STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395197	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at New Wilmington	520 New Castle Street New Wilmington, PA 16142

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for three of four medication carts reviewed (North two, South, and [NAME] medication carts).Findings include: Review of facility policy entitled Vials and Ampules of Injectable Medications dated 2/24/26, indicated The beyond use date. are recorded on the multidose vials. And Medications in multidose vials may be used for twenty-eight days. Review of facility policy entitled Storage of Medications dated 2/24/26, indicated medications and biologicals are stored. following manufacturer's recommendations or those of the supplier. And Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of. Review of manufacturer's guidelines revealed that an open pen of Humalog Insulin must be used within 28 days after opening or be discarded. Manufacturer's guidelines for Trelegy Ellipta (medication used to treat Chronic Obstructive Pulmonary Disease [COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing] and Asthma [a long-term inflammatory disease of the airways that cause the airways to narrow and swell causing symptoms such as wheezing, coughing, chest tightness, and shortness of breath], indicated that Trelegy should be discarded six weeks after opening the foil tray or when the counter read 0, whichever comes first. Manufacturer's guidelines for Serevent Diskus (a medication used to treat asthma and COPD), indicated that Serevent should be discarded six weeks after opening the foil tray or when the counter read 0, whichever comes first. Manufacturer's guidelines for Fluticasone Propionate/Furoate Diskus (medication used to treat asthma), indicated that Serevent should be discarded six weeks or two months after opening the foil pouch or when the counter read 0, whichever comes first. Observation of drug storage on 3/3/26, at 1:27 p.m. of the North two medication cart revealed a Serevent Diskus out of the foil package and lacking an open date. During an interview on 3/3/26, at the time of observation Licensed Practical Nurse (LPN) Employee E1 confirmed that the Serevent lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the Serevent should have been discarded. Observation of drug storage on 3/3/26, at 1:35 p.m. of the South medication cart revealed three Trelegy Ellipta Diskus out of the foil packages, and lacking open dates. During an interview of 3/3/26, at the time of observation LPN Employee E2, confirmed that the three Trelegy Ellipta Diskus lacked open dates, and staff were unable to determine the discarded dates. He/she also confirmed that the three Trelegy Ellipta Diskus should have been discarded. Observation of drug storage on 3/3/36, at 3:05 p.m. of the [NAME] medication cart revealed two Trelegy Ellipta Diskus out of the foil package and in use, one with an open date of 12/1/25, and the other one lacking an open date; two Fluticasone Propionate Diskus out of the foil packages and in use with open dates of 12/12/25; a Fluticasone Furoate Diskus out of the foil package, in use and lacking an open date; and an open, in use insulin pen of Humalog with an expiration date of 2/26/26. During an interview on 3/3/26, at the time of observations LPN Employee E3 confirmed that one of the Trelegy Ellipta Diskus was beyond its use by date and the other one lacked an open date and staff were unable to determine the discarded date; the two Fluticasone Propionate Diskus were beyond their use by dates; and the (continued on next page)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fluticasone Furoate Diskus lacked an open date and staff were unable to determine the discarded date and that the Humalog insulin pen had an expiration date of 2/26/26. He/she also confirmed that the Trelegy Ellipta Diskus, Fluticasone Propionate/Furoate Diskus, and the Humalog insulin pen should have all been discarded. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of an as needed (PRN) psychotropic (mind altering) medication for two of six residents reviewed (Residents R23 and R51).Findings include:A facility policy entitled Use of Psychotropic Medication dated 2/24/26, indicated that Non-pharmacological approaches must be attempted unless clinically contraindicated, to minimize the need for psychotropic medications. Review of Resident R23's clinical record revealed an admission date of 10/25/24, with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R23's physician's orders revealed an order dated 9/26/25, to administer Lorazepam (anti-anxiety) 0.5 milliliter (ml) by mouth every four hours PRN for anxiety. Review of Resident R23's January 2026, February 2026, and March 2026 Medication Administration Records (MARs) revealed that the PRN Ativan was used on 1/2/26, 1/3/26, 1/6/26, 1/7/26, 1/9/26, 1/10/26, 1/13/26, 1/14/26, 1/15/26, 1/16/26, 1/20/26, 1/24/26, 2/3/26, 2/6/26, 2/7/26, 2/8/26, 2/10/26, 2/11/26, 2/16/26, 2/17/26, 2/19/26, and 3/4/26. The clinical record lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam for the administrations listed above in January 2026, February 2026, and March 2026. Review of Resident R51's clinical record revealed an admission date of 4/4/25, with diagnoses that included dysphagia (difficulty swallowing), hypertension (high blood pressure), and anxiety. Review of Resident R51's physician's orders revealed an order dated 1/22/26, to administer Vistaril (anti-anxiety) 50 milligrams (mg) by mouth every eight hours PRN for anxiety. Review of Resident R51's January 2026, February 2026, and March 2026 MARs revealed that the PRN Vistaril was used on 1/27/26, 2/1/26, 2/9/26, 2/18/26, 2/23/26, 2/2526, and 3/5/26. The clinical record lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Vistaril for the administrations listed above in January 2026, February 2026, and March 2026. During an interview on 3/5/26, at 3:37 p.m. the Director of Nursing confirmed that Resident R23 and Resident R51's clinical records lacked evidence that non-pharmacological interventions were attempted prior to the administration of a PRN psychotropic medication for the dates listed above and that non-pharmacological interventions should be attempted and documented in the clinical record. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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 policy, clinical records, and staff interview, it was determined that the facility 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 five residents reviewed (Residents R67 and R71).Findings include: Review of facility policy entitled Transfer Form Instructions dated 2/24/26, indicated Should it become necessary to transfer a resident. a transfer form will be executed and forwarded., The transfer form will be completed. and will include: Current medical findingsDiagnosisSummary of the course of treatment followedPertinent administrative and social informationOther as necessary and appropriate Review of Resident R67's clinical record revealed an admission date of 7/8/25, with diagnoses that included heart failure, anxiety disorder (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hyperlipidemia (high cholesterol). Review of Resident R67's progress notes revealed notes dated 11/18/25, and 12/17/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R71's clinical record revealed an admission date of 12/10/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction), and gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat). Review of Resident R71's progress notes revealed notes dated 1/7/26, 1/11/26, 1/16/26, 1/27/26, 2/2/26, and 2/6/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 3/6/26, at 2:37 p.m. the Director of Nursing confirmed that Resident R67 and Resident R71's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and that when the transfers occurred clinical information should have been provided to the receiving healthcare provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on review of facility policy and clinical records, observations and staff interview, it was determined that the facility failed to provide appropriate treatment to prevent potential complications related to a gastrostomy tube (g-tube - a tube inserted through a small incision in the abdomen into the stomach, used for the administration of liquid nutrition and medications) for one of three residents reviewed (Resident R64). Findings include: Review of facility policy entitled Enteral Tube Feeding Care dated 2/24/26, indicated Nursing staff will follow physician orders and acceptable clinical standards to. reduce the risk of infection. Enteral feeding. tubing must be changed every 24 hours. And Label feeding bags with the date and time they are hung. Review of feeding label and manufacturer's guidelines revealed Hang product up to 48 hours after initial connection when clean technique and only one feeding set are used. Otherwise, hang no longer than 24 hours. Review of Resident R64's clinical record revealed an admission date of 12/21/26, with diagnoses that included anorexia (a serious eating disorder that causes a fear of weight gain, an how one's body looks leading to a significant weight loss), eating disorder (is a serious mental health condition that causes unhealthy eating behaviors because of how one sees their body and weight), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R64's physician's orders dated 1/23/26, revealed orders for Jevity 1.5 (feeding) at 75 ml (milliliters) per hour and another order to change piston syringe (a needleless syringe that is used to flush water through a g-tube) every day on the midnight shift for tube feed water flushes dated 2/11/26. Observations on 3/3/26, at 11:20 a.m. and again at 1:00 p.m. revealed Resident R64's feeding hanging on an IV pole connected to Resident R64's g-tube, the feeding and tubing lacked dates indicating when the tubing and feeding were initiated. Further observations revealed a piston syringe hanging on the IV pole that was dated 2/22/26. During an interview on 3/3/26, at 1:20 p.m. the Director of Nursing (DON) confirmed that the feeding and the tubing lacked dates indicating when they were initiated and that the piston syringe had a date of 2/22/26. The DON also confirmed that the date should be written on the feeding and tubing when they are initiated and that the piston syringe should have been changed per physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment and failed to provide oxygen according to physician's orders for two of three residents reviewed for respiratory care (Residents R18 and R23). Findings include: Review of facility policy entitled Oxygen Tubing, Nasal Cannula and Oxygen Mask dated 2/24/26, indicated Nursing staff will verify the ordered oxygen flow rate., Oxygen tubing, nasal cannulas. must be replaced at least once every seven days., and New oxygen tubing, cannulas, and mask must be stored in a clean, dry area, open supplies must be protected from contamination. Review of facility policy entitled Oxygen Concentrator-Preventative Maintenance dated 2/24/26, indicated Air filter. will need to be cleaned on a weekly basis. Review of facility policy entitled Oxygen Administration dated 2/24/26, indicated Change pre-filled humidification system at least weekly. Review of Resident R18's clinical record revealed an admission date of 10/11/25, with diagnoses that include respiratory failure (a condition where your lungs don't exchange air properly), chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R18's physician's orders revealed an order for supplemental oxygen via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) at two liters/minute every shift dated 10/11/25. Review of Resident R18's care plans revealed a care plan for COPD with intervention of oxygen therapy as ordered by the physician. Another care plan for respiratory distress with intervention of oxygen continuous per order two liters via nasal cannula. Observations on 3/3/26 at 12:55 p.m. and again at 1:05 p.m., revealed Resident R18 lying in his/her bed with supplemental oxygen in place via nasal cannula and the oxygen concentrator (machine used to deliver concentrated oxygen to patients) flow rate set at one and a half liters/minute. The nasal cannula lacked a date and the humidification water bottle was empty. Review of Resident R23's clinical record revealed an admission date of 10/25/24, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), respiratory failure (a condition where your lungs don't exchange air properly), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R23's physician's orders revealed an order for oxygen to keep SpO2 (oxygen saturations) at or above 90 percent dated 4/28/25. Review of Resident R23's care plans revealed a care plan for pneumonia with an intervention that staff will ensure oxygen equipment care/tubing is changed per physician's orders. Observations on 3/3/26, at 12:54 p.m. and again at 1:05 p.m., revealed an oxygen concentrator sitting next to Resident R23's bed. A filter on the back of his/her oxygen concentrator had a large amount of fluffy white substance covering the filter. During an interview on 3/3/26, at 1:20 p.m. the Director of Nursing (DON) confirmed that Resident R18's humidification bottle was empty, the nasal cannula lacked a date, and his/her oxygen flow rate was set at one and a half liters per minute and was not in accordance with physician's orders. The DON also confirmed that Resident R23's oxygen concentrator filter was covered with a large amount of fluffy white substance and should be clean. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to prevent the potential for cross-contamination (transfer of germs from one location to another) during medication administration (West Wing medication cart) and failed to prevent cross-contamination for one resident (Resident R122) receiving nebulizer treatments (a treatment that delivers medication directly to the lungs to treat respiratory conditions). Findings include: Review of facility policy entitled Medication Administration dated 2/24/26, revealed that If breaking tablets. hands are washed with soap and water or alcohol gel prior to handling tablets. Review of facility policy entitled Nebulizer Equipment Management dated 2/24/26, revealed The facility will ensure that nebulizer used for medication administration is maintained. with infection control standards to prevent cross-contamination. and Nebulizer. mouthpiece must be replaced at least once every seven days (weekly). Equipment must also be replaced immediately if: It becomes visibly soiled or contaminated. Observations during medication administration on 3/4/26, at 8:00 a.m. revealed Licensed Practical Nurse (LPN) Employee E3 preparing medications from the [NAME] Wing medication cart. LPN Employee E3 touched a pill from a bottle without sanitizing/washing his/her hands or applying gloves. He/she then proceeded to place the pill into the medication cup with other pills. Further observations revealed that LPN Employee E3 dropped pills onto the floor and then proceeded to pick the pills up and placed them into the medication cup. During an interview on 3/4/26, at the time of observations LPN Employee E3 confirmed that he/she did not sanitize/wash his/her hands or apply gloves before touching a pill and he/she picked pills up off the floor and placed them in the medication cup. LPN Employee E3 also confirmed that he/she should not touch medications without sanitizing/washing his/her hands or applying gloves or place medications off the floor into the medication cup. Review of Resident R122's clinical record revealed an admission date of 2/26/26, with diagnoses that included coronary artery bypass graft (an open-heart surgery that creates a new path for blood flow), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Review of Resident R122's physician's orders revealed an order Ipratropium Albuterol (a liquid medication) solution 3 mg per ml every four hours. Observations on 3/3/26, at 11:00 a.m. and again at 1:03 p.m. revealed a nebulizer machine (a medical device that turns liquid medication into a fine mist) sitting on the bedside stand next to Resident R122's bed with a hand held mouth piece (a device that is connected to a nebulizer machine allowing a person to inhale medication directly into their lungs) lying on the floor and lacking a date. During an interview on 3/3/36 at 1:20 p.m. the Director of Nursing (DON) confirmed that the mouthpiece was lying on the floor and lacked a date. The DON also confirmed that the mouthpiece should not be on the floor and that it should have a date indicating when it was placed. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services