

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  03/05/2026
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to investigate falls to prevent accident hazards for three of 14 sampled residents. (Residents 3, 7, and 10) Findings include:</p> <p>Review of a facility policy entitled, Accidents and Incidents-Investigating and Recording, last reviewed November 2025, revealed that regardless of how minor and accident or injury may be, staff was to report it to the department supervisor, and an Accident or Incident Report Form was to be completed. In an interview on March 5, 2026, at 12:08 p.m., the Regional Clinical Director stated that staff were to also obtain witness statements from the resident involved, and from staff that were present during the incident or were the first to find the resident after the incident. The Regional Clinical Director stated the incident report and witness statements were used to investigate a fall to find the cause and prevent reoccurrence.</p> <p>Clinical record review revealed that Resident 3 had diagnoses that included muscle weakness and a craniotomy (temporary removal of a bone flap). The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively intact and partially dependent on staff for activities of daily living. Review of the care plan revealed Resident 3 was at risk for falls. On February 2, 2026, a nurse noted that the resident was found on the floor in her room between beds after an unwitnessed fall. On February 28, 2026, a nurse noted that Resident 3 fell again when she was about to get a shower. The nurse aide was putting on her gloves and the resident stood up from her wheelchair, stumbled and fell backwards. There was no documented evidence that staff thoroughly completed an investigation to determine the circumstances of Resident 3's falls.</p> <p>Clinical record review revealed that Resident 7 had diagnoses that included anoxic brain damage (when the brain is deprived of oxygen), respiratory failure with hypoxia (lack of oxygen in the blood), and persistent vegetative state (awake but shows no signs of awareness of themselves or their environment), and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). The MDS assessment dated [DATE], indicated that the resident was cognitively impaired and dependent on staff for bed mobility. Review of the care plan revealed Resident 7 was at risk for falls. On November 7, 2025, a nurse noted that the resident was found with his head on the floor and feet still on the bed in his room after an unwitnessed fall. There was no documented evidence that staff thoroughly completed an investigation to determine the circumstances of Resident 7's fall.</p> <p>Clinical record review revealed that Resident 10 had diagnoses that included cerebral infarction (stroke), anxiety, and seizures. The MDS assessment dated [DATE], indicated that the resident was dependent on staff for toileting and dressing. Review of the care plan revealed Resident 10 was at (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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>risk for falls. On February 9, 2026, a nurse noted that the resident was found on the floor near the bathroom door. There was no documented evidence that staff completed an investigation to determine the circumstances of Resident 10's fall.</p> <p>In interviews on March 5, 2026, at 9:10 a.m., and 12:55 p.m., the Regional Clinical Director confirmed that there was no documented evidence that there was any investigation for the fall documented for Resident 10, the investigations for Residents 3's and 7's falls were incomplete, and that there should have been full, completed investigations for the previously mentioned residents.</p> <p>CFR 483.25(d)(2) Free of Accident/Hazards/Supervision Previously cited 7/3/25</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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 facility policy review, resident group interviews, and a review of facility resident council meeting minutes, it was determined that the facility failed to address grievances voiced by the resident group. Findings include: Review of a facility policy entitled, Grievance Policy, dated November 2025, revealed that grievances may include formal, written grievance process or a resident's verbalized complaint to facility staff. The facility was to acknowledge complaints/grievances and actively work toward resolution of the complaint/grievance. During a confidential group interview conducted on March 4, 2026, at 10:40 a.m., four of four residents reported that there were not enough chairs in the facility for visitors and two of four residents stated they were missing laundry. Review of resident council meeting minutes dated February 17, 2026, revealed that the residents reported not enough chairs around the building for their loved ones to sit when they visited and two residents reported missing laundry. There was a lack of evidence that the facility had addressed the residents' ongoing concerns of not enough chairs around the building and missing laundry. CFR 483.10(f)(5)(i)-(iv)(A)(B) Resident/Family Group and Response Previously cited 7/3/25 28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to establish clear advance directives for one of 14 sampled residents. (Resident 4) Findings Include: Review of the facility policy entitled, Advance Directives, dated [DATE], revealed that all residents shall be presumed as having consented to cardiopulmonary resuscitation (CPR) unless there is documentation in the medical record that the resident has specified that a do not resuscitate (DNR) order be written. An advance directive must be accompanied by a physician's order documented in the resident's medical record. Clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that included pressure ulcer of the left buttock, severe protein-calorie malnutrition, and schizophrenia. A review of Resident 4's care plan revealed that the resident had a presumed advance directive that CPR would be performed as needed. On [DATE], a Pennsylvania Orders for Life-Sustaining Treatment (POLST, a form directing medical staff to complete life-sustaining treatment or allow a natural death), indicated that in the event the resident has no pulse and is not breathing do not attempt resuscitation (allow natural death). A review of Resident 4's current physician orders revealed no documented evidence of a physician order addressing Resident 4's advance directive of DNR. The facility failed to ensure that a physician's order reflected the resident's elected DNR status as documented on the POLST. In an interview on [DATE], at 10:09 a.m., the Regional Clinical Director confirmed there was no physician's order for Resident 4's advance directive of DNR and that the care plan and POLST were inconsistent. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.10(c) Resident care policies</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on facility policy review, clinical record review, observation, and staff interview, it was determined the facility failed to assess a resident for a physical restraint and conduct an ongoing assessment of a restraint for one of 14 sampled residents. (Resident 10) Findings include: Review of the facility policy entitled Restraints, last reviewed November 2025, revealed that physical restraints were defined as any device, material, or equipment attached to or adjacent to the resident's body that the resident cannot easily remove which restricts access to one's body. The policy further stated that restraint use would be assessed on admission and readmission, and at least quarterly for elimination, reduction or continued need. Clinical record review revealed that Resident 10 had diagnoses that included cerebral infarction (stroke) and hemiplegia (paralysis on one side). Observations on March 3, 2026, at 10:50 a.m. and 12:39 p.m., and March 4, 2026, at 9:46 a.m. and 10:35 a.m., revealed Resident 10 was in bed with an abdominal binder (wide elastic compression belt that restricts access to a person's stomach area) in place. Observations on March 4, 2026, at 11:52 a.m., revealed Resident 10 in his wheelchair wearing an abdominal binder. In an interview on March 5, 2026, at 9:06 a.m., the Regional Clinical Director stated it was unknown if Resident 10 could remove the abdominal binder without assistance. There was no documented evidence that the facility did an initial restraint evaluation and continued restraint assessments to determine if the restraint was needed per facility policy. 28 Pa. Code 201.12(d)(1) Nursing services. 28 Pa. Code 211.8(e)(f) Use of restraints.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate an injury of unknown origin for one of 14 sampled residents. (Resident 7) Findings include: Review of the facility policy entitled, Abuse Reporting and Investigation, dated November 2025, revealed that injuries of unknown origin were investigated to rule out potential abuse. Clinical record review revealed that Resident 7 had diagnoses that included anoxic brain damage (when the brain is deprived of oxygen), respiratory failure with hypoxia (lack of oxygen in the blood), and persistent vegetative state (awake but shows no signs of awareness of themselves or their environment), and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and needed staff assistance for bed mobility. On January 29, 2026, a nurse noted that the resident had an abrasion on the left knee that measured 2.3 centimeters (cm) long by 1.3 cm wide and that the origin of the wound was unknown. There was no documented evidence that the facility completed an investigation of Resident 7's injury of unknown origin to rule out potential abuse. In an interview on March 5, 2026, at 12:53p.m., the Regional Clinical Director confirmed that there was no documented evidence that an investigation was completed to rule out potential abuse for the injury of unknown origin. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and staff interview, it was determined that the facility failed to implement physicians' orders for two of 14 sampled residents. (Residents 7, 37) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included anoxic brain damage (when the brain is deprived of oxygen), respiratory failure with hypoxia (lack of oxygen in the blood), and persistent vegetative state (awake but shows no signs of awareness of themselves or their environment), and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively impaired and dependent on staff for dressing. On January 13, 2026, the physician ordered for staff to apply Derma Savers (skin protectors) to the right hand and right leg as tolerated. Observations on March 3, 2026, between 10:00 a.m. and 11:30 a.m., revealed that Resident 7 was in a reclining chair without the Derma Savers on his right hand or right leg. Multiple observations on March 4, 2026, between 9:30 a.m. and 12:30 p.m., revealed Resident 7 in bed, without the Derma Savers on his right hand or right lower extremity. Clinical record review revealed that Resident 37 had diagnoses that included diabetes mellitus, congestive heart failure, and major depressive disorder. Review of the care plan revealed Resident 37 had congestive heart failure with an intervention for staff to report changes to the provider as necessary. A physician's order dated August 13, 2025, directed staff to weigh the resident daily and to call the cardiologist (doctor who specializes in heart disease) if the resident gained over 2 pounds (lbs.) overnight and 5 lbs. in one week. Review of the clinical record revealed Resident 37 weighed 196.8 lbs. on February 14, 2026, and 199.4 lbs. on February 15, 2026, a 2.6 lb. weight gain. On February 24, 2026, Resident 37 weighed 193.8 lbs., on February 25, 2026, the resident weighed 198 lbs., a weight gain of 4.2 lbs. On February 23, 2026, Resident 37 weighed 196.2 lbs., on March 2, 2026, the resident weighed 202.4 lbs., a weight gain of 6.2 lbs. There was no documented evidence that staff weighed Resident 37 as ordered on February 28 or March 1, 2026. There was no documented evidence that the cardiologist was notified of the weight changes. In an interview on March 5, 2026, at 9:45 a.m., the Regional Clinical Director confirmed that there was no documented evidence that the Derma Savers were applied to Resident 7's right hand or right leg as ordered, that Resident 37 was weighed daily as ordered, and that the cardiologist was aware of Resident 37's weight changes. CFR 483.25 Quality of Care Previously cited 7/3/25, 2/4/26 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for one of one sampled residents with limited range of motion (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). (Resident 7) Findings include: Clinical record review revealed that Resident 7 had diagnoses that included anoxic brain damage (when the brain is deprived of oxygen), respiratory failure with hypoxia (lack of oxygen in the blood), and persistent vegetative state (awake but shows no signs of awareness of themselves or their environment), and contractures. The Minimum Data Set assessment (a periodic evaluation of resident care needs) dated December 6, 2025, indicated that the resident had limitations in range of motion (ROM) on both sides of both upper and lower extremities (arms and legs). A review of the care plan revealed that the resident required assistance with activities of daily living (ADLs), with an intervention for staff to provide assistance as required for completion of ADL tasks, such as personal hygiene, transferring, and bed mobility. Review of the occupational therapy discharge summary from January 16, 2026, revealed that Resident 7 should utilize orthotics (using a supportive device on a body part to improve positioning, support function, or prevent worsening of a condition) to maintain ROM and skin integrity (condition of the skin being intact, healthy, and free from injury or breakdown). On January 13, 2026, the physician ordered that staff apply a Posey Soft elbow extension splint (non-rigid supportive device to prevent joint contracture) as tolerated and to alternate upper arm use during daytime hours. Observations on March 3, 2026, between 10:05 a.m. and 1:30 p.m., and March 4, 2026, between 9:00 a.m. and 12:30 p.m., revealed that Resident 7 was without the Posey Soft elbow extension splint. A review of the clinical record revealed no documented evidence that the Posey Soft elbow extension splint was implemented as ordered. On March 4, 2026, the Director of Occupational Therapy (OT) documented that Resident 7 had not been wearing the Posey Soft elbow extension splint and staff were unable to find it. In an interview on March 5, 2026, at 9:45 a.m., the Director of OT confirmed that Resident 7's Posey Soft elbow extension splint was to be on as ordered. 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 - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, observations, and staff interview, it was determined that the facility failed to provide adequate hydration for one of 14 sampled residents. (Resident 2) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included dehydration. Review of the Minimum Data Set assessment dated [DATE], revealed Resident 2 had cognitive impairment and required moderate assistance with eating. Review of the current care plan revealed Resident 2 was at risk for dehydration with an intervention for staff to keep water available at bedside at all times. On March 3, 2026, Resident 2 was observed in her room and found to have no fluids at 10:53 a.m. and on March 4, 2026, at 9:30 a.m., 10:45 a.m., 11:51 a.m., and 12:30 p.m. In an interview on March 5, 2026, at 10:00 a.m., the Regional Clinical Director confirmed that Resident 2 was to have water at their bedside per care plan. CFR 483.25(g)(2) Sufficient fluid intake to maintain proper hydration Previously cited 7/3/25 28 Pa. Code 211.12(d)(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 35) Findings include: Clinical record review revealed that Resident 35 had diagnoses that included iron deficiency anemia and diabetes. Review of an appointment consult summary dated January 13, 2026, revealed the consultant doctor recommended the resident take epoetin alfa (a medication that helps produce red blood cells) once every seven days. There was no documented evidence that this recommendation was reviewed with the physician until March 4, 2026. In a interview on March 5, 2026 at 9:15 a.m., the Regional Clinical Director confirmed that the recommendation was not reviewed with the physician in a timely manner. CFR 483.30(a) Physician Supervision. Previously cited 7/3/2528 Pa. code 211.2(d)(3) Medical director.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure that medications/biologicals were securely stored per facility policy in a medication cart on one of one nursing units. Findings include:Review of the facility policy entitled, Medication Administration, last reviewed November 2025, revealed medications were to be administered at the time they are prepared.Observations during the medication pass on March 4, 2026, at 8:47 a.m., revealed Registered Nurse (RN) 1 retrieving medication cups with labels in black marker from her cart. In an interview at that time, RN 1 confirmed she had pre-poured the medications into medication cups. 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 - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on facility documentation review and staff interview, it was determined that the facility failed to ensure that all required staff persons were in attendance at quarterly Quality Assurance and Performance Improvement (QAPI) committee meetings for one of two quarters reviewed. Findings include: According to the QAPI committee minutes for February 18, 2026, the Director of Nursing and the Medical Director were not present. In an interview on March 3, 2026, at 12:10 p.m., the Regional Clinical Director confirmed there is no documented evidence that the Director of Nursing and Medical Director attended the February 18, 2026, QAPI meeting. CFR 483.75(g) Quality assessment and assurance Previously cited 7/3/2528 Pa. Code 201.18(e)(1)(2)(3) Management.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and observation, it was determined that the facility failed to provide a working call bell for one of 14 sampled residents. (Resident 10) Findings include: Clinical record review revealed that Resident 10 had diagnoses that included cerebral infarction (stroke), anxiety, and seizures. The Minimum Data Set assessment dated [DATE], indicated that the resident was dependent on staff for toileting and dressing. Review of the care plan revealed Resident 10 was at risk for falls with an intervention for staff to ensure the call light was within reach and encourage it's use. Observations on March 3, 2026 at 10:50 a.m., and 12:39 p.m., and on March 4, 2026 at 9:46 a.m., 10:35 a.m., and 11:52 a.m., revealed no call bell available. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.</p>