

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/26/2025
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)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for two of 32 sampled residents. (Residents 65 and 170) Findings include: Review of the facility policy entitled, Administering Medications, last reviewed April 30, 2025, revealed that a resident may only self-administer their own medications if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Review of the facility policy entitled, Self-Administration of Medications, last reviewed April 30, 2025, revealed that as part of the evaluation, the interdisciplinary team assessed each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident, if it was deemed safe and appropriate for a resident to self-administer medications, that was documented in the medical record and the care plan. Clinical record review revealed that Resident 65 had diagnoses that included heart failure, diabetes, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated October 30, 2025, revealed that Resident 65's cognition was intact. There was no documented evidence that Resident 65 had been assessed for the ability to self-administer medication. Observation on November 24, 2025, between 11:35 a.m. and 11:57 a.m., revealed a medicine cup containing 12 unidentified pills unsecured on the bedside table in Resident 65's room. An interview with Resident 65 at 11:35 a.m., revealed that the pills were her morning medications that the nurse left on her table. In an interview with RN 1 on November 25, 2025, at 10:33 a.m., RN 1 confirmed she left the medications on the resident's bedside table. Clinical record review revealed that Resident 170 had diagnoses that included frontotemporal neurocognitive disorder. Review of the MDS, dated [DATE], revealed that Resident 170's cognition was intact. There was no documented evidence that Resident 65 had been assessed for the ability to self-administer medication. Observations on November 25, 2025, between 8:05 a.m. and 8:20 a.m. revealed a medicine cup containing seven unidentified pills in Resident 65's room. During that time Resident 170 stated that another nurse brought them to him, but he could not remember when. An interview with LPN 1 at 8:20 a.m., confirmed they were given to the resident during the 6:00 a.m. medication pass. In an interview on November 26, 2025, at 10:17 a.m., the Director of Nursing confirmed that Residents 65 and 170 were not assessed or approved to self-administer the medications as per the facility policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were free from potential chemical restraints for one of five sampled residents who were ordered psychotropic medications. (Resident 93) Findings include: Clinical record review revealed that Resident 93 had a diagnoses that included anxiety and psychotic disorder with hallucinations. On August 27, 2025, a physician ordered staff to administer an anti-anxiety medication, (lorazepam), every 24 hours as needed for anxiety and sleep. There was no date in the order that indicated when staff were to stop administering the as needed medication. Review of Resident 93's Medication Administration Record revealed staff had administered the lorazepam two times in October 2025, and three times in November 2025. On October 14, 2025, a physician ordered staff to administer an anti-anxiety medication (lorazepam), every 24 hours as needed for anxiety and agitation, in addition to the August 27, 2025 as needed anti-anxiety medication order. There was no date in the order that indicated when staff were to stop administering the as needed anti-anxiety medication. Review of Resident 93's Medication Administration Record revealed staff had administered the lorazepam one time in October 2025, and five times in November 2025. There was no documented evidence that the physician had re-evaluated continued use beyond 14 days of the as needed anti-anxiety medication for the second as needed order. Staff had continued to administer both as needed anti-anxiety medications. In an interview on November 26, 2025, at 8:17 a.m., the Director of Nursing stated that there had been no date added to the orders that indicated when staff were to stop administering the as needed anti-anxiety medication. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review, observation and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the resident's status for one of 32 sampled residents. (Resident 11) Findings include: Clinical record review revealed that Resident 11 had diagnoses that included stroke, nontraumatic intracerebral hemorrhage (bleeding inside the brain), unspecified sequelae of other cerebrovascular disease (long-term effects of unknown brain blood vessel problem), coronary artery disease, heart failure, hypertension, occlusion and stenosis of bilateral carotid arteries, atrial fibrillation, type two diabetes mellitus and long-term use of insulin. The MDS assessment dated September, 19, 2025, incorrectly indicated in Section N (Medications) that the resident did not receive insulin injections or an anticoagulant or antiplatelet during the previous seven days. Review of the 2025 Medication Administration Record for September revealed that staff administered an anticoagulant, antiplatelet, and an insulin injection daily during the month of September as ordered by the physician. In an interview on November 26, 2025, at 10:45 a.m., the Director of Nursing confirmed that the MDS assessment did not accurately reflect the medication status of Resident 11.		

