| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395158 | A. Building<br>B. Wing | 05/01/2026 |

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

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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on review of facility policy, facility documents, clinical records, and staff interviews, it was determined that the facility failed to implement sufficient safety precautions to prevent a resident with a history of suicide ideations from inflicting self-harm for one of seven residents reviewed with a history of suicide ideation and resulted in an Immediate Jeopardy situation (Resident R1).Findings include: A facility policy entitled, Suicide Threats dated 4/01/26, indicated that:A staff member must remain with the resident until the nurse supervisor/change nurse arrives to examine the resident.Place the resident on one-on-one observation until the acute episode has been resolved if the resident is physically capable of self-injury.The resident shall remain one-on-one until transfer from the facility or nursing assessment has identified that the resident is no longer a safety risk.The charge nurse or designee shall immediately notify the resident's attending physician, and responsible party of record of such threats.The nurse supervisor will notify the resident's attending physician of the assessment findings and seek further medical instructions from the physician.The resident shall be assessed by the nursing supervisor to determine if acute interventions are required.If the resident remains in facility, an assessment of the resident's behavior will be made by the interdisciplinary care plan team to determine interventions that may be necessary to prevent the recurrence of such threats.Revised care plans will be developed to reflect such interventions.Following the assessment nursing staff will remove any items with which the resident could use to harm self.A behavioral health professional consult is indicated whenever the resident makes a suggestion of suicide. Information submitted by the facility on 4/27/26, at 5:20 p.m. revealed that at approximately 8:00 a.m. on 4/27/26, Resident R1 attempted suicide by cutting his/her wrists with a box cutter and was discovered in his/her room with several horizontal cuts across his/her left arm when staff entered the room to pass his/her breakfast tray. Statements made to staff at that time by Resident R1 indicated that he/she cut himself/herself so they could go to heaven. Resident R1's clinical record revealed an admission date of 11/19/25, with diagnoses that included stroke, suicidal ideations, and post-traumatic stress disorder (mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety). A care plan entitled history of suicidal ideations dated 11/21/25, included the following interventions: one-on-one as indicated; consult psych as needed; document behaviors; notify the doctor as indicated; and redirect from negative thoughts and feelings. On 4/14/26, at 9:19 p.m. a departmental progress note written by the Social Services Director (SSD) revealed: Resident R1's friend called in to request that someone talk to Resident R1 due to his/her being scared regarding his/her health. The SSD indicated that he/she spoke with Resident R1 and that Resident R1 feared he/she would not live through the night due to cancer spreading throughout his/her body, and the level of pain he/she was experiencing. The SSD noted that he/she spoke with the nursing supervisor to see if they could clear up any concerns Resident R1 had regarding medications. The SSD returned to Resident R1 and shared the nursing supervisor's response. At that time Resident R1 stated I might as well kill myself. Resident R1 did not mention a suicide plan and requested to speak with the supervisor. The SSD informed the nursing supervisor of Resident R1's request. There was no evidence on 4/14/26, in Resident R1's clinical record that the nursing<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | supervisor spoke with Resident R1, conducted an assessment, placed Resident R1 on one-on-one observation, staff members remained with Resident R1 until the nurse supervisor/change nurse arrived to examine him/her, notification to Resident R1's attending physician, and responsible party of record of such threats, interdisciplinary care plan team (IDT) to determination of interventions that may be necessary to prevent the recurrence of such threats, care plan revision, removal of any items with which the Resident R1 could use to harm him/her self, and a behavioral health professional consult. On 4/16/26, at 4:31 p.m. a departmental progress note indicated that the behavior committee evaluated Resident R1's psychotropic medications, noted that Resident R1 was seen by psych on 3/23/26, and that Resident R1 was having increased episodes of anxiety/paranoia/delusional thoughts. No documentation of review of suicidal threats. Further review of Resident R1's clinical record revealed that on 4/20/26, and 4/24/26, Resident R1 was assessed by contracted psychiatric professional and there was no indication that Resident R1's suicidal threats were addressed and/or