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	06/26/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that active physician orders incorporated resident wishes related to end-of-life care as documented on the resident's Pennsylvania Order for Life Sustaining Treatment (POLST - a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) for three of 27 residents reviewed (Residents R14, R38, and R50).Findings include: Facility policy entitled Advanced Directives dated [DATE], indicated that All residents shall be presumed as having consented to CPR (Cardiopulmonary Resuscitation - emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest) unless there is documentation in the medical record that the resident has specified that a DNR (Do not attempt resuscitation and allow natural death) order is present on the clinical record. Further review revealed that All DNR orders must be rewritten by the attending physician for each admission / readmission. Resident R14's clinical record revealed an admission date of [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R14's clinical record revealed a POLST dated [DATE], indicating DNR. Review of current physician orders lacked evidence of his/her code status. Resident R38's clinical record revealed an admission date of [DATE], with diagnoses that included Dementia (loss of memory, language, problem-solving, and other thinking abilities), Hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and high blood pressure. Resident R38's clinical record revealed a POLST dated [DATE], indicating DNR. Further review revealed a physician's order dated [DATE] for CPR. During an interview on [DATE], at 1:30 p.m. the Director of Nursing (DON) confirmed Resident R14's clinical record lacked active physician orders reflecting his/her code status, and Resident R38's physician orders and POLST were not consistent with one another. The DON further confirmed that regardless of Resident having a POLST, his/her physician orders are to reflect their code status and that resident's physician's orders and POLST should match. Resident R50's clinical record revealed an admission date of [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Respiratory Failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R50's clinical record revealed a POLST dated [DATE], indicating DNR. Review of current physician orders lacked evidence of his/her code status. During an interview on [DATE], at 1:55 p.m. the DON confirmed Resident R50's clinical record lacked active physician orders reflecting his/her code status. The DON further confirmed that regardless of Resident having a POLST, his/her physician orders are to reflect their code status. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respirator care equipment for two of five residents reviewed (R14 and R50), and failed to obtain a physician's order for the provision of oxygen therapy for one of five residents reviewed (Resident R15). Findings include: Facility policy entitled Medication and Treatment Orders dated 4/21/26, indicated each medication administration will have a corresponding and complete physician's order and oxygen orders will contain: The rate of flow, route, and rationale (i.e., Oxygen 2-3 L/min [liters per minute] per nasal cannula prn [as needed] for SOB [shortness of breath]). Resident R14's clinical record revealed an admission date of 6/20/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications),and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R14's clinical record revealed a physician's order dated 6/2/26, for oxygen via Nasal Cannula (a thin tube with two prongs that fit in a residents nostrils to deliver oxygen) every shift for shortness of breath. Titrate oxygen to maintain saturation greater than or equal to 92%. Further review revealed a physician's order dated 6/18/26, that identified to change oxygen tubing, change humidification bottle, cleanse oxygen filter, inspect easy foam wraps (replace if soiled or missing) every night shift every Monday for maintenance of oxygen equipment. Observation on 6/24/26, at 10:00 a.m. revealed Resident R14 sitting in his/her wheelchair with supplemental oxygen in place and the oxygen concentrator liter flow set at 2 lpm via Nasal Cannula. Further observation of the concentrator filter on the back of the oxygen concentrator revealed a large amount of gray fluffy substance covering the entire filter. During an interview on 6/25/26, at 2:30 p.m. the Director of Nursing confirmed that Resident R14's oxygen concentrator filter contained a large amount of gray dusty substance and should be cleaned. Resident R50's clinical record revealed an admission date of 12/24/25, with diagnoses that included COPD, Respiratory Failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R50's clinical record contained a physician's order dated 4/21/26, to administer Albuterol Sulfate Inhalation Nebulization Solution via nebulizer (medical device that coverts liquid medication into a fine mist that can be inhaled directly into the lungs) every eight hours as needed for wheezing. Observation on 6/23/26, at 2:13 p.m. revealed Resident