

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Palmyra		STREET ADDRESS, CITY, STATE, ZIP CODE 341 North Railroad St Palmyra, PA 17078	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, resident and staff interview, and group interview it was determined that the facility failed to provide care and services in a manner that respected the resident's dignity and preferences to promote quality of life for three of 16 sampled residents (Residents 9, 24, and 35).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 9 had diagnoses that included hemiplegia and hemiparesis (paralysis) of the left side and depression. On July 2, 2025, at 11:10 a.m., the resident stated that there were no chairs in her room for visitors to sit in. At 11:30 a.m., there were no chairs observed in the resident's room.</p> <p>Clinical record review revealed that Resident 24 had diagnoses that included overactive bladder, age related nuclear cataract (vision impairment), and depression. On July 1, 2025, at 10:15 a.m., the resident was observed in her room in bed. She stated that she would like to be able to watch her television but no one gave her the remote control. The remote control was observed on a table behind her bed, out of reach. At 12:35 p.m., the resident was again observed in bed, the remote control remained out of reach.</p> <p>Clinical record review revealed that Resident 35 was readmitted to the facility on [DATE], and had diagnoses that included history of stroke, muscle weakness, and depression. On July 2, 2025, at 2:10 p.m., the resident was observed in his room in bed. He stated that he would like to be able to watch his television but it is not visible from his bed. The television was mounted behind the resident's headboard. He stated that the television had been in that place and he could not watch it since he was readmitted to the facility. On July 3, 2025, at 11:17 a.m., the resident was again observed in bed, the television remained in the same place, behind the resident and out of his field of vision.</p> <p>In a group interview conducted on July 2, 2025, at 10:23 a.m., seven of seven residents in attendance reported that they often do not know what they are getting for their meals. Observation on July 1, 2025, at 10:49 a.m., revealed that the menus posted on the nursing unit were labeled Monday, and listed meal items of meatloaf, mashed sweet potatoes, creamed style corn, and banana bread. Review of the facility menus for Tuesday July 1, 2025, revealed that the lunch menu for that date included pork chops, potato wedges, and apple crisp. The menus that were posted on the nursing unit were not updated to reflect the current date or meal.</p> <p>(continued on next page)</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>483.10(a)(1) Resident rights.</p> <p>Previously cited 8/9/24</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.6(a) Dietary Services.</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on clinical record review, staff interview, and a confidential interview, it was determined that the facility failed to inform a resident's responsible party of treatment options that may affect the resident's well being for one of 16 sampled residents. (Resident 17)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 17 had diagnoses that included dementia. A physician's order dated May 16, 2025, directed staff to administer an antidepressant medication, sertraline, 75 milligrams (mg) once daily. This was an increase from the previously ordered dose of 50 mg. There was no evidence that the resident's responsible party was notified of the increased dose of the medication or alternate treatment options. In a confidential interview on July 1, 2025, at 4:50 p.m., it was reported that Resident 17's responsible party was not notified of the increased sertraline dose and if they were made aware, would have declined the change.</p> <p>In an interview on July 3, 2025, at 11:44 a.m., the Director of Nursing confirmed that the resident's responsible party was not notified of the physician's order to increase the dose of Sertraline to 75 mg.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on a review of facility resident council meeting minutes and resident interview, it was determined that the facility failed to address grievances voiced by the resident group.</p> <p>Findings include:</p> <p>In a group interview conducted on July 2, 2025, at 10:23 a.m., seven of seven residents stated that call bells were not answered in a timely manner and that there had been no hairdresser in months. Review of resident council meeting minutes dated March 7, 2025, revealed that multiple residents reported that call bells were not answered timely and they would like to see a hairdresser. Review of resident council meeting minutes dated June 11, 2025, revealed that multiple residents reported that call bells were not answered timely. There was a lack of evidence that the facility had addressed the residents' ongoing concerns of call bell response times or access to a hairdresser.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on resident interview and staff interview, it was determined that the facility failed to provide reasonable access to mail services as available in the community to all residents of the facility.</p> <p>Findings include:</p> <p>An interview with the resident council group conducted on July 2, 2025, at 10:23 a.m., revealed that seven of seven residents reported that the facility did not deliver mail or provide mail services on Saturdays.</p> <p>In an interview on July 3, 2025, at 11:56 a.m., the Nursing Home Administrator and Director of Nursing stated that although mail was delivered to the front foyer Mondays through Saturdays, the business office only delivers during their scheduled work hours.