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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. Based on a review of clinical records and staff interview, it was determined that the facility failed to implement physicians' orders for one of 32 sampled residents. (Resident 151) Findings include: Clinical record review revealed that Resident 151 had diagnoses that included hypertension (high blood pressure) and chronic systolic (congestive) heart failure. On November 3, 2024, the physician ordered that staff administer blood pressure medication (metoprolol) one time a day. The physician ordered that staff not administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 110 millimeters of mercury (mm/Hg) or if the resident's pulse was less than 60 beats per minute. Review of Resident 151's Medication Administration Records (MAR) for August, September, October, and November of 2025, revealed that staff failed to record the resident's blood pressure or pulse prior to the administration of the medication 10 times in August, seven times in September, and four times in October. Further review of the MAR revealed that the staff administered metoprolol three times in October and three times in November when the resident's SBP was below 110 mm/Hg. On December 30, 2024, the physician ordered that staff weigh Resident 151 every Monday, Wednesday, and Friday for treatment of congestive heart failure, and notify the physician if the resident gained more than two pounds (lbs.) in 24 hours or five pounds in a week. Review of Resident 151's MAR for August, September, October, and November of 2025, revealed that staff failed weigh Resident 151 on August 4 and 18, 2025, September 10, 2025, and November 24, 2025, as ordered. Review of Resident 151's MAR for August, September, October, and November 2025, revealed that Resident 151 gained more than five pounds in one week on the following occasions: August 15, 2025 - August 22, 2025 (22 lbs.) September 1, 2025 - September 8, 2025 (14.5 lbs.) October 1, 2025 - October 8, 2025 (15 lbs.) October 17, 2025 - October 24, 2025 (7 lbs.) November 17, 2025 - November 21, 2025 (5.4 lbs.) There was no documented evidence that the physician had been notified of weight changes greater than five pounds in a week. In an interview on November 26, 2025, at 10:54 a.m., the Director of Nursing confirmed that the medication was administered outside of parameters; that weights, blood pressure and pulse were not recorded, and that the physician was not notified of weight changes for Resident 151 as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **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 provide sufficient enteral nutrition (delivery of nutrition by a feeding tube) to maintain proper hydration and health in accordance with the physician's order for one of four sampled residents receiving nutrition by a feeding tube. (Resident 100) Findings include: Review of the facility policy entitled, Enteral Nutrition, last reviewed on April 30, 2025, revealed that a dietician monitored residents who were receiving enteral nutrition, made appropriate recommendations for interventions to enhance tolerance and nutritional adequacy, that nursing staff and providers monitored the resident for signs and symptoms of altered electrolytes, and that nursing was to confirm the orders for enteral nutrition were complete including instructions for flushing. Clinical record review revealed that Resident 100 had diagnoses that included history of a brain injury, difficulty swallowing, and had a tracheostomy for breathing. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was dependent on staff for activities of daily living and was unable to express needs or understand others. Further review of the MDS assessment revealed that the resident received more than 51 percent of nutrition through an enteral feeding tube. Clinical record review revealed that Resident 100 had bloodwork collected on November 17, 2025, that indicated the resident had a low sodium level of 131 millimoles per liter. Review of a nutrition progress note dated November 19, 2025, revealed a recommendation to decrease Resident 100's water flushes from 200 milliliters (mL) every six hours to 150 mL every six hours, or four times per day, for a total volume of 600 mL per day due to low sodium level. A physician's order dated November 19, 2025, directed staff to administer 150 mL of free water flushes every six hours. Observations on November 24, 2025, at 11:12 a.m., November 25, 2025, at 10:19 a.m., and November 26, 2025, at 11:00 a.m., revealed that the resident was in bed and was connected to the tube feeding pump that was programmed with a water flush of 150 mL every 4 hours, or six times per day, for a total volume of 900 mL per day. In an interview on November 26, 2025, at 11:05 a.m., Licensed Practical Nurse 2 (LPN 2) assigned to Resident 100 stated that they did not verify the pump was programmed based on the updated physician's order. In an interview on November 26, 2025, at 12:00 p.m., the Director of Nursing confirmed the tube feeding pump had not been programmed to match the physician's order and Resident 100 had received 300 mL per day more water than ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) for