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	12/19/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a review of the resident council minutes, the grievance logs, resident group meeting information, observation and staff interview, it was determined that the facility failed to serve food that was palatable, attractive and resident preferences. Findings include:Review of seven months of resident council minutes and grievances identified residents stating that the food was cold, food often not being provided according to the posted menu, condiments not available, food items not being available.During the resident group meeting on 12/16/25 at 2:00 p.m., the resident consensus identified food often served cold, late, not providing condiments, not always get enough or what is posted.During an observation of lunch tray line service on 12/17/25, at 12:10 p.m., dietary staff were not placing sour cream on trays until the surveyor made a statement as to where the sour cream was and a box of sour cream packets were then brought to tray line. The facility failed to have enough bottom hot plate covers for all residents.During a test tray observation on 12/17/25, at 1:29 p.m., the temperatures were:Meat 80 degrees, cool to taste beans 90 degrees, cool to tasterice no temp able to be obtainedmilk 41 During an interview on 12/17/25, at 2:00 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to serve food that was palatable, with all item availability and condiments per resident preferences. Confirmed that the facility failed to have enough bottom hot plate covers for all residents.28 Pa. Code 211.6(b) Dietary Services.

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of the resident council minutes, the grievance logs, the facility posted meal delivery schedule, observations and staff interview, it was determined that the facility failed to provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. Findings include:Review of the resident council minutes from September through current and grievances filed from the same time frame identified the facility failed to deliver meals to residents in a timely manner and according to the posted tray delivery schedule.During an observation on 12/16/25, at 1:45 the last cart was being delivered to the A nursing unit. The delivery schedule indicated the cart delivery to be at 12:35 p.m., and hour and ten minutes late. During an observation on 12/17/25, from 12:10 p.m. through 1:20 p.m., the following was identified: Dining room was to be delivered at 12:00 p.m., it was delivered at 12:20 p.m.A wing first cart was to be delivered at 12:10 p.m., it was delivered at 12:43 p.m.B wing first cart was to be delivered at 12:20 p.m., it was delivered at 12:55 p.m.A wing second cart was to be delivered at 12:35 p.m., it was delivered at 1:10 p.m.B wing second cart was to be delivered at 12:45 p.m., it was delivered at 1:20 p.m. During an interview on 12/17/25, at 1:45 p.m., the Nursing Home Administrator confirmed that the facility failed to provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences and requests.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to ensure the dish machine was in proper working order in the Main Kitchen, the stove was properly heating and that the steam table had a draining system in place that did not have a potential to cause contamination of food and food service equipment due to drainage pipe touching the ground and actual placement within a drain to sewage system. Findings include:During an observation of the dish room on 12/16/25, at 9:50 a.m., the dish machine had been identified as a low temperature, chemical machine. A Chemical verification strip had been placed during the cleaning process and identified the chemical to be at 10 ppm the indication was for the level to be at least 50 ppm. During an interview on 12/16/25, at 10:15 a.m., the Nursing Home Administrator confirmed he was not aware that the dishwasher was inoperable.During a second observation of meal service on 12/17/25, from 12:00p.m., through 1:35 p.m., the following was observed: Dietary Aide Employee E4 was plating food items, left area, made grilled cheese using gloved hands then removed gloves, wiped her hands on pants and shirt then donned new gloves and began labeling container for sandwiches. opened bun bag and cut bread then went back to making grilled cheese, which had now been holding up tray line. Staff in the kitchen had identified that the stove does not heat properly and it takes forever to heat to cook items in a timely manner. During an observation and subsequent interview on 12/17/25, at approximately 2:00 p.m., the Nursing Home Administrator and Maintenance Director Employee E1 confirmed that the steam table had a draining system in place that had a potential to cause contamination of food and food service equipment due to drainage pipe touching the ground and actual placement within a drain to sewage system. The stove in the kitchen is not in proper working condition. 28 Pa Code:201.14(a) Responsibility of Licensee

