| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395549 | A. Building<br>B. Wing | 03/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sherwood Oaks | 100 Norman Drive<br>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) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577<br><br>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for two of five residents (Residents R13 and R23).<br><br>Findings include:<br><br>Review of facility policy SRC-Resident Centered Care Plan-6.0, dated 2/7/25, indicated that the facility will develop a plan of care that is tailored to the resident's specific wishes and clinical care needs and in keeping with the resident and family's overall goals of care; to structure and guide therapeutic interventions to meet resident's needs and achieve expected outcomes. The care plan will be individualized for each resident based upon all available resident-specific information. The care plan is formally reviewed and completed within 21 days after admission at the Interdisciplinary Care Plan Conference and communicated to appropriate staff. The care plan is reviewed and updated at least quarterly, and is based on ongoing assessment and evaluation of resident needs and goals of care. It may specifically be reviewed and updated as the resident's condition changes.<br><br>A review of the clinical record revealed Resident R13 was admitted to the facility on [DATE], with diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and stroke (damage to the brain from an interruption of blood supply).<br><br>A review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/24, indicated the diagnoses remain current.<br><br>Review of Resident R13's physician order dated 11/18/24, indicated Dexcom G7 Receiver Device (Continuous Glucose System Receiver) inject one device subcutaneously (fat layer) in the morning every 10 days. May change every 12 hours as needed for dislodgement or malfunction.<br><br>A review of the clinical record failed to reveal a person-centered care plan was developed for Resident R13 to address goals and interventions relating to Dexcom G7 Receiver Device (Continuous Glucose System Receiver) as required.<br><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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 3/4/25, at 2:40 p.m. the Director of Nursing confirmed the clinical record failed to reveal a person-centered care plan for Resident R13 to address goals and interventions relating to Dexcom G7 Receiver Device (Continuous Glucose System Receiver) as required.<br><br>A review of the clinical record revealed Resident R23 was admitted to the facility on [DATE], with diagnoses that included Parkinsonism (a clinical syndrome characterized by tremor, bradykinesia [slowed movements], rigidity, and postural instability), chronic pain syndrome (a condition where people experience symptoms beyond pain alone, such as depression and anxiety, which interfere with their daily lives), and polyneuropathy (a condition in which a person's peripheral nerves are damaged).<br><br>A review of the MDS dated [DATE], indicated the diagnoses remain current. Further review of the MDS Section N: Medications, Question N0415 indicated Resident R23 received antiplatelet medication seven days a week.<br><br>Review of Resident R23's physician order dated 10/16/24, indicated Clopidogrel (Plavix - medication used to prevent heart attacks and strokes in person's with heart disease) tab 75 mg (milligrams) one time a day for CVA (cerebrovascular accident) prophylaxis related to transient cerebral ischemic attacks and related syndromes.<br><br>A review of the clinical record failed to reveal a person-centered care plan was developed for Resident R23 to address goals and interventions relating to antiplatelet medication (Plavix) usage for CVA prophylaxis.<br><br>During an interview on 3/5/25, at 10:38 a.m., Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that Resident R23's care plan failed to contain goals and interventions relating to antiplatelet medication use.<br><br>During an interview on 3/5/25, at 12:45 p.m., the Director of Nursing (DON) confirmed that the facility failed to develop comprehensive care plans to meet resident care needs for two of five residents (Residents R13 and R23).<br><br>28 Pa. Code 211.10(c.) Resident care policies.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336<br><br>Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to follow physician orders for a lab test for one of four residents (Resident R31).<br><br>Findings include:<br><br>Review of the facility policy Physician Orders dated 2/21/24, indicated physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. To ensure that the residents receive all medications and treatments that are ordered by the physician in a timely manner.<br><br>Review of the admission record indicated Resident R31 was admitted to the facility on [DATE].