OFFICE OF THE LONG-TERM CARE OMBUDSMAN

EST. WITHIN THE PA DEPARTMENT OF AGING

October 20, 2019

First 60-Day Patient Care Ombudsman Report

Re: Cedar Haven Healthcare Center
Case No. 19-11736 (CSS)

As directed by the court, and pursuant to 11 U.S.C. § 333(a)(2), Fed. R. Bankr. P. 2007.2(c), the following is my preliminary 60-day report for the above captioned case.

General Information

Cedar Haven Healthcare Center offers skilled nursing care services in Lebanon, Lebanon County, Pennsylvania, under a regular license issued by the PA Department of Health. The population they serve is primarily geriatric.

The home has a capacity of 324 beds, of which 286 beds are currently occupied.

The current occupancy rates are consistent with facility census reports over the last year under the current administration.

Local ombudsman records indicate that this census, based on the number of available beds, is lower than in other skilled nursing facilities in the area.

Upon notice of my appointment as Patient Care Ombudsman and the bankruptcy process underway, the Lebanon County Office of the Ombudsman began weekly facility coverage visits averaging two hours per visit. These visits occurred on 8/27, 9/09, 9/19, 9/23, 9/26, 9/30, 10/11, 10/17, 10/20, and were completed by certified ombudsmen Weimer and Agee.

Environmental Observations

As the appointed Patient Care Ombudsman, I visited this facility on September 30, 2019. The duration of the visit was three hours.

On this visit, Judy Weimer and Nick Matash, certified ombudsmen, were also present.

This facility is approximately fifty years old and was operated by the county of Lebanon until 2014. It is a large, three-story structure with a lobby main entrance connecting all wings, consistent with other institutions constructed at that time. The environment is more hospital than home-like. The lobby was unremarkable with a receptionist posted near the front door. The doors to a common dining room are directly behind the main area. A somewhat dark hallway to the right leads to a chapel/activities room.

There was a strong odor of feces coming from the resident room hallway to the left of the lobby.

Several residents in wheelchairs observed congregated in the lobby area.

Throughout our walk through the facility, the temperature seemed appropriate in the hallways and common areas. We did not enter any of the resident rooms. No further malodor was detected on any of the upper floors.

Because of the institutional design of this facility, many of the rooms have four occupants, with only a hospital-style curtain separating the beds.

Throughout the resident areas we observed flyers posted on bulletin boards citing generous referral bonuses for staffing referrals. This supports, and contributes to, a general understanding that this facility needs additional staff.

Staffing/Operations

Care staff on various hallways appear to be hurried. One nurse administering medications indicated that she enjoys working there because of the opportunity to work extra shifts, as much as she wants. Ombudsman observation is that while this may be beneficial to staff, it could reduce the quality of care over the long-term because staff are tired and overworked.

In our preliminary meeting to discuss the role of the patient care ombudsman, administrator Steven Zablocki explained that all of families of residents, and the residents, as appropriate, were notified of the bankruptcy in August. In his opinion, the bankruptcy will help address the cash-flow challenges that they had been working through over the last several months/years, especially since the nursing strike in 2017.

He believes that the greatest challenge he faces is recruitment of qualified care staff. He indicated that the new nursing preceptor was awaiting approval from the PA Department of Education in order to begin training a group of newly recruited care aides. This ombudsman's understanding is that new care aides have completed training since the September facility visit.

No vendor concerns are reported at this time.

Resident Initiated Complaints/Concerns

It was clear that the Lebanon County ombudsman has a regular presence at this facility. The residents identified us by our badges and lanyards and there were numerous unsolicited complaints brought forth to us as we walked through the facility.

Summary of observations of residents and resident engagement on September 30th visit:

Resident 1: Complained that the commodes on the 2nd and 3rd floors are consistently dirty. He must flush and wipe them down prior to use. He believes this job should be handled by staff.

Resident 2: Observed sitting in wheelchair at the door to her room, clearly visible to all passersby, with nightshirt pulled up around her waist, with only a diaper on below. She was not alert or oriented. Ombudsmen alerted an aide to expedite help.

