STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395382	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Irwin	249 Maus Drive North Huntingdon, PA 15642

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to protect residents from neglect for one of five residents (Resident R1). Based on review of facility policy, published documents, clinical record review and staff interviews, it was determined that the facility the facility failed to protect residents from neglect for one of five residents (Resident R1). This was identified as past non-compliance. Findings include: Review of the facility policy, Abuse Protection, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary. Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated the patient should always roll toward you not away from you. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/6/25, included diagnoses of muscle weakness, debility, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R1's plan of care initiated 4/13/22, indicated Resident R1 required assistance with changing position in bed due to a decrease in functional ability and physical limitations. Review of a progress note dated 6/29/25, at 4:04 a.m. indicated, Resident rolled out of bed when aide was changing sheets. Aide had resident roll to right, and he started to slide off bed. Aide grabbed the back of his gown, and he slid off bed to sitting position with his legs extended in front of him.Review of facility submitted information dated 6/69/25, indicated, On the morning of 6-29-25 at approximately 0200 (2:00 a.m.), [Resident R1] had an assisted fall out of bed. [Resident R1] was having incontinent care completed at the time of fall. The aide performing incontinent care on [Resident R1] rolled resident away from her instead of towards her. [Resident R1] rolled out of bed on the right side of bed. [Resident R1] is an assist x1 for bed mobility. Review of an employee statement written by NA Employee E2 dated 6/29/25, indicated, [Resident R1] had an assisted fall. When rolling [Resident R1] to change sheet he rolled. I was able to grab his gown so his fall was gentle. I notified nurse. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 7/4/25, included the information, Transfer status of assist x1 for bed mobility was followed however CNA rolled resident away from her while changing which prompted resident to fall out of bed. Allegation of neglect substantiated. On 6/29/25, the facility initiated a plan of correction that included:Investigation launched immediately and CNA suspended pending investigation. A registered nurse assessment was completed immediately - no injuries noted. A verbal one on one education was completed with the aide by clinical management team on the proper way to roll residents who are an assist x1 in bed as well as abuse/neglect policy. House education completed as well. Family, Adult Protective Services, and police all notified of incident. All incidents and accidents are discussed daily during IDT (inter-disciplinary team) and monthly during QAPI (Quality Assurance and Performance Improvement). On 7/15/25, five nurse aides were interviewed, and confirmed they were provided education on abuse and neglect. Review of education sign in sheets on 7/15/25, confirmed in-service on abuse and neglect was completed on 6/30/25.During an interview on 7/15/25, at approximately 12:00 p.m. the Nursing Home Administrator confirmed the facility failed to protect residents from neglect for one of five residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211. 12(d)(1)(2)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls for one of five residents (Resident R1).Based on review of published documents, clinical record review, facility provided documents and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls for one of five residents (Resident R1). This was identified as past non-compliance.Findings include:Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated the patient should always roll toward you not away from you.Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/6/25, included diagnoses of muscle weakness, debility, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R1's plan of care initiated 4/13/22, indicated Resident R1 required assistance with changing position in bed due to a decrease in functional ability and physical limitations. Review of a progress note dated 6/29/25, at 4:04 a.m. indicated, Resident rolled out of bed when aide was changing sheets. Aide had resident roll to right, and he started to slide off bed. Aide grabbed the back of his gown, and he slid off bed to sitting position with his legs extended in front of him.Review of facility submitted information dated 6/29/25, indicated, On the morning of 6-29-25 at approximately 0200 (2:00 a.m.), [Resident R1] had an assisted fall out of bed. [Resident R1] was having incontinent care completed at the time of fall. The aide performing incontinent care on [Resident R1] rolled resident away from her instead of towards her. [Resident R1] rolled out of bed on the right side of bed. [Resident R1] is an assist x1 for bed mobility.Review of an employee statement written by NA Employee E2 dated 6/29/25, indicated, [Resident R1] had an assisted fall. When rolling [Resident R1] to change sheet he rolled. I was able to grab his gown, so his fall was gentle. I notified nurse.Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 7/4/25, included the information, Transfer status of assist x1 for bed mobility was followed however CNA rolled resident away from her while changing which prompted resident to fall out of bed. Allegation of neglect substantiated. On 6/29/25, the facility initiated a plan of correction that included:Investigation launched immediately and CNA suspended pending investigation. A registered nurse assessment was completed immediately - no injuries noted. A verbal one on one education was completed with the aide by clinical management team on the proper way to roll residents who are an assist x1 in bed as well as abuse/neglect policy. House education completed as well. Family, Adult Protective Services, and police all notified of incident. All incidents and accidents are discussed daily during IDT (inter-disciplinary team) and monthly during QAPI (Quality Assurance and Performance Improvement).On 7/15/25, five nurse aides were interviewed, and confirmed they were provided education on bed mobility. The nurse aides were able to verbalize the correct way to roll a resident. During an interview on 7/15/25, at approximately 12:00 p. m. the Nursing Home Administrator confirmed the facility failed to provide adequate supervision to prevent falls for one of five residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility job descriptions, personnel files, and staff interviews, it was determined the facility failed to ensure that staff renewed their nurse aide registration to allow individuals to work as a nurse aide for one of five nurse aides (NA) reviewed (NA Employee E1). Based on review of facility provided documentation, it was determined that the facility failed to have updated certifications on file for one of five Nurse Aides (NA), which allowed NA Employee E1 to work without a current certification.Review of the facility documents provided indicated that nurse aides, Must possess an active Certified Nursing Assistant Certification; having successfully completed a State approved training program and necessary examination.Review of facility submitted information dated [DATE], indicated, As part of a routine internal audit, conducted to ensure compliance with licensure requirements, it was identified that employee's [Nurse Aide Employee E1] license had expired as of [DATE]. Upon identification of the lapse, the employee was immediately removed from the schedule and was not permitted to resume duties until verification of her renewed certification was received. Review of facility provided plan of correction revealed the following: Regular monthly audits x 3 months. Automated reminders for upcoming expiration dates. Facility completed on [DATE], an audit as part of transition to a new electronic HR/payroll software, which allows for live tracking and trending of certification dates. All other licenses and certifications were found an no concerns were noted.All incidents are reviewed at daily clinical meeting and are forwarded to QAPI (Quality Assurance and Performance Improvement committee) for further review, recommendations, and audits.During interviews completed on [DATE], of five nurse aides working in the facility, all had received education and had current certifications. During an interview on [DATE], at 10:45 a.m. the Nursing Home Administrator confirmed the facility failed to ensure that staff renewed their nurse aide registration to allow individuals to work as a nurse aide for one of five nurse aides reviewed.28 Pa. Code 201.29 Personnel Policies and Procedures.