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	04/17/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on four of 13 nursing units. (Nursing Units C3, D2, D3, D4)Findings include: Observations on April 14, 2026, from 10:30 a.m., to April 16, 2026, at 12:00 p.m., revealed the following:On Unit C3, in the men's bathroom, there was a blue privacy curtain that was dirty with stains on both sides. On Unit D2, two mechanical lifts were observed with thick hair and debris wrapped around the wheels. On Unit D3, one mechanical lift and a sit-to-stand lift were observed with thick hair and debris wrapped around the wheels. There was a mobile vital signs basket observed with thick hair and debris wrapped around the wheels. Between rooms [ROOM NUMBERS], there was a Broda chair that had thick hair and debris wrapped around the wheels. In the men's bathroom, there was a mobile bedside commode that had a collection bucket with a yellow liquid and a brown substance spattered inside the bucket. Observations on April 14, 2025, at 10:58 a.m., April 15, 2025, at 12:13 p.m., and April 16, 2025, at 12:07 p.m., revealed the collection bucket with the yellow liquid and brown substance remained in the bathroom and it was not emptied or cleaned. There was an odor of urine coming from the commode. On Unit D4, two mechanical lifts and a mobile vital signs basket were observed with thick hair and debris wrapped around the wheels. There was a dried white substance on the basket legs. CFR 483.10(i) Safe EnvironmentPreviously cited 5/9/2025. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(2.1) Management.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and facility documentation review, it was determined that the facility failed to report an alleged violation to the State Survey Agency for one of 35 sampled residents. (Resident 83)Findings include: Review of the facility policy entitled, Resident Abuse, Neglect, Misappropriation of Property and Other Related Offenses, last reviewed February 7, 2026, revealed that all incidents and allegations of abuse, including injuries of unknown source were to be reported immediately to the Nursing Supervisor, Nursing Administration, Abuse Coordinator, and to local and other officials as mandated by State Law. Clinical record review revealed that Resident 83 had diagnoses that included dementia, cognitive communication deficiency, and Alzheimer's disease. The Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment. On April 6, 2026, a nurse's note indicated that nursing was alerted by Resident 83's family that a patch of hair was missing or extremely short in the front of the resident's scalp. Review of a staff statement dated April 6, 2026, revealed the resident's daughter reported concern that the resident's hair had been shaved and that there was a bruise to her scalp line. There was no evidence that the facility reported the allegations of the facility shaving the resident's hair and the injury of unknown origin to the State Survey Agency and local agencies, as required. In an interview on April 15, 2026, at 9:00 a.m., the Assistant Director of Nursing stated that the facility failed to report the alleged violation to the appropriate state and local agencies. 28 Pa. Code 201.14(c) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for one of 35 sampled residents. (Resident 29)Findings include: Clinical record review revealed that Resident 29 had diagnoses that included vascular dementia (a decline in thinking skills caused by conditions that reduce blood flow to the brain), heart disease, and stroke. A physician's order dated July 25, 2019, directed staff to apply a wander alert bracelet. A review of Resident 29's MDS assessment dated [DATE], incorrectly indicated in section P (restraints and alarms) that the resident was not wearing a wander alarm during the last seven days of the review period. In addition, a physician's order dated July 15, 2024, directed staff to administer an antiplatelet medication (aspirin). Review of the MDS assessment dated [DATE], revealed that the resident was on an anti-coagulant medication during the last seven days of the review period, not an anti-platelet medication. The MDS inaccurately reflected the use of an anti-coagulant medication, as the aspirin was an antiplatelet medication.In an interview on April 16, 2026, at 3:44 p.m., the Registered Nurse Assessment Coordinator confirmed that Resident 29's MDS, completed on January 23, 2026, was inaccurate and should have captured antiplatelet medication and that a wander alert bracelet was used daily.