R50's nebulizer mask lying in the bedside drawer and not stored in a plastic bag. Observation on 6/25/26, at 12:15 p.m. revealed Resident R50's nebulizer mask lying on top of the bedside stand not stored in a plastic bag. During interview on 6/25/26, at 12:15 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R50's nebulizer mask was lying on top of the bedside stand and was not stored in a plastic bag when not in use and should have been. Resident R15's clinical record revealed an admission date of 11/13/25, with diagnoses that included Respiratory Failure, Diabetes, and High Blood Pressure. Observation on 6/23/26, at 2:38 p.m. and 6/25/26, at 1:30 p.m. revealed Resident R15 lying in bed wearing oxygen nasal cannula connected to an oxygen concentrator delivering 2 liters of oxygen per minute. Resident R15's clinical record lacked evidence of a physician's order for the use of oxygen therapy. During an interview on 6/25/26, at 1:35 p.m. LPN Employee E3 confirmed that Resident R15 was administered oxygen therapy and his/her clinical record lacked physician's order for the oxygen therapy as required. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy and employee handbook, observations, and staff interviews, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in one of one main kitchens and two of two pantry refrigerators checked (Unit 1 and Unit 4), failed to served food in a safe and sanitary manner during tray line observation, and failed to monitor resident's personal refrigerators for temperatures for one of one residents reviewed with personal refrigerator (Resident R121). Findings include: Facility policy entitled Food Storage dated 4/21/26, indicated Un-served leftovers shall be labeled, dated and stored for a period not to exceed there (3) days. Facility policy entitled Storage of Perishable Foods dated 4/21/26, indicated products such as salad greens, celery, radishes, etc, should be cleaned, trimmed, rinsed, and stored in plastic bags. Facility employee handbook section entitled Meals indicated if a lunch is brought and must be refrigerated, it can be put in the refrigerator in the break room. Facility policy entitled Personal Refrigerators dated 4/21/26, indicated personal refrigerators are permitted after thorough inspection and will be subject to the same monitoring as other facility refrigerators. The policy further stated that the refrigerator must include a thermometer and will be monitored regularly for temperature compliance. Tour of the main kitchen on 6/23/26, between 10:40 a.m. and 11:30 a.m. revealed the following items labeled, dated, and stored for a period exceeding three days: Large refrigerator had four pitchers of lemonade dated 6/13/26, one pitcher of tomato juice dated 6/10/26, and one small clear sandwich bag with carrot sticks, cucumber slices and celery sticks dated 6/19/26. Tour of the main kitchen on 6/23/26, between 10:40 a.m. and 11:30 a.m. revealed the following items opened and not labeled with an open date: Large refrigerator had one pitcher of iced tea, one rotten green bell pepper (not in a bag), one package of Swiss cheese, and one container of beef base. Tour of the main kitchen on 6/23/26, between 10:40 a.m. and 11:30 a.m. revealed the following employee items in the large refrigerator with facility food: one package of pepperjack cheese, a twix candy bar, and two bottles of water. During an interview on 6/23/26, at 10:48 a.m. Dietary Manager confirmed that the lemonade, tomato juice, and bag of carrot sticks, celery sticks, and cucumber slices exceeded the three day limit and should have been discarded; the iced tea, beef base, and Swiss cheese was not dated and should have been; the green bell pepper was not in a plastic bag as it should have been and was rotten and should have been discarded, and employee items should be stored in the employee breakroom refrigerator and not in the main kitchen as it was. Tray line observation in the main kitchen on 6/23/26, at 11:45 a.m. revealed Dietary Employee E5 with gloved hands assembled five hot plates across the steam table. He/she then proceeded to place a resident meal ticket on each hot plate followed by a plate. He/she then picked up five pieces of chopped steak and placed a piece on each plate and then rubbed his/her gloved hands together followed by picking up a scoop to continue placing the remainder of the meal on each individual plate. He/she then passed the completed plate to the dietary aide to place on the individual trays. Dietary Employee E5 then proceeded to complete the same process a second time. During an interview on 6/23/26, at 11:51 a.m. Dietary Manager confirmed that Dietary Employee E5 should not have picked up the chopped steak with his/her gloved hands and there are tongs that they are to use. Observation on 6/24/26, at 1:34 p.m. of Unit 4 pantry refrigerator revealed six 473 milliliters (ml) cartons of chocolate milk with an expiration date of 6/20/26, and a build-up of ice in the freezer portion. During an interview on 6/24/26, at 1:36 p.m. Assistant Director of Nursing confirmed the six cartons of milk were expired and should have been discarded and there was a build-up of ice in the freezer. Observation on 6/24/26, at 1:46 p.m. of Unit 1 pantry refrigerator revealed one 473 ml carton of chocolate milk with an expiration date of 6/19/26, one peanut butter and jelly sandwich with an expiration date of 6/19/2026, and a build-up of ice in the back of the refrigerator. During an interview on 6/24/26, at 1:55 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the one carton of milk and one sandwich was expired and should have been (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded and there was a build-up of ice in the refrigerator. During an interview and observation with Resident R121 on 6/23/26, at 2:08 p.m. it was observed that Resident R121 had a personal refrigerator to store food items. Resident R121 gave permission for the surveyor to open the refrigerator and observe it for safe storage of food items. Upon observation, it was noted that there were food items in the refrigerator. Upon observation there was no thermometer present to determine the temperature of the refrigerator for safe storage of food items, and no recorded temperatures noted. During an interview on 6/24/26, at 1:57 p.m. the Director of Nursing confirmed that the facility was unaware that Resident R121 had a personal refrigerator in his/her room and there was no thermometer and no temperatures recorded for Resident R121's refrigerator to ensure safe storage of items. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to maintain a clean homelike environment and ensure resident's wheelchairs were in working order for one of four units (Unit 1). Findings include: Facility policy entitled Resident Environment dated 4/21/26, indicated the facility will provide an environment that is safe, clean, comfortable, and homelike. Observation on Unit One on 6/23/26, at 2:01 p.m. revealed Resident R116 sitting in his/her wheelchair with dried dirty substance down the right side of the wheelchair and crumbs / debris on the frame of the wheelchair. Observations on Unit One on 6/23/26, at 2:25 p.m. revealed Resident R59 sitting in his/her wheelchair. The left wheelchair brake was not working, left armrest plastic covering was cracked and pealing exposing the foam underneath it, and the right armrest was missing the foam and plastic covering. During an interview on 6/23/26, at 3:34 p.m. the Director of Nursing confirmed that Resident R116's wheelchair was unclean with dried debris noted, and Resident R59's wheelchair bilateral armrest were in disrepair and his/her left wheelchair brake was broken and needed repaired. 28 Pa. Code 201.18(b)(1) Management

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical record, and staff interviews, it was determined that the facility failed to provide resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for two of three residents reviewed for hospitalization (Residents R12 and R50). Findings include: Facility policy entitled Bed Hold Policy and Procedure dated 4/21/26, indicated that upon discharge from the facility and admission to a hospital, the Social Service Department or the Administrator's designee will contact, by telephone and in writing, the resident/responsible part to inform them that the resident was discharged to the hospital and of the 15-day bed hold, under Medicaid. Resident R12's clinical record revealed an admission date of 7/8/25, with diagnoses that included Breast Cancer, Dementia (loss of cognitive functioning affecting a person's memory and behaviors), and Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications). Resident R12's clinical record revealed a progress note dated 2/21/26, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R12's clinical record also lacked evidence indicating that Resident R12 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Resident R50's clinical record revealed an admission date of 12/24/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Respiratory Failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R50's clinical record revealed a progress note dated 3/13/26, and again 4/16/26, indicating transfers to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R50's clinical record also lacked evidence indicating Resident R50 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. During an interview on 6/26/26, at 9:43 a.m. the Director of Nursing confirmed that Resident R12 and R50's clinical records lacked evidence that necessary clinical information was communicated to the receiving health care provider and lacked evidence that the resident and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical records, and staff and resident interviews, it was determined that the facility failed to obtain a physician's order for the management of a colostomy for one of 27 residents reviewed (Resident R26), and failed to ensure physician's orders were followed for medication administration for one of 27 residents reviewed (Resident R4).Findings include: Review of facility policy dated 4/21/26, entitled Medication Administration revealed Medications are administered in accordance with written orders of attending