

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395416	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/14/2025
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NAME OF PROVIDER OR SUPPLIER: ROSEWOOD REHABILITATION AND NURSING CENTER	STATE LICENSE NUMBER: 701002	STREET ADDRESS, CITY, STATE, ZIP CODE: 401 UNIVERSITY DRIVE SCHUYLKILL HAVEN, PA 17972
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F 0000	INITIAL COMMENT	F 0000		
F 0558 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on Febraury 14, 2025, it was determined that Rosewood Rehabilitation and Nursing Center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	<ol style="list-style-type: none"> 1. Residents 7 and 92 had their call bells placed within reach. 2. To identify other residents who have the potential to be affected, the DON/designee completed an audit of all resident rooms to ensure call bells are within reach. 3. To prevent this from reoccurring, DON/designee completed education with the nursing staff and all facility staff on ensuring call bells are within reach when exiting a resident room. Education for all staff is ongoing. 4. To monitor and maintain ongoing compliance, the DON/designee will audit call bell placement in 10 resident rooms weekly x 4, biweekly x 2, and monthly x 1. Results will be reviewed at the QAPI meeting. 	Completion Date: 04/03/2025 Status: APPROVED Date: 02/28/2025

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F 0558 SS=D	Continued from page 2 Based on clinical record review and observation, it was determined that the facility failed to ensure that a call bell was accessible for two of 27 sampled residents. (Residents 7, 92) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included dysarthria (neurological speech disorder), hemiplegia and hemiparesis (paralysis), and anxiety. Review of the Minimum Data Set (MDS) assessment, dated December 1, 2024, revealed Resident 7 was dependent on staff for Activities of Daily Living (ADL's), including toileting, dressing, and personal hygiene. Review of the care plan revealed that Resident 7 was at risk for falls with an intervention for staff to check that the call bell was in reach before leaving the room. On February 11, 2025, at 11:31 a.m., Resident 7 was observed in bed with the call bell tied to the light string of the adjacent bed, out of reach. Resident 7 was observed again at 1:00 p.m., in bed eating lunch, and again at 2:15 p.m., in bed with the	F 0558		

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F 0558 SS=D	Continued from page 3 call bell tied to the light string, out of reach. On February 12, 2025, at 8:20 a.m., 10:52 a.m., and 12:38 p.m., and on February 13, 2025, at 9:28 a.m., and 11:46 a.m., Resident 7 was observed in bed with the call bell still tied to the light string, out of reach. Clinical record review revealed that Resident 92 had diagnoses that included anxiety, bradycardia (slow heart rate), and fibromyalgia. Review of the MDS assessment, dated November 4, 2024, revealed Resident 92 required partial to moderate assistance from staff for ADL's, including dressing and personal hygiene. Review of the care plan revealed that Resident 92 was at risk for falls with an intervention for staff to be sure the call light was within reach and to encourage the resident to use it for assistance. On February 11, 2025, at 11:30 a.m., Resident 92 was observed in the bed with the call bell draped over a box on the wall behind the bed, out of reach. Resident 92 was observed again at 1:00 p.m., in bed eating lunch, and again at 2:15 p.m., in bed with the call bell draped over a box on	F 0558		

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F 0558 SS=D	Continued from page 4 the wall behind the bed, out of reach. On February 12, 2025, at 8:11 a.m., 10:52 a.m., and 12:38 p.m., and on February 13, 2025, at 9:28 a.m., and 11:46 a.m., Resident 92 was observed in bed with the call bell draped over a box on the wall behind the bed, out of reach. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0558		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 5 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	<p>1. Resident 93 did not sustain any adverse effects from receiving the medication. Physician was made aware of resident 93 receiving medication outside of parameters.</p> <p>2. To identify other residents who have the potential to be affected, the DON/designee completed an audit of residents prescribed medications with parameters.</p> <p>3. To prevent this from recurring, the DON/designee completed education with licensed nurses on checking and following parameters prior to medication administration.</p> <p>4. To monitor and maintain ongoing compliance, the DON/designee will audit 10 residents with medication parameters to ensure accuracy of medication administration weekly x 4, biweekly x 2, and monthly x 1. Results will be reviewed at the QAPI meeting.</p>	Completion Date: 04/03/2025 Status: APPROVED Date: 02/28/2025

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F 0684 SS=D	Continued from page 6 Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 27 sampled residents. (Resident 93) Findings include: Clinical record review revealed that Resident 93 had diagnoses that included hypertension (high blood pressure) and atrial fibrillation (irregular heart beat). A physician's order dated January 31, 2025, directed staff to administer a medication (metoprolol) one time a day for cardiac issues. Further review of the clinical record, revealed a physician's order dated January 30, 2025, that directed staff to administer a medication (amiodarone) one time a day for atrial fibrillation. Staff were not to administer either of the medications 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 (mmHg). Review of Resident 93's medication administration	F 0684		

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F 0684 SS=D	Continued from page 7 records (MARs) revealed that staff administered each medication two times in February 2025 when the resident's SBP was less than 110 mmHg. In an interview on February 14, 2025, at 10:10 a.m., the Director of Nursing confirmed that the medications were administered outside of the established parameters for Resident 93. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 8 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. The noted areas in the kitchen were cleaned and undated food was discarded. The items from the unit 3A refrigerator were discarded. Refrigerator temperature settings were changed to a cooler level. Refrigerators replaced on three units. 2. There were no other instances identified during the survey. 3. To prevent this from reoccurring, the NHA/designee completed education with the dietary manager and kitchen staff on kitchen cleanliness and dating food items. The environmental services manager and staff were educated on checking refrigerator temperatures, discarding food items if temperatures are elevated, and to notify the NHA of reoccurring elevated temperatures. 4.To monitor and maintain compliance, the NHA/designee will complete kitchen audits to check for dated open items and kitchen cleanliness weekly x 4, biweekly x 2, and monthly x 1. To monitor and	Completion Date: 04/03/2025 Status: APPROVED Date: 02/28/2025

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F 0812 SS=D	Continued from page 9	F 0812	maintain compliance, the NHA/designee will complete food pantry refrigerator temperature audits to check for proper refrigerator temperatures weekly x 4, biweekly x 2, and monthly x1. Results will be reviewed at the QAPI meeting.	