Resident 3: Observed sitting in wheelchair in the hallway. Unable to communicate easily. Was appropriately dressed and groomed.

Resident 4: Acknowledged that she regularly attends resident council and food committee meetings. She generally has little to no complaints.

Resident 5: Complaint about irregular meal times. Reports that lunch has been served as late as 2:00 pm and dinner served at 7:00 pm. Resident believes that this is as a result of short-staffing in the kitchen.

Resident 6: Observed sleeping on a wheeled transport cot in the hallway. His blanket was pulled up over his face with a ballcap sitting on top of the blanket. Because of the resident's slender build, it was unclear if there was someone under the blanket. When ombudsman inquired about why he was in the hallway sleeping, the care aide shrugged and said, "he likes to." This ombudsman's opinion remains one of concern.

Resident 7: Resident is younger. We spoke at length about how she came to reside at the facility. She has no major complaints about care or food.

Resident 8: Observed screaming out in pain, complaining of her bottom hurting and needing to be repositioned. Complaining about the "hairy" blanket which covered her. Care aides were ignoring her cries for help. The staff person summoned dismissed her behavior as normal; however, a hospice nurse disclosed that the Hoyer chair (typically used for toileting and transfers) was likely uncomfortable for someone to sit in for extended periods of time. She indicated that she has communicated this to the care staff, but they have not corrected the concern.

Resident 9: Requested a private meeting with ombudsmen in the chapel. Announced that she was speaking with us at the request and on behalf of the residents on her wing. She indicated that there are numerous complaints, but that residents don't want to speak up. 1. Food is generally OK but reiterated what other residents indicated about irregular meal times. She indicates this is distressing because they get hungry in between meals and only receive a packet of crackers if they ask for a snack. Also of concern, when lunch is served late, the residents are unable to participate in the scheduled afternoon activity. 2. Staffing: At times there is only one aide and one nurse for the hallway. As a result, they must wait a long time for their call bells to be answered.

Residents 10-14: Upon observing our ombudsman lanyards and identification, numerous residents and one family member made unsolicited complaints about food temperature and meal delivery time for those who choose to eat in their rooms. As a result, they feel they have no choice but to eat in the dining room in order to be assured of warm food and the opportunity for a second portion, once everyone else has been served. They believe this is because of short staffing in the dining room.

Each week throughout this reporting period, local certified ombudsmen (designates of the State Ombudsman) have completed facility visits. These visits average 2-3 hours each, with interaction with an average of 20 residents per visit.

Reports reflect significant complaints related to facility operation and specifically food service quality and temperature:

- Inconsistent food tray delivery with items missing.
- Empty breakfast trays left in the rooms until lunch trays delivered.
- Cold food in both the dining room and especially on tray service.
- Food such as rice not cooked to a soft consistency.
- One resident indicated that because of short staffing, she is delayed from eating because her blood-sugar levels must be checked before meals, preventing her from eating when the tray is served.

Most of the residents report that they are satisfied with their care. Of those with care concerns, the complaints pertain to the menu, activities, and call bell response time.

Regulatory Issues/Department of Health

The PA Department of Health completed a facility survey on August 2, 2019. Based on clinical record review, it was determined that the facility failed to provide adequate supervision for one of six sampled residents who had falls. Corrective action plan was accepted and approved by the Department of Health on August 14, 2019. No regulatory issues are recorded for the current reporting period.

The State Long-Term Care Ombudsman is confident that the facility will work closely with the local ombudsmen, when appropriate, to respond to resident concerns throughout the bankruptcy process.

We trust that the information included in this report is satisfactory to the Court. We will continue to have the local ombudsman conduct weekly site visits and meet with residents to ensure their quality of care and life continue to be positive.

For additional information or should you have any questions, please do not hesitate to contact the PA Ombudsman Office of the Long-Term Care Ombudsman at (717) 783-7096.

Sincerely,

Margaret D Barajas

Margaret Barajas
State Long-Term Care Ombudsman