</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative of the bed hold and transfer, including the reasons for the move, and Ombudsman information, in writing upon transfer from the facility for five of six sampled residents who were transferred to the hospital. (Residents 12, 20, 28, 32, 33)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 12 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 20 was transferred and admitted to the hospital on [DATE] and May 7, 2025, after changes in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 28 was transferred and admitted to the hospital on [DATE] and March 16, 2025, after changes in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 32 was transferred and admitted to the hospital on [DATE] and May 24, 2025, after changes in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 33 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital.</p> <p>In an interview on July 3, 2025, at 9:19 a.m., the Administrator confirmed there was no documentation to support that the above notices were sent.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 16 sampled residents. (Resident 17)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 17 had diagnoses that included dementia and hypertension (high blood pressure). A physician's order dated December 10, 2024, directed staff to administer a medication for high blood pressure (carvedilol) twice daily. Staff were to hold the medication if the resident's heart rate was less than 60 beats per minute.</p> <p>Review of the Medication Administration Record for June 2025, revealed that staff administered the medication when the resident's heart rate was less than 60 beats per minute on June 14, 23, and 27, 2025.</p> <p>In an interview on July 3, 2025, at 12:38 p.m., the Director of Nursing confirmed that the medication was given outside of parameters on those dates.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to promote healing and prevent pressure ulcers for one of 16 sampled residents. (Resident 16)</p> <p>Findings include:</p> <p>Review of a facility policy entitled, Skin and Wound Management Policy, last reviewed May 16, 2025, revealed that staff were to provide ongoing monitoring and evaluation to ensure optimal resident outcomes for residents with wounds or pressure areas or at risk for skin compromise.</p> <p>Clinical record review revealed that Resident 16 had diagnoses that included muscle weakness. On June 21 and 27, 2025, staff noted that the resident had newly identified open areas to the sacrum. Review of weekly skin assessments dated June 23 and 30, 2025, revealed no evidence that staff adequately assessed and measured the areas. There was no evidence that staff performed a complete weekly assessment and measurements of the resident's open areas.</p> <p>In interviews on July 3, 2025, at 11:51 a.m. and 2:17 p.m., the Director of Nursing stated that staff were to assess and measure the resident's open areas and document the findings in the weekly skin assessment. She confirmed that there was no evidence that staff adequately measured or assessed the resident's open areas.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in facility policy review, clinical record review, observation, review of facility documentation, and staff interview, it was determined that the facility failed to develop and implement interventions to prevent accident hazards for two of 16 sampled residents. (Residents 16 and 17)</p> <p>Findings include:</p> <p>Review of a facility policy entitled, Fall Prevention Policy and Procedures, last reviewed May 16, 2025, revealed that the interdisciplinary team would update care plan interventions promptly after fall events. Post fall management would include notification to the physician and family and completion of an incident report. Nursing was responsible to assess, document, and monitor interventions.</p> <p>Clinical record review revealed that Resident 16 had diagnoses that included history of stroke, difficulty walking, and muscle weakness. Review of the care plan revealed that the resident had a history of falls and staff were to ensure that the resident had non skid footwear in place at all times. Review of facility documentation dated June 15, 2025, revealed that the resident was found on the floor in his room after an unwitnessed fall. On June 15, 2025, staff noted that the resident was admitted to the hospital with a left femoral neck fracture. The resident was readmitted to the facility on [DATE].</p> <p>On July 1, 2025, at 4:49 p.m., and July 2, 2025, at 1:28 p.m., the resident was observed in bed. The resident was observed to be wearing regular socks at that time, non skid footwear was not in place.</p> <p>In an interview on July 3, 2025, at 11:44 a.m., the Director of Nursing confirmed that the resident should have been wearing non skid footwear.</p> <p>Clinical record review revealed that Resident 17 had diagnoses that included dementia, glaucoma, muscle weakness, lack of coordination, muscle wasting, and a history of falls. Review of the care plan revealed that the resident was at risk for falls.</p> <p>Review of facility documentation revealed that the resident sustained falls on April 14, 2025, May 16, 2025, June 2, 21, and 23, 2025. There was no evidence that the facility had implemented new interventions to prevent ongoing falls until June 23, 2025.</p> <p>On June 6, 2025, staff noted that the resident was observed to have tripped over her own feet and stumbled to the floor in her room and also in the bathroom. There was no evidence that staff completed incident reports or notified the resident's physician or responsible party of the falls. There was no evidence that any new interventions were implemented as a result of the falls.</p> <p>In an interview on July 3, 2025, at 2:17 p.m., the Director of Nursing confirmed that there was no evidence of new interventions following the falls.</p> <p>In an interview on July 3, 2025, at 3:01 p.m., the Infection Preventionist confirmed that there was no incident report(s) completed for the falls documented on June 6, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on facility policy review, clinical record review, and observation, it was determined that the facility failed to ensure that adequate catheter care was provided for one of 14 sampled residents. (Resident 20)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Urinary Catheter Care, last reviewed May 16, 2025, revealed that the urinary drainage bag must be held or positioned lower than the bladder at all times and that the catheter tubing and drainage bag must be kept off of the floor.</p> <p>Clinical record review revealed that Resident 20 had diagnoses that included sepsis, hematuria (blood in urine), kidney failure, and urinary retention. The resident required the use of a urinary catheter. On March 20, 2025, the physician ordered for the resident to have an indwelling catheter. Observations on July 1, 2025, at 4:51 p.m. and 5:30 p.m., revealed Resident 20 in his wheelchair with his urinary catheter drainage bag on his lap, above the level of his bladder. At 5:50 p.m. and 6:30 p.m., Resident 20 was observed at the dining room table with his urinary drainage bag on the floor. Observations on July 3, 2025, revealed Resident 20 in his wheelchair with his urinary drainage bag hooked to the arm of his chair, above the level of his bladder.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to adequately monitor and assess the nutritional status of six of six sampled residents at nutritional risk. (Residents 2, 9, 15, 19, 20, and 28)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Resident Weights, last reviewed May 16, 2025, revealed that reweighs would be obtained within 72 hours for a weight change of three percent (%) or greater in one month. All weights, which included reweighs, would be transcribed into the resident's electronic medical record.</p> <p>Review of the facility policy entitled, Nutrition Management, last reviewed May 16, 2025, revealed that the facility would view muscle wasting, depression, dementia, and need for therapeutic or mechanically altered diets as potential indicators or risk factors for malnutrition.</p> <p>Clinical record review revealed that Resident 2 had diagnoses that included muscle weakness, dementia, and dysphagia. Review of the care plan revealed that the resident was at risk for impaired nutrition and required a mechanically altered diet. On May 4, 2025, the resident weighed 165.2 pounds (lbs.). On June 4, 2025, the resident weighed 154.6 lbs., which reflected a significant weight loss of 6.4 percent (%). There was no evidence that staff obtained a reweigh, per the facility policy, or that the resident was evaluated by a dietitian or qualified nutrition professional.</p> <p>Clinical record review revealed that resident 9 had diagnoses that included muscle weakness, depression, and dysphagia. Review of the care plan revealed that the resident was at risk for impaired nutrition. On May 4, 2025, the resident weighed 102.0 lbs., on June 4, 2025, the resident weighed 96.4 lbs., which reflected a significant weight loss of 5.4%. There was no evidence that staff obtained a reweigh, per the facility policy, or that the resident was evaluated by a dietitian or qualified nutrition professional since May 2025. A physician's order dated January 17, 2023, directed staff to obtain a monthly weight. There was no evidence that the resident was weighed in March of 2025. There was no documented refusal.</p> <p>Clinical record review revealed that Resident 15 was admitted to the facility on [DATE] and had diagnoses that included polyneuropathy, congestive heart failure, and cirrhosis of the liver. Review of the care plan revealed that the resident was at risk for impaired nutrition with an intervention for staff to refer to the dietitian for evaluation. On April 8, 2025, the resident weighed 135 lbs. On May 4, 2025, the resident weighed 163.7 lbs., which reflected a significant weight gain of 21.26 %. On June 2, 2025, the resident weighed 184.2 lbs., which reflected a significant weight gain of 11.13 %. There was no evidence that staff obtained a reweigh, per the facility policy, or that the resident was evaluated by a dietitian or qualified nutrition professional since admission.</p> <p>Clinical record review revealed that Resident 19 had diagnoses that included pressure ulcer of the sacral region, diabetes, and edema (swelling). Review of the care plan revealed that the resident was at risk for impaired nutrition with an intervention for the dietitian to evaluate. There was no evidence that the resident was evaluated by a dietitian or qualified nutrition professional.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Clinical record review revealed that Resident 20 had diagnoses that included metabolic encephalopathy (brain impairment), diabetes, anemia, and dysphagia (difficulty swallowing). On May 20, 2025, the resident weighed 133.3 lbs. On June 4, 2025, the resident weighed 150.6 lbs., which reflected a significant weight gain of 12.98 %. There was no evidence that staff obtained a reweigh, per the facility policy, or that the resident was evaluated by a dietitian or qualified nutrition professional since March 2023.</p> <p>Clinical record review revealed that Resident 28 had diagnoses that included end stage renal disease and dependence on renal dialysis. On May 20, 2025, the resident weighed 118.3 lbs. On June 4, 2025, the resident weighed 145.5 lbs., which reflected a significant weight gain of 22.99 %. There was no evidence that staff obtained a reweigh, per the facility policy, or that the resident was evaluated by a dietitian or qualified nutrition professional since October 2024.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide enteral nutrition (delivery of nutrition by a feeding tube) in accordance with resident needs for one of one sampled resident who received enteral nutrition. (Resident 35)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 35 was readmitted to the facility on [DATE], and had a diagnosis of gastrostomy. Review of the care plan revealed that the resident required a feeding tube. A physician's order dated May 22, 2025, directed staff to administer a tube feed formula, Nutren 2.0, at 55 milliliters (ml) per hour for 18 hours. Physician's orders dated May 23 and 27, 2025, directed staff to administer a tube feed formula, Jevity 1.5, for 20 hours. There was no rate noted in the physicians order.</p> <p>On July 2, 2025, at 2:10 p.m., the resident was observed in bed. The tube feed pump was on and administered Jevity 1.5. The screen displayed the rate of 50 ml per hour.</p> <p>In an interview at 2:13 p.m., licensed practical nurse (LPN) 1 was not able to identify a rate in the tube feed order in the resident's electronic medical record.</p> <p>In an interview at 2:50 p.m., the Director of Nursing (DON) confirmed that there was no rate in the physician's order to direct staff to how much Jevity 1.5 formula should be administered to the resident and the 50 ml per hour rate was initiated in error. Additionally, on May 23, 2025, the dietitian recommended a rate of 66 ml per hour of Jevity 1.5 to meet the resident's nutritional needs.</p> <p>There was no evidence that the tube feed formula, Jevity 1.5, was ever administered at a rate of 66 ml per hour which was needed to meet the residents nutritional needs.</p> <p>In an interview on July 2, 2025, at 3:45 p.m., the DON confirmed that Registered Nurse (RN) 2 transcribed the order incorrectly on May 23, 2025, and the order did not include a rate.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that staff provided services consistent with professional standards, including monitoring, for one of two sampled residents receiving dialysis (process of removing excess toxins and water from the blood). (Resident 28)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Hemodialysis Policy and Procedure, last reviewed May 16, 2025, revealed staff would weigh the resident daily.</p> <p>Clinical record review revealed that Resident 28 had a diagnosis of end stage renal disease which required dialysis. Review of Resident 28's care plan revealed he was a risk for fluid volume changes due to dialysis with an intervention to monitor weight. Review of Resident 28's clinical record revealed a lack of evidence that Resident 28 was weighed daily.</p> <p>In an interview on July 3, 2025, at 1:25 p.m., the Infection Preventionist confirmed there was no documented evidence that daily weights were obtained per facility policy.</p> <p>28 Pa. Code 211.12(1)(3)(5) Nursing services.</p>

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a physician supervised care in a timely manner for one of 14 sampled residents. (Resident 15)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 15 had diagnoses that included polyneuropathy, congestive heart failure, and cirrhosis of the liver. Review of the care plan revealed Resident 15 had an altered cardiovascular status related to congestive heart failure with an intervention for staff to report weight changes to the physician. Review of the clinical record revealed Resident 15 weighed 135 pounds (lbs.) on April 8, 2025, and 163.7 lbs. on May 4, 2025, a 28.7 lb. difference. On June 2, 2025, Resident 15 weighed 184.2 lbs. , a 20.5 lb. difference from the previous month. There was no documented evidence that the physician was aware of the significant weight changes.</p> <p>In a interview on July 3, 2025 at 11:42 a.m., the Administrator confirmed that the physician was unaware of the weight changes.</p> <p>28 Pa. code 211.2(d)(3) Medical director.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on group interview, and review of facility documentation, it was determined that the facility failed to provide sufficient nursing staff to meet resident needs.</p> <p>Findings include:</p> <p>During a group interview on July 2, 2025, at 10:23 a.m., seven of seven residents reported that staff typically did not respond to call bells for an extended period of time due to low staffing levels.</p> <p>Review of facility staffing documentation from June 11, 2025, through July 1, 2025, revealed that the facility failed to meet the minimum nurse aide to resident ratios on 17 of 21 days reviewed.</p> <p>Review of facility staffing documentation from June 11, 2025, through July 1, 2025, revealed that the facility failed to meet the minimum licensed practical nurse ratios on 18 of 21 days reviewed.</p> <p>Review of facility staffing documentation from June 11, 2025, through July 1, 2025, revealed that the facility failed to meet the minimum registered nurse ratio on nine of 21 days reviewed</p> <p>Review of facility staffing documentation from June 11, 2025, through July 1, 2025, revealed that the facility failed to meet the minimum the minimum direct care hours per resident on three of 21 days reviewed.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(4)(5) Nursing services.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were reviewed by the physician in a timely manner for five of five sampled residents. (Residents 15, 17, 20, 21, 32)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Pharmacy Services, last reviewed May 16, 2025, revealed that a licensed pharmacist would review the drug regimen of each resident at least once per month. The pharmacist would report any irregularities to the attending physician, the Director of Nursing, and the Medical Director. The reports would be acted upon, signed off, and addressed in the physician's progress note.</p> <p>Clinical record review of the monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 15's medications on February 28, 2025. There was no evidence that the recommendations were addressed by the physician.</p> <p>Clinical record review of the monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 17's medications on February 28, 2025, and March 28, 2025. There was no evidence that the recommendations were addressed by the physician.</p> <p>Clinical record review of the monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 20's medications in February, March, and April 2025. There was no evidence that the recommendations were addressed by the physician.</p> <p>Clinical record review of the monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 21's medications on April 29, 2025. There was no evidence that the recommendations were addressed by the physician.</p> <p>Clinical record review of the monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 32's medications in January, March, and May 2025. There was no evidence that the recommendations were addressed by the physician.</p> <p>In an interview on July 3, 2025, at 11:54 a.m., the Director of Nursing confirmed that there was no documentation regarding the specific pharmacy recommendations noted above and/or that they were acted upon in a timely manner.</p> <p>CFR 483.45 Drug Regimen Review (c)(1)(4)(ii)(iii)</p> <p>Previously cited 8/9/24</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on interview, it was determined that the facility failed to employ a qualified dietitian or clinically qualified nutrition professional to provide frequently scheduled consultations in the absence of a full-time qualified dietitian or clinically qualified nutrition professional.</p> <p>Findings include:</p> <p>In an interview on July 3, 2025, at 11:42 a.m., the Administrator confirmed that the facility did not employ a qualified dietitian or clinically qualified nutrition professional.</p> <p>CFR 483.60(a)(2) Staffing</p> <p>Previously cited 8/9/24</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>

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<p>F 0802</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>(continued on next page)</p>

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<p>F 0802</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Based on clinical record review and observation, it was determined that the facility failed to employ sufficient support personnel who were competent to carry out the functions of dietary services which included safe food preparation for all resident meals, proper sanitation of resident dishes and cookware, and proper preparation of a mechanically altered diet for one of 16 sampled residents. (Resident 17) This failure resulted in an Immediate Jeopardy situation for all residents. Findings include: Observation of the kitchen on July 1, 2025, at 10:51 a.m., revealed that the only two staff members working were a nurse aide (NA) 1 and activities aide (AA) 1. NA 1 and AA 1 were the only two staff members present in the kitchen. They were preparing resident meals, meal trays, and washing resident dishes. NA 1 and AA 1 confirmed that they have had no specialized training on food preparation, safety, or sanitation. NA 1 and AA 1 confirmed that they did not check the water temperature or sanitizer concentration of the dish machine before or during use on this date or when they worked in the kitchen. NA 1 and AA 1 confirmed that they assist with the dietary department and work in the kitchen often. There were no dietary staff in the facility to provide oversight. NA 1 confirmed that she did cook resident meals and had no training related to the preparation of therapeutic diets, mechanically altered diets, or the safe internal cooking or holding temperatures of food. Clinical record review revealed that Resident 17 had diagnoses that included dysphagia and dementia. A physician's order dated November 16, 2024, directed staff to provide the resident a mechanically altered diet. On July 1, 2025, at 12:18 p.m., Resident 17 was observed in the dining room with her meal tray. The resident's tray ticket indicated that she was to have a mechanically soft, ground diet. The resident had consumed >75 % of the meal. The pieces of cut meat on her tray were observed to be large, they were not ground or mechanically soft. In an interview, Registered Nurse (RN) 1 stated that the piece of meat were large and confirmed that the resident's tray ticket indicated she was to have a mechanical soft, ground diet. At 12:52 p.m., NA 1 stated that Resident 17 was ordered for a mechanically soft diet and the meat should have been mechanically altered in a food processor. NA 1 confirmed that she did not mechanically alter the meat in the food processor, the meat was only cut using a rocker knife. There were no competent support personnel providing oversight in the kitchen to ensure that any foods were prepared or served under safe and sanitary conditions or that they were mechanically altered to the appropriate texture before service to residents. In an interview on July 1, 2025, at 3:54 p.m., the Director of Rehabilitation services confirmed that the Resident 17's meat should have been ground which would have resembled a ground or crumbled texture. On July 1, 2025, at 4:23 p.m., the Administrator was notified that the failure to employ sufficient support personnel who were competent to carry out the functions of dietary services resulted in an Immediate Jeopardy situation at F802-L, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility presented an acceptable action plan for removal of the Immediate Jeopardy on July 1, 2025, at 9:56 p.m. The facility's action plan contained the following: 1. The dish machine was taken out of use and the three-compartment sink was used to wash dishes. Resident meals would be served on paper products starting July 2, 2025, and until the dish machine was verified to be in working order. 2. All residents were assessed for signs and symptoms of food borne illness. 3. 100 percent (%) of dietary staff was trained on testing and identifying the proper sanitizer concentration in parts per million (ppm) in the dish machine and three compartment sink, cross contamination prevention, and proper diet textures. The education included demonstration and teach back methods. Competencies were verified by the Regional Certified Dietary Manager. 100% of staff who would support the dietary department, including members of the interdisciplinary team were trained by July 2, 2025. 4. A designated supervisor, dietary manager, Infection Preventionist, and/or Administrator will observe and document sanitizer concentration testing three times per day for seven days and daily for 30 days, review and initial test strip logs every shift, perform random checks of sanitized dishware for cleanliness and residue, culinary specialist and culinary assistants positions have been posted to Indeed, Zip Recruiter, and LinkedIn, job flyers have been sent to trade schools, sign on bonus offered at \$500 with competitive wages. The Administrator will oversee the dietary department in the absence of the Certified Dietary Manager. 5. The facility determined a staffing compliment for the dietary department that included a cook and dietary aide for breakfast, lunch, and dinner meals seven days per week. The projected schedules included cook shifts from 6:00 a.m. until 6:00 p.m., dietary aide shifts from 7:00 a.m. until 7:00 p.m., with competent staff recruited as needed to complete the roster. The survey team validated that the Immediate Jeopardy was removed on July 1, 2025 at 10:58 p.m.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to serve food in a form that meets the residents needs for two of 16 sampled residents. (Resident 17 and 21)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 17 had diagnoses that included dysphagia and dementia. A physician's order dated November 16, 2024, directed staff to provide the resident a mechanically altered diet. On June 29, 2025, staff noted that the resident was shoveling food into her mouth, pocketing the food, and coughing, and became agitated with redirection. On July 1, 2025, at 12:18 p.m., Resident 17 was observed in the dining room with her meal tray. The resident's tray ticket indicated that she was to have a mechanically soft, ground diet. The resident had consumed >75 % of the meal. The pieces of cut meat on her tray were observed to be large, they were not ground or mechanically soft. In an interview, Registered Nurse (RN) 1 stated that the pieces of meat were large and confirmed that the resident's tray ticket indicated she was to have a mechanical soft, ground diet.</p> <p>At 12:52 p.m., NA 1 stated that Resident 17 was ordered for a mechanically soft diet and the meat should have been mechanically altered in a food processor. NA 1 confirmed that she did not mechanically alter the meat in the food processor, the meat was only cut using a rocker knife.</p> <p>In an interview on July 1, 2025, at 3:54 p.m., the Director of Rehabilitation services confirmed that the Resident 17's meat should have been ground which would have resembled a ground or crumbled texture.</p> <p>Clinical record review revealed that Resident 21 had diagnoses that included dysphagia, dementia, and stricture of esophagus. A physician's order dated June 24, 2024, directed staff to provide the resident with a pureed diet. Review of the care plan revealed that the resident was at nutrition risk, required a mechanically altered diet, and required supervision from staff due to eating too fast. On June 20, 2025, staff noted that the resident vomited while being fed dinner. It was noted that the resident received a regular texture meal and ate a few bites prior to vomiting.</p> <p>28 Pa code. 211.12(d)(1)(3)(5) Nursing services.</p> <p>28 Pa Code. 201.14(a) Responsibility of licensee.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, group interview, and staff interview, it was determined that the facility failed to accommodate resident preferences on the nursing unit.</p> <p>Findings include:</p> <p>Review of facility menus for the lunch meal on July 1, 2025, revealed that the meal included a dessert of apple crisp. During observation in the kitchen on July 1, 2025, at 10:51 a.m., nurse aide (NA) 1 stated that the facility did not have the ingredients to prepare apple crisp for the lunch meal. Residents were to be served applesauce as a substitute. In a group meeting on July 2, 2025, at 10:23 a.m., seven of seven residents reported they typically do not know what food was to be served with each meal.</p> <p>Clinical record review revealed that Resident 15 had diagnoses that included depression, anxiety, and protein calorie malnutrition. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident did not have cognitive impairment. In an interview on July 2, 2025, at 12:25 p.m., Resident 15 was observed with her lunch tray. The tray contained a small cup of applesauce. The resident's tray ticket indicated the meal was to include apple crisp. The resident stated that she often does not get what is on her tray ticket or the facility menu, and residents are not notified of substitutions.</p> <p>There was a lack of evidence that the facility notified residents of the substitution of apple sauce for apple crisp for the lunch meal.</p> <p>201.14(a) Responsibility of licensee</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to ensure that adaptive equipment was provided for one of two sampled residents who required adaptive equipment for meals. (Resident 12)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 12 had diagnoses that included tremor and muscle weakness. Review of the care plan revealed that the resident was at nutrition risk and required the use of red foam handles on silverware. A physician's order dated May 6, 2025, directed staff to provide red foam handles on silverware at all meals.</p> <p>On July 2, 2025, at 12:28 p.m., the resident was observed in her room with her lunch tray. The red foam handles were not in place. The resident reported that she was not provided the red foam handles at the breakfast meal that morning either.</p> <p>In an interview on July 3, 2025, at 11:44 a.m., the Director of Nursing confirmed that the resident should have been provided with the red foam handles for the silverware with her meal.</p> <p>483.60(g) Assistive devices.</p> <p>Previously cited 8/9/24</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Based on observation, review of facility documentation, and staff interview, it was determined that the facility failed to serve food under sanitary conditions in the kitchen. This failure resulted in an Immediate Jeopardy situation for all residents. Additionally, the facility failed to prepare and store food under sanitary conditions in the kitchen and dry storage areas. Findings include: Observation of the kitchen on July 1, 2025, at 10:51 a. m. revealed the following: The two staff members working were a nurse aide (NA) 1 and an activities aide (AA) 1. In an interview, NA 1 and AA 1 were the only two staff members present in the kitchen. They were preparing resident meals, meal trays, and washing resident dishes. NA 1 and AA 1 confirmed that they have had no specialized training on food preparation, safety, or sanitation. NA 1 and AA 1 confirmed that they assisted with the dietary department and worked in the kitchen often. NA 1 and AA 1 confirmed that they do not check the water temperature or sanitizer concentration of the dish machine before or during use. It was determined that the dish machine was a low temperature machine that relied on an adequate concentration of a chemical solution to sanitize the dishes during a cycle. A test run of the dish machine determined that the water temperature was below the minimum requirement of 120 degrees Fahrenheit (F), and the test strip did not indicate that any sanitizer solution had been distributed into the machine. Two subsequent cycles were observed, sanitizer test strips remained white after contact with the water, which indicated that there was no sanitizing solution distributed into the machine to sanitize the resident dishes. There were no logs available to provide evidence that staff had been monitoring the water temperature of the machine or concentration of the sanitizer solution. In an interview, NA 1 stated that she did use the three-compartment sink to wash dishes, she did not test the sanitizer concentration in the sink prior to use on this date or when she worked in the kitchen, and that she was not aware of a log where staff were to document the concentration of the sanitizer in the three-compartment sink. At 2:05 p.m., the Certified Dietary Manager stated that there was no log(s) available for staff to document the tests of the water temperature or the concentration of the sanitizer solution during a dish washing cycle. Staff were not monitoring the water temperature or sanitizer concentration regularly, and there was no evidence of the last time the machine was tested by staff and determined to be in working order. At 2:15 p.m., the dish machine was observed, a test strip again remained white after contact with the water at the completion of a cycle, which indicated no sanitizer solution was distributed to sanitize the dishes. At 2:30 p.m., the Administrator stated that an order for sanitizer solution was placed, was never fulfilled, and there was no additional sanitizer solution for the machine in the building. Review of the purchase order revealed that sanitizer solution was ordered on June 16, 2025. Review of a work order dated June 14, 2025, revealed that a service technician was onsite to service the dish machine on this date. There was no evidence that the facility monitored the machine following that service, or that the dish machine was in working order after June 14, 2025. During the tours of the kitchen at 10:51 a.m., and 12:52 p.m., the dish machine was being used for resident dishes. The handwashing sink was observed to be covered in plastic and filled with various items which included an adhesive pest trap. NA 1 and AA 1 confirmed that the handwashing sink was out of order and could not be used to wash their hands, it was the only hand washing sink available and had been out of service for an unknown amount of time, at least more than one month. NA 1 stated that staff must leave the kitchen to go to an operational sink in another area to wash their hands. Additionally, tours of the kitchen and dry storage areas on July 1, 2025, at 10:51 a.m., and 12:52 p.m., revealed the following: The spray nozzle on the hose to the