<br><br>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and atrial fibrillation (irregular heart rhythm), and long-term use of anticoagulant (used to prevent and treat blood clots in blood vessels and the heart).<br><br>Review of physician's order dated 11/5/24, indicated Coumadin (an anticoagulant medication) 3 mg (milligrams) one tablet every Tuesday, Thursday, Saturday, and Sunday in the evening, and Coumadin 4mg one tablet every Monday, Wednesday, and Friday in the evening.<br><br>Review of Resident R31's Medication Administration Record indicated the coumadin was being given as ordered in November 2024, and December 2024.<br><br>Review of Resident R31's coumadin flow sheet dated 10/21/24, indicated the INR (International Normalized Ratio lab values - measures how long it takes for blood to clot) was 2.3 with physician orders to recheck in one month.<br><br>Review of Resident R31's physician order indicated the recheck INR should have been completed on 11/14/24.<br><br>Review of facility provided documentation dated 12/27/24, indicated the INR ordered for 11/14/24, was not correctly transcribed in the electronic health record and therefore; was not obtained as ordered.<br><br>Review of Resident R31's progress note dated 12/20/24, at 9:10 p.m. indicated staff observed miscellaneous bruises on resident arms and back. Resident indicated she bumps into bed while attempting to get into closet. Bruises easily no complaints of pain or discomfort.<br><br>Review of Resident R31's progress note dated 12/25/24, at 1:06 p.m. indicated staff reported new bruise to resident's rear right flank (side of the back, below the ribs and above the hips). Resident takes blood thinners and has a history of easy bruising.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R31's progress note dated 12/26/24, at 2:30 a.m. resident complaints of nausea and vomited small amounts of coffee ground emesis (vomit). Resident is pale and stated she isn't feeling well. Denied abdominal pain. Resident takes coumadin routinely, obtained INR with machine which read >8.0. Physician on call indicated to give Vitamin K (used to treat bleeding) 10ml (milliliters) intramuscularly times one dose and send to the emergency room .<br><br>Review of Resident R31's emergency room information indicated the INR level to be 10.7 (extremely high).<br><br>Review of facility provided documentation dated 12/27/24, indicated the root cause of the residents high INR was associated with the missed INR testing from 11/14/24.<br><br>Review of physician history and physical note dated 1/8/25, at 12:57 p.m. as late entry for 1/7/25, readmission to the facility from coagulopathy (a condition that prevents the blood from clotting properly), and hemorrhagic stroke (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain).<br><br>Interview on 3/5/25, at 9:21 a.m. the Director of Nursing confirmed the facility failed to follow physician orders for a lab test for one of four residents (Resident R31).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18(b)(1)(3) Management.<br><br>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>46336<br><br>Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of four residents (Resident R6).<br><br>Findings include:<br><br>Review of the facility policy SRC- Safety - 2.0 Accidents and Incidents (Residents) dated 2/21/24, indicated an accident/incident is any happening, which is not consistent with routine operations or the routine care of the particular resident. It may be an accident or a situation which might result in an accident.<br><br>Review of admission record indicated Resident R6 was admitted to the facility 5/10/17.<br><br>Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/3/24, indicated diagnoses of muscle weakness, macular degeneration (eye disease that causes vision loss), and allergic rhinitis (an allergic response causing itchy, watery eyes, sneezing, and other similar symptoms).<br><br>-Section C indicated a Brief Interview for Mental Status (BIMS -screening test that aides in detecting cognitive impairment) a score of 12 ( 8-12: indicates moderately impaired cognitive ability).<br><br>-Section GG0130 indicated 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers. Dependent for toileting, transfers, and shower/bathe.<br><br>-Personal hygiene such as combing hair, applying make-up, drying face and hands is 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident<br><br>completes activity.<br><br>-01 sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed (dependent) required for the resident to complete the activity.<br><br>Review of the care conference progress note dated 8/16/24, indicated Resident R6's son told the team Resident R6 tells him she enjoys the meals but forgets soon after.