one of two nursing units observed during medication administration. (Second floor) Findings include: Observation of medication administration on November 25, 2025, from 8:05 a.m. to 9:00 a.m., revealed 38 medication opportunities with two medication errors that resulted in a medication administration error rate of 5.26%. Clinical record review revealed that Resident 152 had diagnoses that included asthma, chronic obstructive pulmonary disease (COPD), and corona virus 2019. A review of the physician's order dated November 20, 2025, revealed that staff was to administer three milliliters (ml) of ipratropium-albuterol inhalation solution 0.5-2.5 (3) milligram (mg)/3ml (a medication used to treat symptoms of COPD) inhaled every 12 hours and to be given prior to administering Advair Diskus Aerosol Powder 500-50 micrograms (a medication used to treat symptoms of COPD). Observation of the medication pass on November 25, 2025, at 9:00 a.m., revealed that Registered Nurse 2 (RN 2) administered the ipratropium-albuterol inhalation solution to Resident 152 after she administered the Advair Diskus, which was not in accordance with the physician's order. Clinical record review revealed that Resident 170 had diagnoses that included frontotemporal neurocognitive disorder, anemia, and high blood pressure. A review of the physician's order dated June 13, 2025, revealed that staff were to administer sennosides 8.6 mg, (a medication to treat constipation) every 12 hours. Observation of the medication pass on November 25, 2025, at 8:05 a.m., revealed that RN 2 administered Senna Plus (a tablet that contained two medications for constipation, sennosides and a stool softener, Colace) which was the incorrect medication. In an interview on November 26, 2025, at 10:20 a.m., the Director of Nursing confirmed that RN 2 administered the incorrect medication and RN 2 did not give ipratropium prior to administering the Advair Diskus. 28 Pa Code 211.12(d)(1)(5) Nursing services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation it was determined that the facility failed to store food in a sanitary manner on one of three nursing units. (MedBridge)Findings include:Observation in the MedBridge resident refrigerator on November 25, 2025, at 9:34 a.m., revealed that the top shelf had a thick layer of crumbs and dried liquid debris. On the middle shelf there was an area of a white sticky substance and part of a plastic bag was stuck to the shelf. The area along the length of the bottom of the refrigerator under the drawers had a thick layer of a dark sticky substance. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.		

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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 on one of three nursing units. (MedBridge) Findings include: Review of the facility policy entitled, Isolation- Categories of Transmission-Based Precautions, last reviewed April 30, 2025, revealed that transmission based precautions (TBPs) included contact precautions, droplet precautions, airborne precautions and required certain personal protective equipment (PPE). If a resident was identified as having a communicable disease, then TBPs were to be initiated. Staff were to post a sign on the residents' door and chart that alerted all personnel and visitors entering the room of the need for and the type of precaution. If a resident was on contact precautions, staff and visitors were expected to wear gloves and a disposable gown upon entering the room and remove before leaving the room. If a resident was on droplet precautions, masks were to be worn when entering the room, and gowns, gloves and goggles when there was risk of spraying respiratory secretions. Review of the facility policy entitled, Coronavirus Disease (COVID-19)- Identification and Management of Ill Residents, last reviewed April 30, 2025, revealed that staff who entered the room of a resident with suspected or confirmed Covid-19 infection would adhere to standard precautions and use a NIOSH- approved particulate respirator with N95 filter or higher, a gown, gloves, and eye protection such as a goggles or face shield that covers the front and sides of the face, and these residents were to remain on precautions for at least ten days. Review of the facility policy entitled, Enhanced Barrier Precautions last reviewed April 30, 2025, revealed that staff were to wear gloves and a gown prior to performing high contact resident care activities like bathing, providing hygiene, changing briefs, dressing, and changing linens. Clinical record review revealed that Resident 1 tested positive for Coronavirus disease 2019 (COVID-19) on November 16, 2025. A physician's order dated November 16, 2025, directed staff to implement droplet/contact precautions for covid every shift for ten days. Review of the care plan revealed that Resident 1 had a recently confirmed case of COVID-19. Observations on November 24, 2025, from 12:13 p.m. through 12:17 p.m., revealed licensed practical nurse (LPN) 2 entered Resident 1's room wearing gloves and a mask. Observations at that time revealed a sign was posted on the doorway of Resident 1's room indicating that droplet/contact precautions were in place and staff and visitors were to wear personal protective