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F 0812 SS=D	Continued from page 10 Based on facility policy review, staff interview, and observation, it was determined that the facility failed to store food in a sanitary manner in the dietary department and on one of four nursing unit pantries. (Nursing unit 3A) Findings include: Review of the facility policy entitled, "Dating and Labeling Policy," dated December 9, 2024, revealed that staff were to label food items with the date the package was opened and the date was to be written legibly. Observations during the kitchen tour on February 11, 2025, at 10:00 a.m., revealed the following: At the handwashing sink, the soap dispenser lever was covered with thick dried food debris. In the cooks' utensil drawer, there was a measuring cup with a dried, flaky substance along the bottom of it and it was stored with clean utensils.	F 0812		

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F 0812 SS=D	<p>Continued from page 11</p> <p>In the thickened liquid cooler, there was an opened package of sliced cheese and a large opened bulk container of grape jelly that were not dated. Inside the length of the door, there was an area of dried pink substance.</p> <p>In the walk-in cooler, there were two areas of a dried white substance on the floor under two sets of shelves. One set of shelves had meat on it and the other set of shelves stored milk cartons. There was a large opened bulk container of grape jelly that was dated but not legible.</p> <p>In an interview on February 11, 2025, at 10:30 a.m., the Dietary Manager confirmed that the previously mentioned items should have been dated and the date should have been legible.</p> <p>Review of the facility policy entitled, "Food From Home or Outside Sources-Safety," dated December 9, 2024, revealed that staff were to check the temperatures of the resident refrigerators in order to determine the proper working order of</p>	F 0812		

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F 0812 SS=D	Continued from page 12 the refrigerator. The refrigerators temperatures were to be at or below 41 degrees Fahrenheit. Observation of the Nursing unit 3A pantry on February 12, 2025, at 9:15 a.m., revealed a temperature of 47 degrees Fahrenheit by two thermometers that were inside. At 11:36 a.m., the temperature was 48 degrees Fahrenheit and on February 13, 2025, at 11:15 a.m., the temperature was 46 degrees Fahrenheit. At each observation, there were eight milk and three yogurt containers in the refrigerator. In an interview on February 13, 2025, at 2:20 p.m., the Administrator confirmed the refrigerator was used for resident foods. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management.	F 0812		

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F 0812 SS=D	Continued from page 13	F 0812			

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P 5640	<p>Nursing services.</p> <p>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5640	<p>1. The staffing minimum required nursing care hours ("HPPD") is unable to be corrected for the selected dates.</p> <p>2. No other dates were identified during the survey.</p> <p>3. To prevent this from reoccurring, the DON/designee will continue to work with Nursing Supervisors and the Staffing Coordinator to ensure the HPPD is at 3.20 or the state staffing minimum. Bonuses, position advertising, staffing flexibility, and agency use are measures used to secure staffing. Staffing will be based on current census and supervisors, or scheduler will contact other staff or agencies to cover call offs.</p> <p>4. To monitor and maintain ongoing compliance, the DON/designee will audit schedules and HPPD weekly x 4, biweekly x 2, and monthly x 1. Results will be reviewed at the QAPI meeting.</p>	<p>Completion Date: 04/03/2025</p> <p>Status: APPROVED</p> <p>Date: 02/28/2025</p>
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P 5640	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 hours of direct care for each resident for 21 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from January 23 through February 12, 2025, revealed the following total nursing care hours below minimum requirements: January 23, 2025: 3.06 care hours per resident. January 24, 2025: 3.12 care hours per resident. January 25, 2025: 3.07 care hours per resident. January 26, 2025: 3.06 care hours per resident. January 27, 2025: 3.10 care hours per resident. January 28, 2025: 3.12 care hours per resident. January 29, 2025: 3.07 care hours per resident. January 30, 2025: 3.04 care hours per resident. January 31, 2025: 3.03 care hours per resident. February 1, 2025: 2.98 care hours per resident. February 2, 2025: 3.07 care hours per resident.	P 5640		

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NAME OF PROVIDER OR SUPPLIER: ROSEWOOD REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 401 UNIVERSITY DRIVE SCHUYLKILL HAVEN, PA 17972		
STATE LICENSE NUMBER: 701002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 2 February 3, 2025: 3.07 care hours per resident. February 4, 2025: 3.06 care hours per resident. February 5, 2025: 3.07 care hours per resident. February 6, 2025: 3.03 care hours per resident. February 7, 2025: 3.05 care hours per resident. February 8, 2025: 3.04 care hours per resident. February 9, 2025: 3.03 care hours per resident. February 10, 2025: 3.03 care hours per resident. February 11, 2025: 3.14 care hours per resident. February 12, 2025: 3.07 care hours per resident. During an interview on February 14, 2025, at 11:15 a.m., the Administrator confirmed that the facility did not meet the minimum required nursing care hours on the days identified.	P 5640		



Certified End Page

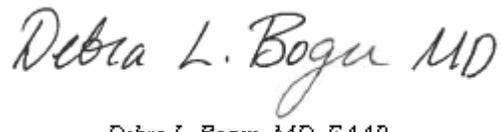
ROSEWOOD REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 701002

SURVEY EXIT DATE: 02/14/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY