

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2025
NAME OF PROVIDER OR SUPPLIER  Kadima Rehabilitation & Nursing at Irwin		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the Resident Assessment Instrument User's Manual, clinical record, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set Assessments were accurate and fully completed for one of eight residents (Resident R1). Finding include: Review of the facility policy Resident Assessment/Minimum Data Set, dated [DATE], indicated the facility will conduct initially and periodically a comprehensive, accurate, and standardized reproducible assessment of each resident's functional capacity under the direction of a designated registered nurse. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS-periodic assessment of care needs) dated October 2024, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 Should Resident Mood Interview Be Conducted? should be coded as 0 if the resident is rarely/never understood, and it should be coded 1, and the assessment should be completed if the resident is at least sometimes understood. Review of Resident R1 clinical record revealed an MDS completed on 5/6/25. Review of Section B: Hearing, Speech, and Vision indicated Resident R1 was not in a persistent vegetative state/no discernible consciousness. The remainder of the questions in B0700 Makes Self Understood-Ability to express ideas and words consider both verbal and nonverbal was marked as Sometimes Understood. Review of Section C: Cognitive Patterns-Should brief interview for mental status (C0200-C0500) be conducted the resident was marked as Rarely/Never Understood. Section C- C0700 Short Term Memory OK- Seems or Appears to recall after 5 minutes the resident was marked as Memory Problem, Section C1000 Cognitive Skills for Daily Decision Making-Made decisions regarding tasks for daily life the resident was marked as Severely Impaired-Never/Rarely made decisions. Section C-BIMS was not completed. Section D: Mood not assessed with Resident Mood Interview not completed. Staff Assessment of Resident Mood completed with a severity score of 5, score should be between 00-30. During an interview on 8/5/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that comprehensive MDS assessments were accurate and fully completed for one of eight residents. 28 Pa. Code: 211.5(f) Clinical Records.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395382	If continuation sheet Page 1 of 4

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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.  (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical and facility record review, facility submitted documents and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent a fall and an elopement for two of eight residents (Resident R1 and Resident R2). Finding include: Review of facility policy, Transfer of Residents dated 9/18/24, indicated residents will be evaluated, supervised, or assisted to ensure the appropriate method of transferring a resident is identified to minimize emotional and physical trauma to the resident. Review of facility policy, Resident Elopement dated 9/18/24, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the premises or a safe area without authorization. Review of facility policy, Elopement Drill dated 9/18/24, indicated elopement drills will be held to prepare staff to search for a resident who is missing or has eloped. Review of facility policy, Abuse Protection dated 9/18/24, indicated the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporeal punishment, involuntary seclusion, neglect and misappropriation of property. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included aphasia (a language disorder that affects a person's ability to communicate whether by speaking, understanding, reading, or writing), muscle wasting and atrophy (shrinking and loss of muscle tissue, often resulting in decreased strength and mobility), vascular dementia (person has problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), personal history of transient ischemic attack and cerebral infarction without residual deficits (a past history of temporary disruption of blood flow to the brain, causing stroke like symptoms that resolved within 24 hours or when a portion of the brain is deprived of blood but no long-lasting neurological deficits occurred). Review of the Minimum Data Set (MDS-periodic assessment of resident care needs) dated 5/6/25, indicated the diagnoses remained current. Review of and Elopement Risk Assessment completed on 2/18/25 and 4/21/25 revealed that Resident R1 was cognitively impaired, had poor decision-making skills, did not demonstrate exit seeking behaviors, and did not wander; oblivious to safety needs. Review of the physician's orders on 8/5/25, indicated prior to the incident on 7/14/25, Resident R1 was not ordered any interventions to prevent an elopement. Review of orders did show that on 7/14/25, Resident R1 was ordered a Wander Guard (device that alarms when a resident is near and exit), and to check placement every shift. Review of Resident R1's plan of care on 8/5/25, revealed prior to the incident on 7/14/25, Resident R1 did not indicate risk for elopement, nor did it have interventions in place to prevent