STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395158	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Greenville	110 Fredonia Road Greenville, PA 16125

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on review of facility policies and clinical record and staff interview, it was determined that the facility failed to develop a comprehensive plan of care for one of five residents reviewed (Resident R12).Findings include: A facility policy entitled MDS[Minimum Data Set-a periodic assessment of resident care needs]/RAI/Care Planning dated 1/20/26, indicated the facility will develop a written plan of care individualized for each resident. A facility policy entitled Resident Elopement dated 1/20/26, indicated that any resident with a successful elopement will be reassessed and additional interventions will be identified and included with the Plan of Care. A facility policy entitled Resident Elopement Follow-Up Procedure dated 1/20/26, indicated the plan of care will be modified to incorporate an increased elopement risk and increased monitoring as needed based on behaviors. Resident R12's clinical record revealed an admission date of 11/7/14, with diagnoses that included Paranoid Schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and disorganized thinking), Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Review of information submitted by the facility revealed that on 2/26/26, Resident R12 eloped from the facility. Clinical record review revealed an Elopement Risk Assessment completed 2/26/26, that identified Resident R12 was at risk for elopement. Review of Resident R12's comprehensive plan of care failed to reveal a care plan for Resident R12's risk for and/or actual elopement. During an interview on 3/6/26, at 10:41 a.m. Registered Nurse Assessment Coordinator Employee E1 confirmed that Resident R12's comprehensive plan of care did not include a care plan for his/her risk for or actual elopement. 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, manufacturer's guidelines, and clinical records and staff and resident interviews, it was determined that the facility failed to ensure insulin was administered in accordance with good nursing principles and practices for three of 35 residents reviewed (Residents R7, R1, and R2)Findings include: A facility policy, Medication Administration dated 1/20/26, revealed medications are administered, as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so to comply with Federal Laws governing Medication Administration and in order to ensure the safe, accurate and timely administration of medications. Manufacturer's guidelines for Humalog (Insulin Lispro) revealed a subcutaneous injection (medication is injected into the fatty tissue beneath the skin) should be administered within 15-minutes before a meal or immediately after a meal. Manufacturer's guidelines for Novolin Regular (Insulin) revealed a subcutaneous injection should be administered within 30-minutes before a meal or immediately after a meal. Resident R7's clinical record revealed an admission to the facility on 6/20/25, with diagnoses that included Diabetes (a health condition caused by the body's inability to produce enough insulin), Congestive Heart Failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply causing blood and fluids collect in your lungs and legs over time), and Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing). Resident R7's physician's orders revealed Insulin Lispro Sliding Scale with coverage before meals. The February 2026 Medication Administration Record (MAR) revealed a blood sugar at 5:00 p.m. on 2/26/26, was 336. The clinical record revealed that Licensed Practical Nurse (LPN) Employee E5 administered 10 units of insulin per physician's orders. On 2/26/26, at approximately 5:45 p.m. Resident R7 had not yet received his/her meal tray and experienced a hypoglycemic episode (blood sugar becomes low often times resulting in symptoms such as paleness, shakiness, sweating, slurred speech, confusion, etc.) requiring the administration of Glucagon (medication given to increase your blood sugar) at 5:50 p.m. and again at 6:10 p.m. Resident R1's clinical record revealed an admission to the facility on [DATE], with diagnoses that included Diabetes, Altered mental status (a quick change in brain function ranging from confusion to coma), High Blood Pressure, and Coronary Artery Disease (a heart condition caused by plaque buildup that narrows/blocks arteries in the heart). Resident R1's physician's orders revealed Novolin R Flexpen Injection (Insulin Regular Sliding Scale with coverage with meals. The March 2026 MAR revealed a blood sugar at 11:30 a.m. on 3/05/26, was 315. The clinical record revealed that LPN Employee E3 administered 5 units of insulin per physician's orders. On 3/05/26, at 1:25 p.m. Resident R1's meal for lunch was delivered; confirmed by Certified Nursing Assistant (CNA) Employee E2. Evening insulin administration on 3/05/26, at 4:00 p.m. for Resident R1 revealed LPN Employee E4 administered Novolin R 4 units for a blood sugar of 276. During an interview on 3/05/26, at approximately 5:15 p.m., LPN Employee E4 indicated he/she typically administers insulin one hour before the resident's meal. The dinner meal was then observed being served to Resident R1 at 6:50 p.m. Resident R2's clinical record revealed an admission to the facility on 1/01/26, with diagnoses that included Diabetes, COPD, Gastrointestinal Hemorrhage (blood loss from the digestive tract), and Hypovolemic Shock (a life-threatening emergency caused by a large amount of blood loss from the body). Resident R2's physician's orders revealed Insulin Lispro Sliding Scale with coverage with meals. The March 2026 MAR revealed a blood sugar at 4:00 p.m. on 3/05/26, was 236. LPN Employee E4 administered 3 units of insulin per physician's orders. During an interview on 3/05/26, at approximately 5:15 p.m., LPN Employee E4 indicated he/she typically administers insulin one hour before the resident's meal. The dinner meal was then observed being served to Resident R2 at 6:49 p.m. During an interview on 3/05/26, at 7:30 p.m. the Nursing Home Administrator (NHA) confirmed that insulin should be administered timely before/after a resident's meal such as a 15-minute time (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	span to prevent adverse effects such as hypoglycemia. The NHA further confirmed the manufacturer's guidelines for insulin administration is timely before/after meals. 