| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395393 | A. Building<br>B. Wing | 03/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cedarwood Rehabilitation & Healthcare Center | 951 Washington Avenue<br>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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on review of policies, clinical records, and facility reports, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation after a fall to rule out abuse or neglect for one of seven residents reviewed (Resident 4).Findings include: The facility's policy regarding accidents and incidents - investigating and reporting, dated January 27, 2026, revealed the nurse supervisor/charge nurse and the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Incident accident reports would be reviewed by the safety committee for tends related to accident or safety hazards in the facility and to analyze any individual vulnerabilities. The report should include the circumstances surrounding the accident or incident, the names or witnesses and their account of the incident, and other pertinent data as necessary. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated February 15, 2026, revealed that the resident had moderate cognitive impairment, used a wheelchair, was independent with the ability to wheel at least 50 feet, and had diagnoses that included difficulty walking and generalized muscle weakness. A nursing note, dated March 21, 2026, revealed that at 1:58 p.m. Resident 4 had fall in the hallway where he reports he hit his head. Post event he complained of severe left shoulder pain and had a hematoma to back of head. Resident 4's family was updated and requested he be sent to emergency department for evaluation. Interview with Nurse Aide 1 on March 31, 2026, at 11:03 p.m. confirmed that she was assisting another aide with another resident when Resident 4 fell. She heard kitchen staff picked Resident 4 up off the floor. Interview with Nurse Aide 2 on March 31, 2026, at 2:04 p.m. confirmed that Nurse Aide 3 (who was working on another floor) responded when she heard that Resident 4 fell and was told that dietary staff had picked him up off the floor. Nurse Aide 3 then assisted to transfer the resident from a wheeled desk chair to his wheelchair for safety. Interview with Nurse Aide 3 on March 31, 2026, at 2:10 p.m. confirmed that she was told by a kitchen staff member there was a resident on the floor. However, when she went upstairs Resident 4 was sitting in a desk chair. Nurse Aide 3 told both dietary workers that they should not have moved the resident and she submitted a witness statement. Interview with Registered Nurse 4 on March 31, 2026, at 2:45 p.m. confirmed she was on another floor when staff reported that a resident fell. She assessed him sitting in his wheelchair. Resident 4 was holding his arm, guarded, and would cry out in pain. He also hit his head, and she sent him to the emergency room for evaluation. Registered Nurse 4 said she heard that dietary staff assisted the resident but since she did not witness them she did not include the information in her incident report. Usually when a resident sustained a fall staff would notify her and she would assess them before being moved. Interview with Dietary Aide 5 on March 31, 2026, at 3:07 p.m. confirmed that her and Dietary Aide 6 were on the unit and Resident 4 was on the floor. She tried to find a nurse but could not find anyone. Dietary Aide 6 was pulling him up off the floor and I had to help her. We put him on a desk chair, and then I went downstairs to tell someone. Interview with Dietary Aide 6 on March 31, 2026, at 3:17 p.m. confirmed that Resident 4 was on the floor, and she did not want to leave him there, so she assisted him off the floor. She indicated that she had completed a witness statement. A facility investigation, dated January 22, 2026, revealed that Resident 4 had an unwitnessed fall and included only the witness statements from Nurse Aide 2 and Licensed Practical Nurse 7. A witness<br>(continued on next page) |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | statement from Nurse Aide 2 dated March 21, 2026, revealed that she was notified by another aide that Resident 4 fell. He was in a wheeled desk chair by the housekeeping closet. We transferred him to his wheelchair for safety. He said his head and shoulder hurt. A witness statement from Licensed Practical Nurse 7 dated March 21, 2026, revealed that after lunch the unit was flooded with visitors, children, and lots of people going back and forth. It seemed to make all the residents more anxious than usual. The unit also has an increase in humidity and stuffiness with temperatures increasing and the heat being on. All the residents have an increase in confusion, irritability, agitation, and wandering when it feels hot and stuffy. Resident 4 did not want to go to bed after lunch as he seemed mesmerized with watching all the children and visitors coming and going. However, Licensed Practical Nurse 7 also recalled that she was not on the floor at the time of the incident because she was on break. When she returned to the floor Registered Nurse 4 was assessing Resident 4. A witness statement from Nurse Aide 3 dated March 21, 2026, revealed that she was working on the third floor when a dietary worker told her that a resident was on the floor. Nurse Aide 3 went upstairs, and two dietary workers already had him up off the floor, and on a rolling computer chair in the hallway. Nurse Aide 3 called the Registered Nurse that was working and went to find the Nurse Aides who were on the fourth floor. An orthopedic consultation dated March 31, 2026, at 11:00 a.m. revealed that Resident 4 had a left proximal humerus fracture after a fall on cement. Resident 4 would need a computed tomography (ct scan- noninvasive imaging) for surgical planning and needed to have a family member attend the next appointment to have surgical discussions or conservative care. The facility's investigation revealed no documented evidence that a thorough investigation was conducted, as there was no documented evidence that the investigation included witness statements from the dietary aides that assisted the resident after the fall on March 21, 2026. Interview with Director of Nursing on March 31, 2026, at 3:43 p.m. confirmed that she did not obtain witness statements from dietary staff because she did not believe they would have done that. She also indicated that she did not investigate the lack of RN assessment prior to the resident being moved to a rolling desk chair. Interview with Nursing Home Administrator on March 31, 2026, at 3:53 p.m. confirmed that all facility staff were trained upon hire to report to a nurse if a resident had a change in condition. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that recommendations from a wound consultant were reviewed with the attending physician for one of 5 residents reviewed (Resident 1).Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.An annual Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 24, 2026, indicated that the resident w as cognitively intact, had a stage 4 pressure ulcer (a localized injury to the skin and underlying tissues, caused by prolonged pressure)Physician's orders for Resident 1 dated March 10, 2026 included an order for the right hip wound and surrounding tissue to be cleaned with soap and warm water, rinsed with saline, and a wound vac applied (a medical device that applies gentle continuous suction to a wound to accelerate healing using a special foam dressing, an airtight seal and a vacuum pump to remove fluids, reduce bacteria, increase blood flow, and draw wound edges together) making sure to place some of the black foam into the tunneling, change every Monday, Wednesday and Friday and continue suction at 120 mmHg.A wound consultant note for Resident 1, dated March 20, 2026, revealed that the resident had a stage 4 pressure ulcer to her right hip and required her wound vac suction to be changed from 120 mmHg to 150mmHg.A review of Resident 1's Treatment Administration Record (TAR), dated March 2026, revealed that as of March 31, 2026, the resident's recommended change in wound vac suction to her right hip had not been initiated. Interview with the Director of Nursing on March 31, 2026, at 12:25 p.m. confirmed that wound care recommendations made by the wound care clinic on March 20, 2026, were not updated in her clinical record as of March 31, 2026.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |