

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Sherwood Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Norman Drive Cranberry Township, PA 16066	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>49469</p> <p>Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of three medication carts (medication cart assignment two).</p> <p>Findings include:</p> <p>Review of facility policy Resident Rights dated 1/31/17, reviewed 4/4/23, indicates a resident has a right to personal privacy and confidentiality of their personal and medical records.</p> <p>During an observation on 4/24/24, at 8:37 a.m. Registered Nurse (RN), Employee E1 went into Resident R16's room to administer medications. RN, Employee E1 left the computer screen open with resident information visible to anyone passing by in the hallway. A report sheet with resident information was also present on the medication cart along with a binder that had a sheet of paper labeled fluid restrictions with a resident's name, all visible to anyone passing by in the hallway.</p> <p>During an interview on 4/124/24, at 8:56 a.m. RN, Employee E1 confirmed the facility failed to provide privacy and confidentiality of resident health information on one of three medication carts (medication cart assignment two).</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code: 211.5(b) Clinical records.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 31343</p> <p>Based on review of facility policies, documents, clinical records and staff interviews, it was determined that the facility failed to make certain a resident was free from abuse and neglect for four of six residents reviewed (Resident R2, R134, R135 and R9).</p> <p>Findings include:</p> <p>The facility's policy Abuse Neglect, and Exploitation Policy dated 2/21/24, with a previous review date of 4/4/23, indicated it is the facility's policy to provide a safe environment where residents are protected from all forms of abuse and strive to achieve a culture that treats every resident with dignity and respect while providing person centered care and services. The facility goal is to prevent and prohibit all types of abuse, neglect, misappropriation of property and exploitation. The facility assures that residents are free from neglect by identifying the needed care and services to all residents.</p> <p>Review of clinical record indicated that Resident R2 was admitted to the facility on [DATE], with diagnoses which included dementia, repeated falls, anticoagulant use, history of fractures of face and arm, and difficulty walking. A MDS (Minimum Data Set- a periodic review of resident care needs) dated 2/26/24, indicated the diagnoses remained current.</p> <p>Review of Resident R2's MDS dated [DATE], Section G0110 indicated Resident R2 required the assistance of two staff for transfers.</p> <p>Review of Resident R2's plan of care dated 12/7/20 through current indicated Resident R2 was a transfer of two staff for all transfers.</p> <p>Review of a facility provided document dated 8/6/23, indicated that Resident R2 had been transferred with assistance of one Nurse Aide using the pivot disc and when Resident R2 slid off of the bed, the Nurse Aide had to lower Resident R2 to the floor. The incident did not cause any injuries for Resident R2. The document indicated that the Nurse Aide was re-educated.</p> <p>Review of the clinical record indicated that Resident R134 was admitted to the facility on [DATE], with diagnoses which included heart failure, hallucinations, Myelodysplastic disease (cancer of blood cells causing bone marrow to not mature causing fatigue, bleeding disorders and shortness of breath), heart disease with heart valve disease and need for a pacemaker and osteoporosis. MDS dated [DATE], indicated Resident R134 diagnoses remained current with additional diagnosis of a fractured right hip after a fall on 9/4/23, during a transfer.</p> <p>Review of an MDS Section G0110 dated 9/14/23, indicated Resident R134 was an assistance of two staff for all transfers.</p> <p>Review of Resident R134's plan of care dated 12/12/22, indicated Resident R134 was to be transferred with two staff and use of a full body lift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility provided document dated 10/31/23, indicated that Resident R134 had been transferred with assist of two staff and a walker. Resident R134 was determined to not have any injuries. The two Nurse Aides were removed from his care and re-educated.</p> <p>Review of the clinical record indicated that Resident R135 had been admitted to the facility on [DATE], with diagnoses which included dementia, heart disease, a brain bleed, falls with fractures and a cognitive communication deficit. A MDS dated [DATE] indicated the diagnoses remained current.</p> <p>Review of a facility provided document dated 10/31/23, indicated Resident R135 had fallen in her room and three Nurse Aides had responded to LPN Employee E4 call for assistance to get Resident R135 off of the floor and as statements indicated that LPN Employee E4 kicked Resident R135 's foot and stated move I need to get in there and Resident R135 stated don't be so rough to her.</p> <p>Review of clinical record indicated that Resident R9 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure), hyperlipidemia (high fat in the blood), and osteoarthritis (pain, swelling and stiffness of joints). A MDS dated [DATE], indicated the diagnoses remained current.</p> <p>Review of Resident R9's plan of care dated 8/23/22, through current indicated resident R9 was a transfer with a sit to stand lift and assist of two for all transfers.</p> <p>Review of a facility provided document dated 2/18/24, indicated that Resident R9 had been transferred with assistance of one Nurse Aide (NA) to a chair when Resident R9 ' s legs began to slide. The NA had to lower Resident R9 to the floor. The incident did not cause any injuries for Resident R9. The document indicated that the Nurse Aide was immediately re-educated.</p> <p>During an interview on 4/25/24, at 9:48 a.m. the Director of Nursing confirmed that the facility failed to make certain a resident was free from abuse and neglect for four of six residents reviewed (Resident R2, R134, R135 and R9).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing services.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343</p> <p>Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for one of five residents (Resident R134).</p> <p>Findings include:</p> <p>Review of the facility policy Abuse, Neglect, Exploitation last reviewed on 2/21/24, with a previous review date of 4/4/23, indicated that the facility shall provide a safe environment where residents are protected from all forms of abuse including injuries of unknown origin. Some cases if abuse may not be directly observed and these areas shall be identified and investigated reported to the state agencies as required.</p> <p>Review of the clinical record indicated that Resident R134 was admitted to the facility on [DATE], with diagnoses which included heart failure, hallucinations, Myelodysplastic disease(cancer of blood cells causing bone marrow to not mature causing fatigue, bleeding disorders and shortness of breath), heart disease with heart valve disease and need for a pacemaker and osteoporosis. A MDS dated [DATE], indicated his diagnoses remained current with additional diagnosis of a fractured right hip after a fall on 9/4/23, during a transfer.</p> <p>Review of a progress note dated 11/1/23, indicated that Resident R134 had a skin assessment revealing an abrasion of his left hip measuring 6.2 cm x 1.7 cm and a dark purple bruise of his right lateral back measuring 2.1 cm x 0.8 cm.</p> <p>During an interview on 4/24/24, at 9:35 a.m., the Director of Nursing confirmed that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for one of five residents (Resident R134).</p> <p>28 Pa Code: 201.18 (e)(1)(2) Management</p> <p>28 Pa Code: 201.29 (a)(c)(d) Resident Rights</p> <p>28 Pa Code: 211.12 (a)(c)(d)(1)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide adequate protection from hazards for hot pack use for one of five residents (Resident R18), which resulted in a erythema (reddened) area requiring monitoring until identified as healed 8 days later.</p> <p>Findings include:</p> <p>Review of the facility policy Accidents and Incidents dated 2/21/24, with a previous review date of 4/4/23, indicated a safe environment will be promoted for all residents, report occurrences appropriately, and review and analyze for the opportunity for preventative measures.</p> <p>Review of the facility policy Heated Compress last reviewed on 2/21/24, with a previous review date of 4/4/23, indicated that warm moist heat such as a heating pad, gel pack or instant pack may be used as nursing intervention or as a physician order.</p> <p>Review of the clinical record indicated that Resident R18 was admitted on [DATE], with diagnoses which included repeated falls and bilateral primary osteoarthritis of knees. A MDS (Minimum Data Set- a periodic review of resident care needs) dated 2/8/24, indicated the diagnoses remained current.</p> <p>Review of Resident R18's plan of care for pain management, joint pain initiated 11/30/22, application of hot/cold packs to bilateral knees per her request. Leave in place for 20 minutes and check skin after pack removal and report concerns to nurse.</p> <p>Review of a facility provided document dated 3/4/24, indicated that Resident R135 had a hot pack placed on her right knee by Nurse Aide(NA) Employee E6 and developed a 3.5 cm x 2 cm area of erythema with no blistered area once the hot pack was removed. Registered Nurse(RN) Employee E5 assessed the area and initially applied Calazime barrier cream and after assessed by the Nurse Practitioner, the area was to be left open to air with no treatment and monitor.</p> <p>During review of Resident R135's statement indicated that she remembered the hot packs being very warm.</p> <p>Review of the statement from NA Employee E6 dated 3/5/24, regarding the incident of 3/3/24, stated that at 7:30 p.m., he placed a hot pack wrapped in a pillowcase on each of Resident R135's knees and when checking if resident R135 needed a brief change at 10:40 p.m., he repeated the hot packs.