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R6's progress note dated 1/5/24, at 6:50 p.m. indicated called into room by walkie for nurse STAT. Resident lying on bathroom floor, feet at sink and head at doorway lying on right side. Wheelchair in upright position with left chair on and right chair lock off, acing toilet. Resident eye open but not communicating with staff when spoken to. When attempting to assist to roll resident over, observed laceration on right side of head, with hematoma (collection of blood outside a vessel) present. Moderate amount of bright red blood present. Noted skin tear to left forearm. Vitals obtained, resident becoming nauseated, but no vomit noted. Ambulance left with resident on stretcher at 7:18 p.m.<br><br>Review of facility provided documentation indicated Resident R6 suffered a comminuted proximal humeral fracture of the right arm through the humeral head and neck (a severe shoulder injury where the upper part of the humerus bone (near the shoulder joint) is broken into multiple pieces, with the break extending through both the ball like joint surface and the narrow area connecting the head to the bone shaft). Right forehead laceration was sutured at the emergency room and will require removal in 10 - 12 days. Right upper arm shoulder sling in place.<br><br>Review of Nurse Aide (NA) Employee E5's Employee Statement Form dated 9/2/24, indicated Resident R6 was at the sink to brush her teeth. NA Employee E6 locked both wheelchair locks and gave her the toothbrush, got the room ready for bed. Resident was asked if she was okay or needed more time. Resident replied Yes to more time. We told resident to ring when she was done. Cord of bathroom call bell draped around sink faucet. Around 6:40 p.m. we checked in on her and she was washing her face. We went to care for another room and on the way back resident was opening her lotion to put on her face around 6:45 p.m. Went to care for another room and were walking back we heard a thud. Ran into room and found Resident R6 on her right side on the floor with blood coming from her head. The right wheelchair lock was not locked upon discovering resident.<br><br>Review of NA Employee E6's Employee Statement Form Dated 9/2/24, indicated the same timeline as NA Employee E5, with the addition of adding they asked the resident if she wanted privacy, and the resident said yes.<br><br>Review of NA Employee E7's Employee Statement Form Dated 9/2/24, indicated I heard my coworkers shout, and I entered Resident R6's room . Resident was lying on the floor diagonal to the bathroom door. NA Employee E6 was in the bathroom with her. The right wheel of the chair was unlocked, and the left was locked. We placed a towel on residents head to clot (stop) the bleeding. Resident was very sweaty, confused and unaware of the situation. Blood pressure was significantly low (93/55), and she appeared nauseous.<br><br>Interview on 3/5/25, at 9:21 a.m. the Director of Nursing confirmed that the facility failed to make certain each resident received adequate supervision and assistance to prevent accidents for one of four residents (Resident R6).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18(b)(1)(3) Management.<br><br>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>46336<br><br>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in three of four medications carts (West cart, Founder Cart, and Lake Cart).<br><br>Findings include:<br><br>Review of the facility policy Disposition of Medications dated 2/7/25, indicated medications that are no longer required for example, expired medications should be dispositioned as indicated.<br><br>Observation on 3/4/25, at 8:14 a.m., the [NAME] medication cart revealed the following medication stored improperly:<br><br>-Ipratropium/albuterol (an inhaled medication to breathe easier) with a multi-dose foil package opened and without a date.<br><br>Interview on 3/4/25, at 8:14 a.m., Registered Nurse (RN) Employee E2 confirmed that the medication should have been dated when opened and was stored improperly.<br><br>Observation on 3/4/25, at 8:37 a.m., the Founder's medication cart revealed the following medication stored improperly: Ipratropium/albuterol with a multi-dose foil package opened and without a date.<br><br>Interview on 3/4/25t, at 8:37 a.m., Licensed Practical Nurse (LPN) Employee E3 confirmed the medication should have been dated when opened and was stored improperly.<br><br>Observation on a.m., the Lake medication cart revealed Xdemvy eye drop container (used to treat blepharitis- mites live on the skin) opened and without a date.<br><br>Interview on 3/3/25 at 10:54 a.m., RN Employee E4 confirmed that the medication should have been dated when opened and was stored improperly.<br><br>Interview on 3/6/25, at 12:45 p.m., the Director of Nursing confirmed that the facility failed to properly store medications in three of four medications carts (West cart, Founder Cart, and Lake Cart).<br><br>28 Pa. Code: 211.10(c.) Resident care policies.<br><br>28 Pa. Code: 211.12(d)(1)(5) Nursing services. |