physicians; The Resident's E-MAR (Electronic Medication Administration Record) is initialed by the person administering a medication in the space provided under the date and on the line for that specific medication dose administration. Documentation is done immediately after the administration and/or refusal of the medication or attempt; The employee who administers medications to residents shall record and sign on the individual medication record of each resident the medication, dosage and time it was given. This shall be done as soon as possible after the medications have been given. Resident R26's clinical record revealed an admission date of 4/14/25, with diagnosis that include Colostomy Status(an opening in the colon, allowing feces to be diverted through an opening on the abdomen), schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and high blood pressure. Review of Resident R26's current physician orders lacked evidence of an active order for colostomy care. Further review of physician orders revealed an order dated 6/2/25 and discontinued on 12/25/25 for change colostomy appliance, wafer, and barrier ring every day shift every Thursday. Interview with Resident R26 on 6/24/26, at 2:46 p.m. revealed Resident R26 has a colostomy. He/she stated the facility used to care for it, but that he/she has been changing it for months now. Resident R4's clinical record revealed an admission date of 4/13/26, with diagnoses that included Sepsis due to Methicillin Resistant Staphylococcus Aureus (systemic bacterial infection), fracture of the left femur (a break in the thigh bone), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R4's clinical record revealed a Physician's order dated 5/14/26, for Cathflo Activase Injection Solution Reconstituted (a medication used to clear out blood clots that are blocking a medical catheter such as a Peripherally Inserted Central Catheter [PICC-a thin, soft flexible tube placed in the vein of the upper arm also called an IV to deliver fluids and medications]) Use 2mg (milligrams) IV one time only for clogged PICC for one day. Review of Resident R4's clinical record under E-MAR and progress notes lacked evidence that Cathflo was administered as ordered; Physician's order dated 5/3/26, for Saline Flush Solution 0.9% (Sodium Chloride Flush) Use 10ml (milliliters) IV (Intravenous) every shift for health monitoring. Administer before and after every IV medication and once every shift while not in use. Out of 86 opportunities to document completion, 71 were documented as completed and 15 were blank. Interview with Resident R4 on 6/25/26, at 10:45 a.m. revealed that he/she had a PICC in May, and the facility often would not flush the PICC at night with Saline as ordered and then it would get clogged. During an interview on 6/25/26, at 11:50 a.m. the Director of Nursing (DON) confirmed that Resident R4's clinical records lacked evidence that Cathflo and Saline Flushes was administered in accordance with physician's orders. The DON also confirmed that Resident R26's did not have an active order for Colostomy care. The DON further confirmed that Resident R26 should have an order for colostomy care and that he/she transferred to the hospital on [DATE] and the order for colostomy care was not reordered when he/she returned to the facility as required. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(i)(x) Medical records 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment related to smoking for one of six residents who smoke at the facility reviewed (Resident R48). Findings include: Facility policy entitled, Smoking Policy, dated 4/21/26, revealed Designated smoking areas have been established outside the building for these residents, staff or visitors who choose to smoke; Smoking restrictions apply to all smoking methods including cigarettes, pipes, cigars and electronic cigarettes; To ensure the safety of all residents, smoking supplies for all residents will be kept locked in the medication cart and provided to the resident upon request. Review of Resident R48's clinical record revealed an admission date of 2/12/26, with diagnoses that included gastro-esophageal reflux disease (GERD-a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and high blood pressure. Review of Resident R48's Quarterly Minimum Data Set (MDS-a periodic assessment of resident care needs), dated 5/15/26, revealed under Section C: cognitive patterns, questions from C0500 BIMS Summary Score: Resident R48 scored an 8, indicating cognitive impairment. Review of Resident 48's clinical record revealed a Smoking Assessment completed 2/12/26 indicating safe to smoke with apron and supervision. The assessment indicated that Resident is aware that the facility needs to store lighter and cigarettes. Observation on 6/24/26, at 1:00 p.m. and 1:30 p.m. revealed Resident R48 sitting in his/her wheelchair in his/her room with one pack of cigarettes and disposable lighter sitting on his/her bedside table. During an interview on 6/24/26, at 1:30 p.m. Registered Nurse Employee E4 confirmed that Resident R48's cigarettes and lighter were on his/her bedside table. He/she further confirmed that resident's cigarettes and lighters are to be kept locked in the medication cart in the smoking area. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3) Management