equipment (PPE) upon entering the room which included a gown and eye protection. LPN 2 did not wear a gown or eye protection while in the resident's room. Clinical record review revealed that Resident 20 tested positive for COVID-19 on November 18, 2025. A physician's order dated November 18, 2025, directed staff to implement isolation droplet/contact precautions for covid every shift for ten days. Review of the care plan revealed that Resident 20 had a recently confirmed case of COVID-19. Observations on November 24, 2025, from 10:32 a.m. to 10:35 a.m., revealed that LPN 2 entered Resident 20's room wearing gloves and a mask, and from 12:30 p.m. to 12:32 p.m., nurse aide (NA) 1 entered and exited Resident 20's room twice wearing gloves and a mask. Observations at that time revealed a sign was posted on the doorway of Resident 20's room indicating that droplet/contact precautions were in place and staff and visitors were to wear PPE upon entering the room which included a gown and eye protection. LPN 2 and NA 1 did not wear a gown or eye protection while in the resident's room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review revealed that Resident 59 tested positive for COVID-19 on November 20, 2025. A physician's order dated November 20, 2025, directed staff to implement isolation droplet/contact precautions for covid every shift for ten days. Review of the care plan revealed that Resident 59 had a recently confirmed case of COVID-19. Observations on November 24, 2025, from 11:50 a.m. to 11:54 a.m., revealed LPN 2 entered Resident 59's room with a glucometer and supplies, and from 12:25 p.m. through 12:29 p.m., LPN 2 entered Resident 59's room with an insulin pen and supplies wearing a mask and gloves. Observations at that time revealed a sign was posted on the doorway of Resident 59's room indicating that droplet/contact precautions were in place and staff and visitors were to wear PPE upon entering the room which included a gown and eye protection. LPN 2 did not wear a gown or eye protection while in the resident's room. Clinical record review revealed that Resident 84 tested positive for COVID-19 on November 20, 2025. A physician's order dated November 20, 2025, directed staff to implement isolation droplet/contact precautions for covid every shift for ten days. Review of the care plan revealed that Resident 84 had a recently confirmed case of COVID-19. Observations on November 24, 2025, from 12:30 p.m. to 12:33 p.m. revealed that LPN 2 entered and exited Resident 84's room wearing a mask and gloves. Observations at that time revealed a sign was posted on the doorway of Resident 84's room indicating that droplet/contact precautions were in place and staff and visitors were to wear PPE upon entering the room which included a gown and eye protection. LPN 2 did not wear a gown or eye protection while in the resident's room. Clinical record review revealed that Resident 90 tested positive for COVID-19 on November 16, 2025. A physician's order dated November 16, 2025, directed staff to implement isolation droplet/contact precautions for covid every shift for ten days. Review of the care plan revealed that Resident 90 had a recently confirmed case of COVID-19. Observations on November 24, 2025, from 12:32 p.m. through 12:39 p.m., revealed that NA 1 entered and exited Resident 90's room wearing gloves and a mask and carrying a bag of dirty linens. Observations at that time revealed a sign was posted on the doorway of Resident 90's room indicating that droplet/contact precautions were in place and staff and visitors were to wear PPE upon entering the room which included a gown and eye protection. NA 1 did not wear a gown or eye protection while in the resident's room. Clinical record review revealed that Resident 100 had diagnoses that included history of a brain injury, difficulty swallowing, had a feeding tube, and had a tracheostomy for breathing. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was dependent on staff for activities of daily living and was unable to express needs or understand others. Review of the care plan revealed that Resident 100 required enhanced barrier precautions related to her tracheostomy and feeding tube and staff were to wear gloves and a gown during high contact care activities. Observations of a sign posted on the doorway of Resident 100's room indicated that enhanced barrier precautions were in place and staff were to clean hands and wear PPE including a gown for high contact resident activities. Observations on November 24, 2025, at 11:48 a.m., revealed NA 1 gathered fresh linens and entered Resident 100's room wearing a mask and gloves. Resident 100 was observed in her bed at that time. At 11:55 a.m., NA 1 was observed stripping resident 100's bed and wearing a mask and gloves and Resident 100 was observed in her chair. At 12:05 p.m., NA 1 exited Resident 100's room with a bag containing soiled linens. NA 1 did not wear a gown while changing Resident 100's linens. In an interview on November 26, 2025, at 9:43 p.m., the Director of Nursing confirmed that droplet and contact precautions should have been implemented and the policies were not followed by staff. (continued on next page)		

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