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of resident and staff interviews it was determined that the facility failed to respond to resident concerns and grievances identified during council meetings and review of 5 of 6 months no grievance resolutions. Finding include: During resident group meeting on 12/18/25, at 2:00 p.m. residents indicated that they discuss the same concerns every meeting-specifically call bells, food and mealtimes, care, staff badges, and showers. Residents indicated that they do not get feedback on their concerns. During review of resident council minutes from July 2025, through November 2025, revealed 30 areas of old business (issues/complaints discussed during meetings) with interventions listed as staff educated or manager aware and for resolved no, ongoing (19/30) or yes, resolved (11/30) documented. During an interview on 12/19/25, at 11:30 a.m. Nursing Home Administrator confirmed that call bells, food, mealtimes, staff badges, showers are discussed with grievances files and the facility failed to respond to resident groups on-going concerns. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, facility documents and staff interviews it was determined that the facility failed to document, resolve, and provide responses to residents and/or their responsible party regarding concerns for 16 of 18 grievances from July 2025 through November 2025. Finding include: Review of the facility policy Grievances dated 9/3/25, indicated the resident has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Review of June 2025 through November 2025 facility provided grievance log indicated there were a total of 18 resident entries and as of 12/19/25, at 11:30 a.m. sixteen of them had no date of parties being informed of findings or disposition completed. Interview on 12/19/25, at 11:30 a.m. the Nursing Home Administrator confirmed that the facility provided grievance logs indicated the facility failed to document, resolve, and provide response to residents and/or responsible party regarding concern for 16 of 18 grievances between June 2025 and November 2025. 28 Pa. Code 201.14(b) Responsibility of licensee. 28. Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(a) Resident Rights.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of resident and staff interviews, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 8 of 13 residents (Residents R2, R3, R5, R11, R14, R29, R500, R501). Findings include:During an interview on 12/16/25, at 12:30 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R2 stated, No. Resident R2 stated that call light response takes a long time.During an interview on 12/16/25, at 12:32 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R3 stated, Could be better and is worse on the off shift and weekends.During an interview on 12/16/25, at 12:35 p.m. when asked if he felt the facility maintained enough staff to care for resident needs, Resident R3 stated, Not at all. Resident R2 further stated that call light response times can be long, and he waits a long time for assistance to get out of bed.During a confidential staff interview, when asked if the staff member felt there was sufficient staff to care for resident needs, the staff member stated, not enough help to get people up and out of bed with 3-11 shift being worse.'During a confidential staff interview, when asked of the staff member felt there was sufficient staff to care for resident needs, the staff member stated, call offs are frequent thus decreasing staff, second shift is worse.During a confidential staff interview, when asked of the staff member felt there was sufficient staff to care for resident needs, the staff member stated, call offs cause us to be short, need more staff to help cover the call offs, you then have to do what you can with what you have.During a confidential staff interview, when asked of the staff member felt there was sufficient staff to care for resident needs, the staff member stated, short staffed more than not, not just because of call offs. We can't do the showers on regular scheduled days because of short staffing.During a confidential staff interview, when asked of the staff member felt there was sufficient staff to care for resident needs, the staff member stated, staffing is short because of call offs, worse on 3-11 shift, not enough more times than not.Review of a grievance filed on behalf of Resident R11, dated 5/28/25, revealed concerns documented for incontinence care, grooming, availability of fresh water, protective booties not applied, and call light availability.Review of a grievance generated from a resident council meeting dated 9/17/25, indicated staff answered call bells and immediately shut them off with a response of I'm not your aide. Review of a grievance filed on behalf of Resident R29 and R5, dated 11/7/25, indicated Resident R29 reported that staff hardly came to check on them and would shut off light without returning, Resident was not put back into bed until the 11p-7a shift and wanted to go earlier. Resident R5 reported nobody was answering their call bell, no one touched her all shift and she was soaked, wants to talk to someone.Review of a grievance filed on behalf of Resident R14, dated 7/30/25, revealed concerns documented for incontinence care and call light response times.Review of grievance log for November revealed Resident R500 and R501 were to have filed a grievance for care concerns with no grievance form provided in compilation of grievances.Review of Resident Council minutes revealed in July, September and October resident revealed that on the 3-11 shift staff were not answering call bells, staff gave residents attitude when asked who their aide was, still not answering call lights or coming in and turning them off, staff still not introducing themselves to the resident, wait time too long for call bells.During an interview on 12/19/25, at approximately 1:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 8 of 13 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code: 201.20(a) Staff development.28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.