reviewed. Resident R1's clinical record included a departmental progress note written by the Registered Nurse Supervisor dated 4/27/26, at 8:50 a.m. revealed: At approximately 8:00 a.m. he/she was notified that a significant amount of bright red blood was observed on bed resident's bed sheets, floor, trash can, and clothing. When asked what happened Resident R1 reported I cut myself so I can go to heaven. Assessment revealed several horizontal lacerations on Resident R1 left forearm. Area cleansed and pressure immediately applied, 911 notified. Pressure maintained to area until Emergency Medical (EMS) arrived and took over. Resident R1 left with EMS via stretcher at 8:25 a.m. Report called to hospital. Review of a witness statement submitted by Registered Nurse (RN) Employee E6 dated 4/27/26, revealed that shortly after 6:15 a.m. he/she passed Resident R1 in the hallway standing outside of the door to his/her room. And then when RN Employee E6 passed Resident R1's room around 6:30 a.m. the door was shut. Review of a witness statement submitted by Nurse Aide Employee E1 dated 4/27/26, revealed that he/she went to drop off Resident R1's breakfast tray and noticed a lot of blood on the floor and bed, went out the room quick and told a nurse and he/she went into see about it. Review of a witness statement submitted by Licensed Practical Nurse Employee E5 dated 4/27/26, revealed that he/she was called to Resident R1's room by Nurse Aide due to blood being seen upon entering room, blood could be seen on bed, floor, and tray table. Upon further assessment, cuts were seen to Resident R1's right forearm. During an interview on 4/30/26, at 9:50 a.m. the Nursing Home Administrator confirmed that the facility hasn't been able to determine how Resident R1 got the box cutter, and all they could determine was that he had it for a while. During an interview on 4/30/26, at approximately 10:05 a.m. Maintenance Employee E2 confirmed that the instrument used by Resident R1 was known as a break-away utility knife and that the facility does not use them due to the thinness of the blade. Maintenance Employee E2 also confirmed that ?they' couldn't figure out how Resident R1 got the knife. Observation on 4/30/26, at 10:15 a.m. in the Director of Nursing (DON) office revealed a thin utility knife with break-away blades and a yellow handle. The knife and glove were noted to have a moderate amount of dried blood. The DON confirmed that the knife was located in Resident R1's room at the time of the incident and that the facility hadn't figured out how he/she got it. During an interview on 4/30/26, at 11:45 a.m. the Assistant Director of Nursing confirmed that there was no evidence of the following: that the facility implemented increased monitoring, documented an assessment, notified the attending physician and representative, that the IDT reviewed the care plan and revised the care plan, removed of any items that may be used by Resident R1 to self-harm, and requested a behavioral health consult for Resident R1 between his/her suicidal threats on 4/14/26, and his/her self-harm on 4/27/26. In an interview on 4/30/26, at 1:05 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility should have taken more safety measures to prevent Resident R1 self-harm. The facility failed to implement sufficient safety measures to prevent residents with a history of suicidal ideations from attempting self-harm, putting a resident with a history of suicide ideations at risk and causing an Immediate Jeopardy. The NHA and DON were notified of the Immediate Jeopardy (IJ)<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | situation on 4/30/26, at 4:05 p.m. An Immediate Action Plan was requested and the IJ template was provided to the NHA. The Immediate Action Plan was provided by the NHA and DON on 4/30/26, at 5:58 p.m., which was accepted at 6:03 p.m.The plan included:Inspection of Resident R1's room for items that may be used for self-harm on 4/30/26.4/30/26, audit current residents for suicidal ideations and update care plans to reflect resident's current condition and include safety interventions as appropriate.4/30/26, NHA, DON, and Regional Clinical consultant will review and update the facility policy and procedures for suicidal threatsStaff will be re-educated on the facility policy and procedures for suicidal threats, care plans, and supervision of residents identified with suicidal ideations prior to their next shift.Education started on 4/27/26 and will be completed by 5/05/26.As needed, casual staff and frequent agency staff will be called and educated by 5/12/26.All incidents and accidents will be reviewed daily and results reported to the Quality Assurance and Process Improvement Committee for review and frequency of audits. After reviewing facility documentation, observations, and staff interviews, the implementation of the above stated action plan was confirmed on 5/01/26, at 3:27 p.m. and the NHA was informed that the Immediate Jeopardy situation was removed. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing Services |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>Based on review of facility records and job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to make certain that proper supervision and self-harm prevention interventions were effectively implemented in the facility. Findings include: The NHA's job description revealed that the NHA's primary purpose is to manage the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations that govern long-term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times. The DON's job description revealed that the DON's primary purpose is to plan, organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality of care is maintained at all times. The findings in this report identified that the facility failed to consistently supervise and maintain all safety interventions to prevent self-harm for their residents, and the NHA and the DON failed to fulfill their essential job duties to ensure that the federal and state guidelines and regulations were followed. Refer to F689 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing Services |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on review of clinical records, facility documentation, facility policies, and staff interview, it was determined that the facility failed to maintain complete and accurate records for six of seven residents reviewed (Residents R1, R2, R3, R4, R5, and R6).Findings include:A facility policy entitled, Admission date 4/01/26, indicated that an inventory of all resident valuables will be completed, staff will record the quantity and description of each item, staff and resident/representative will sign the form.Resident R1's clinical record revealed an admission date of 11/19/25, with diagnoses that included stroke, suicidal ideations, and post-traumatic stress disorder [PTSD-mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety].Resident R1's admission checklist lacked documentation that his/her inventory was completed and signed.Resident R1's Inventory of Personal Effects indicated he/she had clothing items, a wheelchair, shaving kit, and phone and charger upon admission to the facility and further review of Resident R1's Inventory of Personal Effects lacked the resident/representative signature. Resident R2's clinical record revealed an admission date of 12/01/23, with diagnoses including suicidal ideations, dementia, stroke, and recurrent depression.Resident R2's clinical record lacked evidence of a completed admission checklist and/or a completed Inventory of Personal Effects. Resident R3's clinical record revealed an admission date of 11/10/25, with diagnoses including suicidal ideations, dementia, anxiety disorder, and recurrent depression.Resident R3's clinical record lacked evidence of a completed admission checklist.Resident R3's Inventory of Personal Effects indicated he/she had clothing items upon admission and was not signed by the resident and/or representative. Resident R4's clinical record revealed an admission date of 5/18/25, with diagnoses including PTSD, bipolar disorder [also known as manic depressive illness or manic depression, is a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes], recurrent depression, and anxiety disorder.Resident R4's clinical record lacked evidence of a completed admission checklist.Resident R4's Inventory of Personal Effects indicated he/she had clothing items, shaving kit, hearing aids and glasses, a laptop computer, and a purse upon admission. There was no evidence that the contents of his/her purse were inspected and the Inventory of Personal Effects sheet was not signed by facility staff. Resident R5's clinical record revealed an admission date of 7/26/24, with diagnoses including PTSD, below the right knee amputation, phantom limb syndrome with pain (occurs when a person perceives sensations, including pain, in a limb that no longer exists), broken back, ribs, hip, and facial bones.Resident R5's clinical record lacked evidence of a completed admission checklist.Resident R5's Inventory of Personal Effects indicated he/she had clothing items, multiple orthopedic braces, a cell phone and charger, and personal papers. The Inventory of Personal Effects was not signed by facility staff. Resident R6's clinical record revealed an admission date of 10/28/17, with diagnoses including intentional self-harm by jumping from a high place, Schizophrenia [severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking] mood disorder, and anxiety disorder.Resident R6's clinical record lacked evidence of a completed admission checklist.Resident R6's Inventory of Personal Effects on admission included clothing items, stuffed animals and a yellow ring, and was not signed by the resident/representative or facility staff.Resident R6's Inventory of Personal Effects dated 4/30/26, indicated that Resident R6 refused to allow facility staff to inspect his/her belongings and that Resident R6 possessed two plastic bags of clothes, and the form was not signed by the resident or facility staff. During an interview on 4/30/26, 11:45 a.m. the Assistant Director of Nursing and Licensed Practical Nurse Employee E4 confirmed the above lack of documentation for Residents R1, R2, R3, R4, R5, and R6. 28 Pa. Code 211.5(f)(v) Medical records28 Pa. Code 211.12(d)(1)(5) Nursing services |