dish machine was continuously leaking water. The back splash and hose had an accumulation of a black substance on the surfaces. There was a significant accumulation of wet food particles in the trap of the dish machine. During a cycle, water would spray out of the drain and trap onto the floor. There was an odor in this area of the kitchen. There was a set of measuring spoons hanging from a screw on a cord covering on the wall. There was a rolling rack that contained an accumulation of crumbs and debris, towels, hot pads, food wrap, and plastic lids. The shelf under the steam table was soiled with debris. There were metal shelves that contained various items that were unorganized and not contained which included parchment paper, spatulas, brown sugar, and rolls. There was an opened box of gluten free pasta that was stored next to an opened bag of all-purpose flour. There was an opened package of gluten free bread that was stored next to regular bread. There was only one toaster that was used for all bread types. There was an opened container of peanut butter that was not labeled with an open date. In the freezer, there were opened bags of frozen omelettes and diced carrots that had been removed from the original boxes and not dated. There was an</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Palmyra		STREET ADDRESS, CITY, STATE, ZIP CODE 341 North Railroad St Palmyra, PA 17078	

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 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>Based on observations and staff interview, it was determined that the facility failed to employ nutrition and physical therapy staff to promote the wellbeing of it's residents.</p> <p>Findings include:</p> <p>Review of clinical records revealed a lack of documentation to support that residents were being evaluated by a registered dietitian or offered physical therapy services.</p> <p>In an interview on July 3, 2025, at 11:29 a.m., the Administrator confirmed the facility did not employ a registered dietitian or physical therapist and that the services those positions provide were not being offered or provided to residents.</p> <p>28 Pa Code 201.18(e) Management.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on review of the facility's assessment, facility provided documentation, and staff interview, it was determined that the facility failed to conduct and document a facility-wide assessment, using evidence-based methods, which identified the specific resources necessary to care for it's specific resident population.</p> <p>Findings include:</p> <p>Review of the Facility Assessment, last reviewed by the facility on April 30, 2025, failed to accurately identify the specific needs and services required by the various subsets and characteristics of the resident population.</p> <p>The Facility Assessment was incomplete after page one and failed to include the resources needed, including an evaluation of the overall number of facility staff and the capabilities needed to ensure a sufficient and competent number of qualified staff are available to meet each resident's needs.</p> <p>During an interview on July 3, 2025 at 11:58 a.m., the Administrator confirmed that the Facility Assessment did not contain all of the required information.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2) Management</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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>Based on clinical record review and staff interview it was determine the facility failed to maintain clinical records that were complete and accurate for three of 11 sampled residents. (Residents 1, 9, 11)Findings include:</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included iron deficiency anemia, muscle wasting, and osteomyelitis. In an interview on August 22, 2025, at 4:05 p.m., the Administrator stated that the resident was seen by the wound consultant on August 12 and 19, 2025, and the assessments should have been scanned into the resident's clinical record. There was a lack of evidence in the resident's clinical record that the resident was seen by the wound consultant on those dates.</p> <p>Clinical record review revealed that Resident 9 had diagnoses that included Parkinson's disease. In an interview on August 22, 2025, at 4:05 p.m., the Administrator stated Resident 9 was seen by the wound consultant on August 12 and 19, 2025, and that the assessments should have been scanned into the clinical record. There was a lack of evidence in the resident's clinical record that the resident was seen by the wound consultant on those dates.</p> <p>Clinical record review revealed that Resident 11 had diagnoses that included hypertension (high blood pressure). In an interview on August 22, 2025, at 4:05 p.m., the Administrator stated Resident 11 was seen by the wound consultant on August 19, 2025, and that the assessment should have been scanned into the clinical record. There was a lack of evidence in the resident's clinical record that the resident was seen by the wound consultant on that date.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility's Quality Assurance Committee failed to meet on a quarterly basis.</p> <p>Findings include:</p> <p>Review of facility documentation revealed no evidence that the facility's Quality Assurance Committee had met since January 2025.</p> <p>In an interview on July 3, 2025, at 3:32 p.m., the Administrator confirmed that there was no evidence that the facility's Quality Assurance Committee had met quarterly prior to January 2025 or between January 2025 and June 2025.</p> <p>CFR 483.75(g) Quality assessment and assurance.</p> <p>Previously cited 8/9/24</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>