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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 facility policy, observations and staff interview, it was determined that the facility failed to maintain a clean homelike environment for one of two resident shower rooms (A wing shower room).Findings Include:During an observation on 12/16/25 at 11:24 a.m., the following was identified:Resident shower room on the A wing nursing unit hall had broken floor trim exposing broken drywall leaving pieces of metal that had been lifted and bent. During an interview on 12/18/25 at 11:38 a.m., the Maintenance Director Employee E1 and the Nursing Home Administrator confirmed that the facility failed to maintain a homelike environment for one of two shower rooms (A wing shower room).28 Pa. code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c)(d) Resident rights.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for one of three residents (Residents R1). Findings include: Review of facility's policy MDS/RAI/Care Planning dated 9/3/25, indicated the facility will develop a written plan of care individualized for each resident, which identifies through an assessment process his/her strengths, problems, and needs. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 10/15/25, indicated diagnoses of PTSD (post-traumatic stress disorder). Review of a psychiatry note dated 11/10/25, indicated Resident R1 has a diagnosis of PTSD. Review of Resident R1's current care plan dated 10/9/25, failed to reveal a care plan with goals and interventions for PTSD. During an interview on 12/19/25, at 11:30 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that a comprehensive resident care plan was complete for resident care needs for Residents R1. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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** Based on review of clinical record and staff interview it was determined that the facility failed to provide appropriate treatment and care for one of three residents (Resident R66).Finding include:Review of facility policy Splint/Brace Management dated 9/3/25, previously dated 9/18/24, indicated residents will be assessed to determine a splint/brace device program to attain, maintain, and prevent decline in joint mobility.Resident R66 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS- standardized assessment of each resident's functional capabilities and health needs) dated 10/29/25, indicated the diagnoses of transient cerebral ischemic attack (temporary blockage of blood flow in brain, results in weakness, vision/speech issues, dizziness that resolves in 24-hrs), high blood pressure, contracture left hand, muscle wasting and atrophy of unspecified origin, left upper arm (loss or thinning of muscle leading to decreased strength in that extremity).Review of order summary revealed an order on 8/12/25, for resting hand splint on left hand while in bed, off for skin integrity checks and activities of daily living.During multiple observations throughout the day on 12/16/25, 12/17/25, 12/18/25 and 12/19/25, it was noted that Resident R66's brace was never placed on her left hand.During multiple observations throughout the day on 12/16/25, 12/17/25, and 12/19/25, it was noted that Resident R66's call bell was wrapped around a chair behind the head of her bed, it was on the floor behind her bed or was on the floor next to her bed.During an interview on 12/19/25, at 11:30 a.m. the Director of Nursing confirmed the facility failed to provide care and services as needed with assisted devices as ordered for Resident R66.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.29(a)(c.3)(1) Resident Rights.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. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medication and/or biologicals in one of two medication rooms (A Wing Medication Room). Finding include: Review of facility policy Storage of Medication dated 9/3/25, previously review 9/18/24, indicated medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. During an observation on 12/18/25, at approximately 9:00 a.m. of the A Wing medication room the following was observed- 16 boxes (10 syringes/each) Influenzae Vaccine 2024-2025 formula- Expired 6/30/25- 1 box (9 syringes Influenzae Vaccine 2024-2025 formula-Expired 6/30/25- 2 boxes-Gvoke HypoPen (glucagon Injection Pen)- Expired 6/2025- 4 boxes 50% Dextrose Injection-Expired 5/2025 During a review of all residents clinical record for administration of Influenzae vaccines, no residents were found to have received the expired medications. During an interview on 12/18/25, at 2:00 p.m. with the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to properly store medication and/or biologicals in one of two medication rooms. 28 Pa. Code 211.9(a)(1)(j)(1)(k) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing Services.