28 Pa. Code 211.5(f)(i)(x) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of facility policy, job descriptions, clinical records, resident council minutes, and grievances, observations, and resident and staff interviews, it was determined that the facility failed to provide sufficient nursing staff and services to promote the physical and mental well-being and meet the needs for eight of 15 residents reviewed (Residents R1, R3, R4, R5, R8, R9, R10, and R11).Findings include: A facility policy entitled Call Light Response dated 1/20/26, indicated that staff will respond to the call light and the resident's needs in a timely manner. A facility job description for a Certified Nursing Assistant and RN Charge Nurse revealed part of their Specific job function is to Answer resident calls promptly and Ensure that residents who are unable to call for help are checked frequently. Part of their Customer Service and Resident Rights is to Ensure that call lights are answered by all employees of the facility regardless of department. If you are not trained to assist with request / need then inform resident that you will seek appropriate personnel immediately, then do so. Review of Resident Council minutes over three months from December 2025, and January and February 2026, revealed the following: 12/29/25 Resident Council minutes revealed eight residents in attendance and there are times when the call bells are not answered as timely as they prefer. 2/23/26 Resident Council minutes revealed 20 residents in attendance and staff are not answering call bells on afternoon and midnight shift. Review of grievance logs from December 2025, and January and February 2026, revealed the following related to call bell response: 1/5/26 Resident reported there are times on afternoon shift he/she has to wait longer than preferred for bell to be answered. 1/12/26 Resident reported it takes staff two to three hours to come and help them. 1/13/26 Resident reported staff taking thirty minutes to help him/her. 1/16/26 Resident reported one of the aides makes his/her roommate wait a long time when he/she is using the restroom and they would like their call bell answered timelier. Interviews on 3/05/26, and 3/06/26, with Resident R1 and R1's resident representative, and Residents R3, R4, R5, R8, R9, R10, and R11 all revealed they must wait longer than 30 minutes for their call bell to be answered. Interviews with these residents in addition to a response of 30 minutes or greater revealed the following: Resident R4 indicated during an interview on 3/05/26, at 10:45 a.m. that he/she no longer utilizes his/her call bell since nobody responds to it timely. Resident R4 indicated that he/she just does things himself/herself. Resident R2 indicated during an interview on 3/05/26, at 10:55 a.m. that he/she waited two hours for staff to assist him/her the evening of 3/04/26. Resident R1 indicated during an interview on 3/05/26, at 11:05 a.m. that he/she stopped using the call bell and tap bell provided. Resident R1 stated, I would pound on that bell and nobody would come, so I just holler out. Resident R1's resident representative nodded his/her head in agreement. Observation and interview on 3/05/26, at 12:15 p.m. revealed Resident R8 resting in bed, upset and calling out for a nurse. Resident R8 indicated at this time he/she called 911 due to bleeding related to a foley catheter. Resident R8 further indicated that he/she placed his/her call bell on at 10:30 a.m. and had been waiting for staff to assist him/her. The Director of Nursing (DON) confirmed while at Resident R8's bedside on 3/05/26, at 12:30 p.m. that Resident R8 was bleeding with large blood clots observed. Emergency medical service with a stretcher did arrive at Resident R8's room at 12:30 p.m. and he/she was transferred to the hospital. Resident R8 returned to the facility evening of 3/05/26 without additional medical interventions. Resident R5 indicated during an interview on 3/05/26, at 3:15 p.m. that he/she must propel his/her wheelchair to the nurses' station to get staff to assist him/her. During an interview on 3/05/26, at 6:20 p.m. the DON confirmed that all residents should have their call bells responded to in a timely manner, and waiting 30 minutes or greater is an unacceptable response to have their needs met by staff. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility policies and clinical record, and staff interview, it was determined that the facility failed to maintain accurate and complete documentation related to an incident for one of five residents reviewed (Resident R12).Findings include: A facility policy entitled Documentation dated 1/20/26, indicated nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate and that it will communicate resident's status and provided accurate accounting of care and monitoring provided. A facility policy entitled Resident Elopement dated 1/20/26, indicated that residents shall be reassessed at least quarterly related to elopement risk. Resident R12's clinical record revealed an admission date of 11/7/14, with diagnoses that included Paranoid Schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and disorganized thinking), Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Review of facility reported incident revealed that on 2/26/26, Resident R12 eloped from the facility. Clinical record progress notes lacked any evidence of Resident R12 eloping from the facility, his/her safe return, and/or physician and/or resident representative notifications. Review of Elopement Risk Assessment's completed on Resident R12's revealed they were completed on 1/14/25, 4/17/25, and 2/26/26. The clinical record lacked evidence that they were completed quarterly. During an interview on 3/6/26, at 10:35 a.m. the Director of Nursing (DON) confirmed that Resident R12's clinical record lacked evidence of Resident R12 eloping from the facility, his/her safe return, and/or physician and/or resident representative notification. The DON further stated that Risk Management and/or a progress note should have been completed for Resident R12. During an interview on 3/06/26, at 10:30 a.m. the DON and Registered Nurse Assessment Coordinator (RNAC) Employee E1 stated they were not sure how often Elopement Risk Assessments were completed on each resident. During an interview on 3/6/26, at 11:44 a.m. Nursing Home Administrator (NHA) was unable to verify how often Elopement Risk Assessments were done and would check with the RNAC. The NHA confirmed that Resident R12's clinical record lacked evidence of Elopement Risk Assessments being completed on a quarterly basis. 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the call bell system was adequately working for one of six halls (500 hall)Findings include: A facility policy entitled Call Light Response dated 1/20/26, revealed that a call bell or alternative device will be placed within the reach of each resident while in their room, toilet, or bathing area. The policy further revealed that staff will be alerted to signals that the call bell is on by the following: Flashing light on intercomBeeping of intercomLighted call signal over the resident's doorSounding of a tap bell During an interview on 3/05/26, at 9:15 a.m. the Nursing Home Administrator (NHA) revealed that the call bell system on Unit 1 had stopped working and a new system was installed and functioning effective 12/10/25. NHA revealed that some residents still utilized a tap bell per their preference. Observations on 3/5/2026, at 1:22 p.m. revealed each resident room had two assigned numbers outside their room. One number was for the room call bell and the second number was for the bathroom call bell. Observations also revealed an oblong digital unit sitting on the nurse's desk that displayed a two-digit number when a call bell was activated. If the digital unit was cleared of any call bell alerts and a call bell was activated the digital unit beeped three times and displayed a two-digit number. The number remained on the digital unit at the nurse's station until the call bell was acknowledged in the resident's room and/or bathroom but did not continue to beep to notify staff and there was no visible overhead light that illuminated down the hall or outside the resident's room. It was observed that if another resident activated their call bell before the first call bell was acknowledged, the two-digit number was displaced on the digital unit, but there was no audible sound or light that illuminated to alert staff. The digital unit that displayed the two-digit number could only display up to eight numbers at a time. If more than eight call bells are activated, they would not be displayed on the digital unit until previously activated call bells were acknowledged. Testing and observation of all call bells on 500 hall revealed that call bell number 47 associated with room [ROOM NUMBER] did not display on the digital unit when activated. Interview on 3/5/26, at approximately 1:00 p.m. with Resident R7 and his/her family revealed the call bells have not been working adequately for probably a few months now. Resident R7 revealed the facility provided him/her with a tap bell, but his/her daughter purchased him/her a cow bell to use instead to ensure staff heard it. Interviews with facility staff working Unit 1 on 3/5/26, at 1:22 p.m. revealed that even if they hear the three beeps for the first call bell that is activated the only way they know which room it is, is to go to the nurse's station and look at the box sitting on the desk to see which number is displayed. Since the unit only displays two-digit numbers, they then must refer to a list that has all resident room numbers and what their correlating call bell number is to know which resident is calling for something. The staff further revealed they have no way to know if more than one call bell was activated unless they go to the nurse's station to look at the box. During interview on 3/5/26, at 1:33 p.m. Certified Nursing Assistant (CNA) Employee E2 confirmed that the call bell for room [ROOM NUMBER] did not display on the digital unit at the nurse's station when activated. During interview on 3/05/26, at 3:30 p.m. Resident R6's resident representative indicated that the call bell is not working for Resident R6. Observation on 3/6/26, at 1:26 p.m. on Unit 1 revealed the digital unit audible alert was changed from three beeps to a siren that went off four times. Testing and observation of all call bells on 500 hall revealed for a second day that call bell number 47 associated with room [ROOM NUMBER] did not display on the digital unit when activated. During interview on 3/6/35 at 1:40 p.m. Director of Nursing confirmed that the call bell for room [ROOM NUMBER] did not display on the digital unit at the nurse's station when activated. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management