan. Non-interviewable residents were observed and assessed to determine if they had any injuries as a result of improper assistance with bed mobility.</p> <p>Education records, dated April 8 and 9, 2025, revealed that all of the facility's nursing staff received education regarding the facility's abuse/neglect policy, as well as reviewing the resident's Kardex/care plan prior to providing resident's with care.</p> <p>The Director of Nursing or designee will audit five random resident's care to ensure that their plan of care was followed five days a week for one week, and then three days a week for one week, and then weekly for one month. Further audits will be completed as determined by the Quality Assurance Performance Improvement (QAPI) committee.</p> <p>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on April 9, 2025.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012</p> <p>Based on review of investigation reports and clinical records, as well as staff interviews, it was determined that the facility failed to provide adequate supervision and assistance to prevent accidents for one of four residents reviewed (Resident 2) who required two staff for bed mobility, resulting in a fall with fractures. This deficiency is being cited as past non-compliance.</p> <p>Findings include:</p> <p>Admission paperwork for Resident 2, dated April 4, 2025, revealed that the resident was admitted to the facility on [DATE], after having fallen at home and suffering a hip fracture, which required surgery on March 30, 2025. The resident was alert with slight confusion and required extensive assistance from two staff members for care, including bed mobility. The resident's care plan, initiated April 4, 2025, revealed that the resident required two staff members for bed mobility.</p> <p>An incident note for Resident 2, dated April 7, 2025, revealed that the resident was receiving care from Nurse Aide 1 while in bed. Nurse Aide 1 rolled the resident to do a complete bed change when the resident rolled out of bed and landed face down on the floor. Nurse Aide 1 was the only nurse aide providing care for the resident at the time of her fall out of bed.</p> <p>X-ray reports, dated April 7, 2025, confirmed that Resident 2 had a nasal bone fracture, an acute nondisplaced fracture through the base of the odontoid process (also known as the dens, a bony projection of the second cervical vertebra), and a left frontal scalp laceration requiring sutures.</p> <p>Education records for Nurse Aide 1 revealed that he signed that he received education regarding the facility's policy for reviewing the residents' Kardex (a documentation system that helps nursing staff access key patient information from their care plan) on February 14, 2025.</p> <p>A written statement by Nurse Aide 1, dated April 7, 2025, revealed that he did not review the resident's Kardex prior to providing care for her and therefore, he did not know that she required two staff for care. He stated that while she was on her side she was holding onto the nightstand; however, she fell to the floor.</p> <p>An interview with the Director of Nursing on April 17, 2025, at 10:21 a.m. confirmed that Nurse Aide 1 failed to follow Resident 2's care plan for bed mobility resulting in her falling out of bed and sustaining facial and neck fractures.</p> <p>Following the incident on April 7, 2025, the facility's corrective actions included:</p> <p>On April 7, 2025, the resident was immediately assessed and transferred to the hospital for further assessment. Nurse Aide 1 was immediately removed from care, interviewed, and suspended. He was then terminated for admitted ly not following the resident's care plan regarding bed mobility.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>The alert and oriented residents of the facility were interviewed to determine if they were transferred and received care according to their care plan. Non-interviewable residents were observed and assessed to determine if they had any injuries as a result of improper care with bed mobility.</p> <p>Education records dated April 8 and 9, 2025, revealed that all of the facility's nursing staff received education regarding reviewing the resident's Kardex/care plan prior to providing resident's with care.</p> <p>The Director of Nursing or designee will audit five random resident's care to ensure that their plan of care was followed five days a week for one week, and then three days a week for one week, and then weekly for one month. Further audits will be completed as determined by the Quality Assurance Performance Improvement (QAPI) committee.</p> <p>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on April 9, 2025.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		