STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395465	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarbrook Senior Care and Rehabilitation	350 S. Cedarbrook Road Allentown, PA 18104

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48578 Based on observation and staff interview, it was determined that the facility failed to ensure that meals were served in a manner that promoted and maintained each resident's dignity for two of 36 sampled residents. (Resident 82 and 175) Findings include: Observations of the lunch meal on the Station 5 unit on April 3, 2024, at 12:19 a.m., revealed Residents 82, 106, 117, 198, 490, and 497 were seated at a table together in the dining room. All the residents at the table were served and eating meals except Resident 82. Resident 82 was observed without a meal, looking around the room and reaching for the trays of other residents. Residents at other tables were being served their meals. Resident 82 was not served her lunch tray until 12:29 p.m. Observations of the lunch meal on the Station 5 unit on April 2, 2024, at 12:50 p.m., revealed Residents 82, 106, 117, 175, 198, 490, and 497 were seated at a table together in the dining room. All the residents at the table were served and were eating their meals except Resident 175. Resident 175 was observed throwing her hands in the air, making the sign of praying hands to a person walking by, and reaching towards other resident's trays. At 1:20 p.m., staff members escorted Resident 175 to the resident's room and served the lunch tray. In an interview on April 4, 2024, at 11:58 a.m., ADON 1 (Assistant Director of Nursing) confirmed that meals in the dining room should be served one table at a time. 28 Pa. Code 201.29(a) Resident rights.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39766 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessments were completed to accurately reflect the resident's status for two of 36 sampled residents. (Residents 310, 437) Findings include: Clinical record review revealed that Sections C (Brief Interview for Mental Status) and D (Mood Interview) of Resident 310's MDS assessment dated [DATE], were incomplete. Clinical record review revealed that Sections C and D of Resident 437's MDS assessment dated [DATE], were incomplete. In an interview on April 4, 2024, at 9:57 a.m., RN 1 (MDS Coordinator) confirmed that the MDS sections were not completed during the assessment period to reflect the resident's current status.

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(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. 39766 Based on resident interview, clinical record review, and staff interview, it was determined that the facility failed to ensure that physicians' orders were implemented for three of 36 sampled residents. (Residents 402, 437, 450) Findings include: Clinical record review revealed that Resident 402 had diagnoses that included congestive heart failure, diabetes mellitus, and dementia. On December 22, 2023, the physician ordered that staff weigh the resident daily and notify the physician if the weight was less than 150 pounds (lbs.) or greater than 160 lbs. Review of Resident 402's weight records revealed that the resident weighed 163.3 lbs on March 30, 2024, and 164 lbs. on March 31, 2024. There was no documented evidence in the clinical record that Resident 402's physician was notified of the weight changes. In an interview on April 4, 2024, at 8:50 a.m., the ADON 1 confirmed that the physician was not notified of Resident 402's weight changes. Clinical record review revealed that Resident 437 had diagnoses that included chronic kidney disease and edema (fluid retention in the lower legs). On February 6, 2024, the physician ordered that staff apply compression stockings (devices to relieve swelling in the legs) to both of the resident's lower legs while out of bed to prevent edema. The resident was observed without compression stockings on his lower legs on April 2, 2024, at 10:35 a.m., while out of bed in the solarium. The resident was observed again at 10:55 a.m., 12:18 p.m., and 3:05 p.m., without the compression stockings on while out of bed. During an interview on April 4, 2024, at 1:24 p.m., the Director of Nursing confirmed that the physician order was not followed. Clinical record review revealed that Resident 450 had diagnoses that included a history of stroke, high blood pressure, and dementia. On March 8, 2024, the physician ordered that staff administer 5 milligrams (mg) of a blood pressure medication (amlodipine besylate) daily. Staff was to hold the medication if the systolic blood pressure (SBP) (the top number on a blood pressure reading) was below 110 millimeters of mercury (mm Hg) and to call the physician if the SBP was greater than 150 mm Hg. A review of the March 2024 Medication Administration Record revealed that staff administered the medication when the resident's systolic blood pressure was over 150 mm Hg on March 17, 18, 22, 27, and 29, 2024. A review of the resident's progress notes revealed a lack of evidence to support that a physician was notified of the elevated SBP. In an interview on April 4, 2024, at 8:52 a.m., ADON 1 confirmed that the physician was not notified of Resident 450's elevated SBP readings between March 17 and 29, 2024. 28 Pa. Code 211.12(d)(1)(5) Nursing services.