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	01/31/2025

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

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 51307 Based on a review of facility policy, federal regulation, and staff interview, it was determined that the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for 4 of 12 months (January 2024 through April 2024). Findings include: Review of the facility policy Admission Transfer and Discharge 9/21/23 and 9/18/24, indicated no resident will be discharged without timely notification of the resident, responsible party, or authorized representative. Review of Title 42 Code of Federal Regulations S483.15(c)(3) Notice Before Transfer: indicates, before a facility transfers or discharges a resident, the facility must (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Federal Regulations further define emergency transfers as, When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer. During an interview on 1/27/25, at 2:30 p.m., the Nursing Home Administrator confirmed the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for 4 of 12 months (January 2024 through April 2024). 28 Pa. Code 201.18(b)(3)(e)(2) Management.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS- assessments completed indicating a change in condition of a resident requiring change in care) assessment for one of three residents reviewed (Residents R97). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective 10/1/2019, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Review of the facility policy Resident Assessment/Minimum Data Set reviewed 9/18/24, indicated the facility will conduct a comprehensive assessment of a resident in a timely manner, within 14 days after the facility determines that there has been a significant change. The change is a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard clinical interventions. The change impacts more than one area of the resident's health status ad requires interdisciplinary review and or revision of the care plan. A review of the clinical record indicated that Resident R97 was admitted to the facility on [DATE], with diagnoses which included dementia (group of symptoms that affects memory, thinking and interferes with daily life), repeated falls, and anxiety. A review of the MDS dated [DATE], indicated the diagnoses remain current. A review of a physician order dated 7/5/24, indicated Resident R97 was admitted to hospice care (a special model of care for patients who are in the late phase of an incurable illness and wish to receive end-of-life care) on 6/14/24. Review of a care plan dated 7/8/24, indicated Resident R97 was receiving hospice care. Review of Resident R97 ' s MDS assessments revealed a MDS significant change was not completed to include Hospice services. During an interview on 1/31/25, at 10:05 a.m. Licensed Practical Nurse Assessment Coordinator Employee E2 confirmed the facility failed to complete a MDS significant change within 14 days of Resident R97 ' s hospice admission. 28 Pa. Code: 211.5(f) Clinical records.

