

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Cedar Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1265 South Cedar Crest Blvd Allentown, PA 18103	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45125</b></p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs identified in the comprehensive assessment for one of 30 sampled residents. (Resident 194)</p> <p>Clinical record review revealed that Resident 194 was admitted to the facility on [DATE], and had diagnoses that included retention of urine, Parkinson's disease, and dementia. The Minimum Data Set Care Area Assessment summary dated September 3, 2024, noted that the resident's urinary incontinence and cognitive decline/dementia were to be addressed in the care plan. There was no evidence that interventions to address Resident 194's urinary incontinence and cognitive decline/dementia were addressed in the current care plan.</p> <p>In an interview on October 9, 2024, at 2:40 p.m., the Director of Nursing confirmed there was no documented evidence that the identified care areas were addressed in Resident 194's current care plan and they should have been.</p> <p>28 Pa. Code 211.12(d)(1)(5)Nursing services.</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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