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to properly store medications, and failed to properly date two [NAME]-dose vial of Aplisol (an injectable diagnostic solution test to determine if a person has been infected with tuberculosis) in one of three medication storage rooms reviewed (Unit One medication storage room). Findings include: A facility policy entitled Storage of Medications with a policy review date of 4/21/26, revealed Medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. No discontinued, outdated, or deteriorated medications are available for use in the facility. All such medications are destroyed. Review of the manufacturer's instructions for Aplisol revealed, Aplisol vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded. An observation on 6/24/26, at approximately 9:49 a.m., of the Unit One medication storage room revealed two multi-use vials of Aplisol opened and in the refrigerator for use not dated with an opened or use by date. Licensed Practical Nurse (LPN) Employee E6 confirmed that the vials should be dated after opened for use with open and use by date and was unable to determine if they were opened within 30 days. Another observation in the same medication storage room revealed two resident medications sitting on top of the refrigerator and not stored properly. Employee E6 confirmed that the medications should be in the medication cart and not sitting on top of the refrigerator. During an interview with the Director of Nursing (DON) on 6/24/26, at approximately 10:30 a.m., it was confirmed that multi-use vials should be dated with open and use by dates to confirm that they are still safe for use, and resident medications should not be stored on top of refrigerators in the medication room. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1) Nursing services

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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Greenville	110 Fredonia Road 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)
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 records and staff interviews, it was determined that the facility failed to maintain accurate and complete documentation for one of 27 residents reviewed (Resident R4). Findings include: Review of facility policy dated 4/21/26, entitled Medication Administration revealed Medications are administered in accordance with written orders of attending physicians; The Resident's E-MAR (Electronic Medication Administration Record) is initialed by the person administering a medication in the space provided under the date and on the line for that specific medication dose administration. Documentation is done immediately after the administration and/or refusal of the medication or attempt; The employee who administers medications to residents shall record and sign on the individual medication record of each resident the medication, dosage and time it was given. This shall be done as soon as possible after the medications have been given. Review of facility policy dated 4/21/26, entitled Documentation revealed Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate; Documentation for subsequent and/or routine care and procedures may be completed by exception, or the use of a checklist, flowcharts or other documentation tools; Nursing documentation will provide accurate reflection of resident condition and will meet federal and state requirements. Resident R4's clinical record revealed an admission date of 4/13/26, with diagnoses that included Sepsis due to Methicillin Resistant Staphylococcus Aureus (systemic bacterial infection), fracture of the left femur (a break in the thigh bone), and anxiety(a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R4's May 2026 E-MAR revealed the following orders: Physician's order dated 5/3/26, for Saline Flush Solution 0.9% (Sodium Chloride Flush) Use 10ml (milliliters) IV (Intravenous) every shift for health monitoring. Administer before and after every IV medication and once every shift while not in use. Out of 86 opportunities to document completion, 71 were documented as completed and 15 were blank. Physician's order dated 5/14/26, for Cathflo Activase Injection Solution Reconstituted(a medication used to clear out blood clots that are blocking a medical catheter such as a Peripherally Inserted Central Catheter [PICC-a thin soft flexible tube placed in the vein of the upper arm also called an IV to deliver fluids and medications]) Use 2mg (milligrams) IV one time only for clogged PICC for one day. Review of Resident R4's clinical record under E-MAR and progress notes lacked documentation that Cathflo was administered. During an interview on 6/25/26, at 11:50 a.m. the Director of Nursing confirmed that Resident R4's clinical records were incomplete regarding medication administration documentation. 28 Pa. Code 211.5(f)(ii)(viii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services