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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 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** 43725 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for two of four residents reviewed (Residents R51 and R66). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of facility policy Nursing Care of the Diabetic Resident reviewed 9/21/23 and 9/18/24, indicated the facility will recognize, assist, and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident and include vital signs, level of consciousness, assessment of the skin, emotional/mood changes, and pain/discomfort. Document results of any fingerstick blood glucose monitoring, interventions to stabilize blood glucose levels, and notification to physician. Review of facility policy Notification of Condition Change: Physician reviewed 1/31/24 and 1/9/25, indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident ' s condition. Document assessment data, attempted or actual correspondence with physician, and physician ' s response in the medical record. Review of facility policy Documentation reviewed 1/31/24 and 1/9/25, indicated nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate. Review of facility Hypoglycemic Protocol reviewed 1/31/24 and 1/9/25, indicated if resident ' s blood glucose is less than 70 administer rapidly absorbed simple carbohydrate such as four ounces (oz) of juice, five or six oz of regular soda, or tube of glucose gel. Repeat blood glucose in 10-15 minutes and repeat protocol if still less than 70. If resident is symptomatic, notify physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE], with diagnoses that included hypoglycemia, diabetes, and high blood pressure. Review of Resident R51' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 11/20/24, indicated the diagnoses remain current. Review of Resident R51 physician ' s order revealed the following orders - On 9/29/24, indicated Glucose Gel 40% (used to treat low blood sugar) give one applicatorful as needed for hypoglycemia of less than 70. - On 10/4/24, inject Novolog (begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and last between two to four hours) per sliding scale, if below 70 follow hypoglycemic protocol. - On 11/4/24, indicated to inject Novolog six units before meals. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 11/3/24, at 12:00 p.m. the CBG was noted to be 55. - On 1/4/25, at 10:45 a.m. the CBG was noted to be 448. - On 1/21/25, at 8:36 a.m. the CBG was noted to be 429. Review of the care plan dated 8/25/24, indicated the following interventions: Accuchecks as ordered, call MD per order, monitor resident for signs and symptoms of hyper-/hypoglycemia, provide insulin/meds as per resident ' s individual order. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of a clinical record indicated Resident R66 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R66 physician ' s orders revealed the following orders: - On 3/7/24, indicated Accuchecks two times a day. - On 5/8/24 through 7/17/24, inject insulin Aspart (begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and last between two to four hours) six units before meals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/23/23 through 8/9/24, inject Basaglar (reaches the bloodstream several hours after injection and tends to lower glucose levels up to 24 hours) 16 units one time a day. - On 7/17/24 through 7/30/24, inject Fiasp (insulin Aspart) six units before meals. - On 7/30/24 through 8/2/24, inject Fiasp ten units before meals. - On 8/2/24 through 9/6/24, inject Fiasp 12 units before meals. - On 8/9/24, indicated Basaglar 20 units one time a day. - On 9/6/24 through 12/20/24, inject insulin Aspart 12 units before meals. Review of Resident 66's eMAR revealed that the resident's CBG's were as follows: - On 6/13/24, at 4:46 p.m. the CBG was noted to be 455. - On 6/18/24, at 7:20 a.m. the CBG was noted to be 440. - On 6/18/24, at 4:05 p.m. the CBG was noted to be 496. - On 6/19/24, at 7:13 a.m. the CBG was noted to be 425. - On 6/20/24, at 8:12 a.m. the CBG was noted to be 426. - On 7/23/24, at 7:45 a.m. the CBG was noted to be 406. - On 7/24/24, at 4:26 p.m. the CBG was noted to be 413 - On 7/25/24, at 7:29 p.m. the CBG was noted to be 483. - On 7/26/24, at 3:46 p.m. the CBG was noted to be 418. - On 7/30/24, at 5:03 p.m. the CBG was noted to be 434. - On 7/31/24, at 3:21 p.m. the CBG was noted to be 414. - On 8/6/24, at 11:11 a.m. the CBG was noted to be 426. - On 8/6/24, at 3:12 p.m. the CBG was noted to be 418. - On 8/25/24, at 3:20 p.m. the CBG was noted to be 413. - On 10/11/24, at 9:59 a.m. the CBG was noted to be 435. - On 10/11/24, at 8:37 p.m. the CBG was noted to be 417. Repeat CBG at 8:38 p.m. was 417. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 10/13/21 and 4/19/22, indicated the following interventions: Accuchecks as ordered, call MD per order, monitor resident for signs and symptoms of hyper-/hypoglycemia, provide insulin/meds as per resident ' s individual order. Review of Resident R66's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. During an interview on 1/17/25, at 9:00 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, failed to document an assessment or interventions used related to blood glucose, and failed to follow physicians orders for Residents R51 and R66. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of clinical records and staff interviews, it was determined that facility staff failed to maintain ongoing communication with the dialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of four residents reviewed (Resident R2). Findings include: Review of the facility policy Dialysis Care reviewed 9/18/24, indicated residents ordered dialysis will be monitored and documentation will be maintained in the medical record. All resident ' s receiving dialysis will be assessed before and after dialysis treatment and for compliance with their individualized plan of care. Review of the clinical record indicated Resident R2 was readmitted to the facility on [DATE], with diagnoses that included end-stage renal disease (ESRD - the kidneys permanently fail to work), high blood pressure, and depression. Review of the Minimum Data Set (MDS - periodic assessment of care needs) date 1/15/25, indicated the diagnoses remain current. Review of a physician ' s order dated 3/31/24, indicated Resident R2 was to receive dialysis three days a week on Tuesday, Thursday, and Saturday, obtain vitals pre and post dialysis. Review of a care plan dated 8/24/20, indicated to keep open communication with the dialysis center. Review of the dialysis communication forms from 1/20/24 through 1/30/25, revealed 84 communication forms out of 156 scheduled treatments were observed. Review of the dialysis communication forms from 1/20/24 through 1/30/25, revealed thirty-four forms not fully completed before treatment, after treatment, or both. During an interview on 1/31/25, at 09:20 a.m. the Director of Nursing confirmed the facility failed to ensure the dialysis communication form was completed pre and post treatment between the facility and dialysis center. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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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. 43725 Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to properly store refrigerated medication in one of three medication carts observed (B unit Short Hall medication cart). Findings include: Review of facility policy Storage of Medications reviewed 9/18/24, indicated medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses station. Review of Humalog (Lispro) Instructions for Use guidelines revised July 2023, indicate unused pens should be stored in the refrigerator at 36 - 46 degrees Farenheit. Unused pens may be used until the expiration date printed on the label, IF the pen has been kept in the refrigerator. Review of Highlights of Prescribing Information insert for Lantus insulin revised June 2023, indicate 10 ml (milliliter) multi-dose vial and 3 ml single-patient prefilled pen are good for 28 days if unopened at room temperature. During an observation on 1/28/24, at 9:20 a.m. B unit Short Hall medication cart contained 12 insulin pens and one insulin multi-dose vial not dated. This included: - four Novolog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin pens - three Lantus (long-acting type of insulin that works slowly, over about 24 hours) insulin pens - one open Lantus multi-dose vial - one Humulin R (regular-acting insulin that starts to work 30 minutes after injection, peaks in 2-3 hours, and keeps working for 3-6 hours) insulin pen - one Humalog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin pen - three Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin pens. During an interview on 1/28/25, at 9:20 a.m. Licensed Practical Nurse (LPN) Employee E4 stated she was unsure why so many insulin pens were in the drawer instead of being stored in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25, at 9:30 a.m. the Director of Nursing confirmed the medications should be dated upon opening and extras not being used should have been stored in the refrigerator per policy. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(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. 26071 Based on a review of facility policies and documents, and staff interviews, it was determined that the facility failed to properly monitor equipment in the Main Kitchen creating the potential for food-borne illness. Findings include: A review of facility policies Equipment Temperature Logs dated 9/18/24, indicated that the Dietary Services Manager will use the Refrigeration and Freezer Temperature Log to record the temperatures of all refrigerators and freezers daily. The forms will be posted in the Dining Services Department and kept on file for a period of one year. A review of the Equipment Temperature Log, To Be Taken daily by the Dietary Services Manager documents dated 12/1/24 through 1/27/25 did not include documentation that temperatures were taken on the following days for the walk in and reach in coolers and freezers, and milk cooler: 1/6/25. 1/13/25. 1/16/25. 1/18/25. During an interview on 1/27/25, at 9:50 a.m., the Nursing Home Administrator and Dietary Services Manager E1 confirmed the above findings, and that the facility failed to monitor equipment temperatures creating the potential for food-borne illness. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.