</p> <p>Review of skin assessment documentation from 3/4/24, through 3/12/24, did not identify any new areas and on 3/12/24, the area was healed .</p> <p>Review of a facility provided email document dated 3/5/24, indicated the Director of Nursing (DON) sending all staff a Must Read document indicating Resident R135 having a minor burn and also called it superficial. The document indicated that Nurse Aides are not to place or remove hot/cold packs, only Nurses are responsible for doing so.</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>Review of a training provided to all nursing staff indicated only nurses are to apply/remove hot/cold packs and that staff are not to heat anything in the microwave. Any use must be care planned. A staff attendance was attached with the names of the staff involved on the form.</p> <p>During an interview on 4/24/24, at 8:35 a.m., NA Employee E7 stated that she is not allowed to place hot/cold packs, only nurses can do so.</p> <p>During an interview on 4/24/24, at 8:38 a.m., NA Employee E8 stated that nurses can only place hot/cold packs.</p> <p>During an interview on 4/24/24, at 8:40 a.m., NA's Employee E9 and E10 stated they ask the nurses to place and remove them.</p> <p>During an interview on 4/24/24, at 8:42 a.m., NA Employee E11 stated that nurses can only place and remove hot/cold packs.</p> <p>During an interview on 4/25/24, at 9:13 a.m., the DON confirmed that the facility failed to provide adequate protection from hazards for hot pack use for one of five residents (Resident R18), which resulted in a erythema (reddened) area requiring monitoring until identified as healed 8 days later.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.20(b)(1) Staff Development.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49469</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly secure medications in one of three medication carts (medication cart assignment two).</p> <p>Findings include:</p> <p>Review of the facility policy Medication Storage dated 12/16, reviewed 4/4/24, indicate medications are stored and maintained under strict conditions to accept standards.</p> <p>During an observation on 4/24/24, at 8:37 a.m. Registered Nurse (RN) Employee E1 was completing a medication pass for Resident R16. RN Employee E1 administered medications for Resident R16, after using Trelegy Ellipta inhaler (relaxes and opens airways in lungs) she placed inhaler on top of medication cart and returned to room to complete medication administration. The medication cart was placed outside of Resident R16 's room and the medication was left unattended.</p> <p>During an interview on 4/24/24, at 8:56 a.m. RN Employee E1 confirmed the medication (Trelegy Ellipta inhaler) was left unattended and not properly secured on top of the medication cart accessible to anyone passing by in the hallway.</p> <p>28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49469</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly disinfect reusable equipment between residents for one of three medication carts (medication cart assignment two) and failed to implement infection control practices during administration of eye drops on two of three residents (Resident R27)</p> <p>Findings include:</p> <p>Review of facility policy Cleaning of Non-critical Patient Care Equipment dated 10/2/23, last reviewed 4/4/23, indicated it is the policy to clean and disinfect shared noncritical patient care equipment in a manner that prevents the transmission of microorganisms while maintaining the integrity of the equipment. Non-critical items are those that come in contact with intact skin but not mucus membranes.</p> <p>Review of facility policy Medication Administration: Eye dated 12/1/06, last reviewed 4/4/23, indicate to provide a safe, effective eye medication administration process including but not inclusive to carry medication into resident room, put on clean gloves, instill eye drops.</p> <p>During an observation on 4/24/24, at 8:37 a.m. Registered Nurse (RN) Employee E1 was completing medication pass, during the medication pass RN Employee E1 removed a pulse oximeter (equipment used for non- invasive method for monitoring a person ' s blood oxygen saturation) from the side section of medication cart. Employee E1 took the pulse oximeter into resident R16's room and placed on finger to obtain reading. RN Employee E1 then placed the pulse oximeter back into the side section of medication cart.</p> <p>During an interview on 4/24/24, at 8:56 a.m. RN Employee E1 confirmed the pulse oximeter was not properly disinfected.</p> <p>During an observation on 4/24/24, at 9:05 a.m. RN Employee E2 was completing a medication pass. RN Employee E2 took Resident R27's Systane eye drops (for dry eyes) into room with oral medications, after administering oral medications RN Employee E2 proceeded to instill the eye drops without utilizing gloves.</p> <p>During an interview on 4/24/24, at 9:40 a.m. RN Employee E2 confirmed the failure to implement infection control practices during administration of eye drops.</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p>		