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to provide care and services to maintain adequate grooming for two of four sampled residents who required assistance with activities of daily living (ADLs). (Residents 7 and 272)Clinical record review revealed that Resident 7 had diagnoses that included a stroke and hemiparesis (paralysis on left side of the body). Review of the care plan revealed the resident required assistance from staff for ADLs. On April 14, 2026, at 10:55 a.m., the resident was observed in bed. Her fingernails were long, chipped, and dirty with a substance underneath her nails. She stated that she preferred her nails to be kept short, her nails needed to be cut, staff had not offered to cut her nails, and she had not refused. On April 15, 2026, at 10:30 a.m., and on April 16, 2026, at 10:24 a.m., the resident was observed in bed. Her fingernails were long, chipped, and dirty with a substance underneath her nails. There was no evidence that staff had offered to provide the resident with nail care. There were no documented refusals. Clinical record review revealed that Resident 272 had diagnoses that included primary hypertension (high blood pressure) and chronic congestive heart failure. Review of the care plan revealed the resident required assistance from staff for ADLs. On April 14, 2026, at 10:55 a.m., April 15, 2026, at 10:30 a.m., and April 16, 2026, at 10:24 a.m., the resident was observed out of bed in the wheelchair. Her fingernails were long, chipped, and dirty with a substance underneath her nails. There was no evidence that staff had offered to provide the resident with nail care. There were no documented resident refusals. During an interview on April 16, 2026, at 1:00 p.m., the Director of Nursing confirmed that both residentsshould have been provided with fingernail care. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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** Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for three of 35 sampled residents. (Residents 7, 83, 450)Findings include: Review of the facility policy entitled, Administration of Medication, last reviewed on February 7, 2026, revealed that staff should check the medication label three times to verify the right resident, right medication, right dosage, right time, right route, and right evaluation of necessary documentation before the medication was administered. Clinical record review revealed that Resident 7 had diagnoses that included frequent urinary tract infections, risk for infection related to frequent urinary tract infections, and cerebral infarction with hemiparesis (paralysis of left side, non-dominant side). A physician's order dated November 8, 2025, directed staff to administer a medication (methenamine one gram daily) for prevention of urinary tract infections. The physician ordered that staff were not to administer the medication if the resident was ordered an antibiotic. On March 31, 2026, the physician ordered for the resident to receive an antibiotic (cephalexin 500 milligrams) to be taken for seven days. On April 7, 2026, the physician ordered an additional antibiotic (doxycycline 100 milligrams) to be taken for seven days. Review of Resident 7's Medication Administration Records (MAR), revealed that staff administered the cephalexin March 31 through April 6, 2026, and the doxycycline April 7 through April 14, 2026, without holding the methenamine. In an interview on April 16, 2026, at 12:30 p.m , the Director of Nursing confirmed that physician's orders for Resident 7 were not followed and medications were administered outside the ordered parameters as identified. Clinical record review revealed that Resident 83 had diagnoses that included diabetes, chronic kidney disease, and Alzheimer's disease. A physician's order dated April 1, 2026, directed staff to administer five units of a fast-acting insulin medication (insulin lispro) subcutaneously with meals to treat diabetes. On April 3, 2026, the physician increased the amount of insulin to be administered to eight units. Staff were to hold the medication if the resident was not eating or if the blood sugar level was less than 100 milligrams per deciliter (mg/dL). A review of Resident 83's MAR for April 2026, revealed that Resident 83 received the medication with her breakfast four times, on April 2, 4, 7, and 13, 2026, when the documented blood sugar level was less than 100 mg/dL. In an interview on April 16, 2026, at 3:19 p.m., the Assistant Director of Nursing confirmed that staff had administered the medication to Resident 83 when it should have been held. Clinical record review revealed that Resident 450 had diagnoses that included vesicointestinal fistula (surgical repair of the resident's uterus and intestines). The resident was admitted to the facility on [DATE], and physician orders from the hospital indicated that the resident was to be scheduled to have a cystogram test (x-ray of the bladder using a contrast dye) in two weeks. Review of the resident's clinical record revealed that on March 31, 2026, her attending physician approved and ordered the test and directed staff to schedule the appointment. During an interview on April 14, 2026, at 11:39 a.m., Resident 450 stated that she was supposed to have the cystogram two weeks from discharge from the hospital and she was not aware that an appointment had been scheduled. There was no evidence that staff requested an appointment for the cystogram until April 6, 2026. On April 14, 2026, staff noted that the appointment for the cystogram was scheduled for April 20, 2026, which was six days greater than the two-week timeline, as ordered by the physician. In an interview on April 17, 2026, at 11:04 a.m., the Director of Nursing confirmed that the request for an appointment was not sent to the scheduler in a timely manner. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to implement adequate safety interventions for one of 35 sampled residents. (Residents 83)Findings include: Clinical record review revealed that Resident 83 had diagnoses that included dementia, cognitive communication deficiency, and Alzheimer's disease. The Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment and required supervision from staff for bathing and personal hygiene such as shaving, combing hair, and washing hands and face. Review of the care plan revealed that the resident was at risk for severely impaired decision making capacity related to her diagnosis of Alzheimer's disease, dementia, and cognitive communication deficit, and staff were to provide set up assistance for hygiene and grooming and provide cues at times for safety depending on the resident's fluctuating cognitive status. It was also noted that the resident had a behavior of wrapping jewelry and other personal belongings in tissues and placing items in various areas in her room such as drawers, purses, and pillowcases. Review of facility documentation dated March 11, 2026, revealed that the resident was moved to a secure unit after multiple observations of the resident having wandering and exit seeking behaviors. On April 6, 2026, a nurse's note indicated that a patch of hair was missing or extremely short in the front of the resident's scalp and that Resident 83 stated she did it to herself with a razor. Review of facility documentation dated April 6, 2026, revealed that during a search of Resident 83's room, a disposable razor with a few small hair follicles was found inside a purse that was in Resident 83's closet. In an interview on April 15, 2026, at 9:00 a.m., the Assistant Director of Nursing stated that the resident should not have had a razor in her possession. CFR 483.25(d)(2) Free of Accidents/Hazards/SupervisionPreviously cited 5/9/202528 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that adaptive equipment was provided to one of 35 sampled residents. (Resident 4)Findings include: Clinical record review revealed that Resident 4 had diagnoses that included vascular dementia (a progressive decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), muscle weakness, and tremors. Review of the care plan revealed that the resident was at risk for nutrition problems and required the use of foam handles on utensils, a suction lip plate, and a cup with two handles and a lid for all meals. A physician's order dated September 9, 2025, directed staff to provide a two-handled cup with a lid to all meal trays, and physician's orders dated October 6, 2025, directed staff to provide foam handles on utensils and a suction lip plate with all meal trays. On April 14, 2026, from 12:05 p.m., through 12:20 p.m., and on April 15, 2026, from 11:50 a.m., through 12:05 p.m., Resident 4 was observed in the dining room with her lunch tray. The suction lip plate and the foam handles for the utensils were not in place. On April 16, 2026, from 11:50 a.m., through 12:10 p.m., Resident 4 was observed in the dining room with her lunch tray. The foam handles for the utensils, a suction lip plate, and the two-handled cup with a lid were not in place. In an interview on April 16, 2026, at 3:30 p.m., the Director of Nursing confirmed that the resident should have been provided with the foam handles for her utensils, the suction lip plate, and the cup with two handles with a lid at all meals. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for one of 35 sampled residents. (Resident 2)Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed on February 7, 2026, revealed that staff was to wear a gown and gloves during high contact resident care activities, such as changing briefs, to prevent infections. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included diabetes, chronic kidney disease, and obstructive uropathy (a blockage in the urinary system). Review of the Minimum Data Set assessment dated [DATE], revealed that the resident had an indwelling catheter (a device used to drain urine from the bladder). Review of the care plan revealed that Resident 2 required Enhanced Barrier Precautions, and the interventions were for staff to wear gloves and gowns during close contact interactions. On April 16, 2026, at 10:29 a.m., Nurse Aide (NA) 1 was observed changing Resident 2's brief without wearing a gown. At the time of the observation, a registered nurse (RN 1), who was also present during the observation period, stated that NA 1 should have worn a gown when changing Resident 2's brief. In an interview on April 17, at 10:30 a.m., the Director of Nursing confirmed that staff should have worn a gown while changing Resident 2's brief. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.