elopement. In review of Resident R1's plan of care it was noted that on 7/14/25, a plan of care for potential for elopement and associated injury related to exit seeking behavior was initiated. The goals are for Resident R1 to remain free of injury related to elopement risk through next review period, resident will not wander out of facility through next review, and resident will remain on unit unless supervised by facility staff or responsible party through next review. Review of facility provided incident report dated 7/14/25, at 10:10 a.m. indicated resident was let out of the facility by a staff member onto the front patio at approximately 10:00 a.m. for fresh air. Resident is nonverbal and was unable to explain why he wandered down the parking lot before being found by facility staff at 10:10 a.m. Resident was wearing appropriate clothing and footwear at the time of the elopement. Head to toes RN assessment was completed with no injuries noted to resident. Resident has not been identified as an elopement risk since admission and has not exhibited exit seeking behaviors. Review of the progress notes dated 7/14/25, at 1:17 p.m. by Registered Nurse, Nursing Supervisor completed a head-to-toe assessment on return to the facility. Multiple staff were interviewed that saw the resident at the front doors to the facility, staff saw him on the patio, and then the staff member that alerted someone that he had moved off the patio. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE], with diagnoses that include vascular dementia, diabetes (blood sugar levels are either too high or too low), aphasia, and muscle weakness. Review of the MDS dated [DATE], indicated the diagnoses remained current. Review of Resident R2's clinical record revealed orders for the resident to be an assist x2 (two persons) for bed mobility on 3/22/23, and transfers to use Hoyer lift, large sling, assist x2 written on 12/19/24 and revised on 7/17/25. The resident was placed on Hospice on 12/31/24 with orders placed by Hospice personnel for their staff to follow. Resident has history of falls without injuries, his bed is in the lowest position, and he has fall mats in place. Review of facility provided incident report dated 7/16/25 at 11:36 a.m. indicated resident was being transferred from bed to shower</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policies, clinical procedures and staff interviews, it was determined that the facility failed to make certain medical records on each resident are complete and accurately documented for one of eight residents. (Resident R1).Findings include:A review of the facility policy Documentation dated 9/18/24, indicated nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. 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.A review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included aphasia (a language disorder that affects a person's ability to communicate whether by speaking, understanding, reading, or writing), muscle wasting and atrophy (shrinking and loss of muscle tissue, often resulting in decreased strength and mobility), vascular dementia (person has problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), personal history of transient ischemic attack and cerebral infarction without residual deficits (a past history of temporary disruption of blood flow to the brain, causing stroke like symptoms that resolved within 24 hours or when a portion of the brain is deprived of blood but no long-lasting neurological deficits occurred).A review of the Minimum Data Set (MDS-periodic assessment of resident care needs) dated 5/6/25, indicated the diagnoses remained current.On 7/14/25, the resident was let out of the facility by a staff member to the front patio at 10:00 am for fresh air. Resident was found at 10:10 am approximately 75 feet down the parking lot, he is non-verbal and was unable to explain why he wandered down the parking lot.A review of the clinical record revealed that the resident does not have a follow-up note or any notes since the day of the Elopement on 7/14/25. The note from this day states resident assessment, alert and nonverbal. Temp 97.2, HR (heart rate) 64, resp (respirations) 16, bp (blood pressure) 132/74. Resident dressed in t-shirt, shorts, shoes and socks in w/c (wheelchair) with Hoyer pad underneath. Not at risk of hypo/hyperthermia. Does have scrapes to right leg. Appears to be in no pain. No anxiety or SOB (shortness of breath). There is no documentation regarding what was done for the fresh scraps to the leg, no documentation of the Elopement Risk Assessment being completed, the wander guard being placed and where (information was obtained, orders, and kardex as to wander guard placed on left lower extremity), and no documentation regarding if the resident has attempted to wander or is displaying any wander behaviors since the date of the incident.During an interview on 8/5/25, at 1:00 p.m. the Nursing Home Administrator (NHA) confirmed the above findings, and the facility failed to document a follow-up to the incident regarding the scrapes to right leg, any documentation since the date of the incident regarding any wandering behaviors, and that medical records are complete and accurately documented.28 Pa. Code: 211.5 (f)(g)(h) Clinical Records.</p>		