

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 Saxonburg Boulevard Cheswick, PA 15024	

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 Saxonburg Boulevard Cheswick, PA 15024	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, resident and staff interviews, it was determined the facility failed to keep Resident R96 free from hazards and provide the necessary monitoring and supervision for a resident with known suicidal ideation and history of a suicide attempt for one of three residents (Resident R96). This failure created an immediate jeopardy situation. Findings include: Review of facility policy Suicide Threats dated 11/24, indicated resident suicide threats must be taken seriously and immediately reported to the nurse supervisor charge nurse. A staff member must remain with the resident until the nurse supervisor/charge nurse arrives to examine the resident. The resident will be placed on 1:1 observation until the acute episode has been resolved if the resident is capable of self-injury. The resident shall remain on 1:1 monitoring until transfer from the facility for acute intervention or nursing assessment has identified the resident is no longer a safety risk. The charge nurse or designees shall immediately notify the resident's attending physician, and responsible party. Following the assessment of nursing staff will remove any items with which the resident could use to harm self which may include, but not limited to call bell cords (replace with tap bells), light and/or nurse call pull cords to be shorted to length no longer than eight inches or replace with wooden or plastic type, and remove all plastic trash liners (including bathroom). Review of facility policy Accidents and Incidents-Investigating and Reporting dated 11/24, revealed all accidents or incidents occurring on the facility premises must be investigated and reported to the administrator. Should you witness an accident or find it necessary to aid a resident post-accident you should render assistance immediately. Regardless of how minor an accident or incident, it must be reported to the nursing supervisor. Do not leave an accident victim unattended unless it is necessary to summon assistance. Review of the clinical record revealed Resident R96 was admitted to the facility on [DATE]. Review of Resident R96's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/5/25, revealed diagnoses of Depression and Adjustment Disorder with depressed mood. Review of Section D0150. Resident Mood Interview revealed the resident had felt down, depressed, or hopeless nearly every day. Review of Resident R96's progress note entered by Registered Nurse, Employee E13, dated 8/12/25, at 2:59 p.m. revealed the resident was found with a phone cord wrapped around [his/her] neck. The resident was pulling on the cord and expressed I want to kill myself. and I need help. The physician was notified, and the resident was sent to hospital for further evaluation. Review of Resident R96's progress note dated 8/12/25, at 10:13 p.m. revealed the resident returned from the hospital. Review of Residents R96 care plan dated 8/13/25, indicated the resident was a suicide risk as evidence by feelings/actions which indicate suicidal ideation. Interventions included to tie down cords beneath bed, shorten call light and call bells so it's within reach but not enough to get around [his/her] neck. Review of Resident R96's physician orders revealed every 15 minutes checks (Q15 minute checks) were ordered on 8/13/25, for one day. Review of Resident R96's clinical record failed to include evidence the resident was provided Q15 minute checks as ordered on 8/13/25. During an interview on 10/27/25, at 11:05 a.m. the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the facility failed to provide evidence documentation the physician ordered Q15 minute checks were completed as ordered. Review of Resident R96's late entry progress note dated 10/18/25, entered by Registered Nurse Supervisor, Employee E2, on 10/22/25, revealed Nurse Aide (NA), Employee E1 entered Resident R96's room to complete care, and the resident wrapped the telephone cord around [his/her] neck and expressed suicidal ideation. Resident R96 expressed wanting to die, was upset and crying. Review of Resident R96's clinical record failed to include a physical assessment that was completed or Q15 minute checks or a 1:1 was implemented after Resident R96 was found with a telephone cord wrapped around their neck and expressed suicidal ideation on 10/18/25. Review of Resident R96's hospital record dated 10/19/25, instructed the residents to follow up with psychiatry within one week. Review of Resident R96 physician order dated 10/20/25, stated to see psychiatry as soon as possible. Review of Resident R96 clinical record on 10/27/25, failed to include evidence the resident was seen by psychiatry as ordered. Review of information submitted by the facility on 10/22/25, revealed a nurse aide reported when they entered Resident R96's room to complete care on 10/22/25, the resident had their telephone cord wrapped around their neck and expressed suicidal ideation. All call bells and bed controls have been secured, and the facility will purchase a cordless phone for residents to use at bedside. Residents have a continued safety care plan in place. Resident has an order for Q shift behavioral checks During an observation on 10/27/25 at 10:09 a m</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 Saxonburg Boulevard Cheswick, PA 15024	
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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R96).Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R96).Findings include: Review of facility policy Suicide Threats dated 11/24, indicated resident suicide threats must be taken seriously and immediately reported to the nurse supervisor charge nurse. A staff member must remain with the resident until the nurse supervisor/charge nurse arrives to examine the resident. A behavioral health professional consult is indicated whenever the resident suggests suicide. Review of the clinical record indicated Resident R96 was admitted to the facility on [DATE]. Review of Resident R96's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/5/25, revealed diagnoses of depression and adjustment disorder with depressed mood. Section D0150. Resident Mood Interview revealed the resident had felt down, depressed, or hopeless nearly every day. Residents R96 care plan dated 8/13/25, indicated the resident was a suicide risk as evidence by feelings/actions which indicate suicidal ideation. Information the facility submitted to the Department of Health revealed on 10/18/25, Nurse Aide (NA), Employee E1 entered Resident R96's room to complete care, and the resident was attempting to wrap their telephone cord around their neck and expressing suicidal ideation. Resident R96 expressed wanting to die, was upset and crying. Review of Resident R96's October Medication Administration Record revealed the facility monitors Resident R96 for suicidal ideations. Review of documentation on 10/18/25, failed to include documentation that the resident displayed suicidal ideations. The facility documented no, the resident did not display any behavioral issues on any shift on 10/18/25. Review of Resident R96's hospital record dated 10/19/25, instructed the residents to follow up with psychiatry within one week. Review of Resident R96 physician order dated 10/20/25, stated to see psychiatry as soon as possible. Review of Resident R96 clinical record on 10/27/25, failed to include evidence the resident was seen by psychiatry as ordered. During an interview on 10/27/25, at 10:48 a.m. Registered Nurse, Employee E2 confirmed a RN failed to assess the resident immediately after suicide attempt on 10/18/25. During an interview on 10/27/25, at 11:05 a.m. the Director of Nursing stated if someone expresses suicidal ideation, a staff member should stay with the resident until someone is notified. Safety is always number one, nursing skin and pain assessment should be conducted, and the resident is monitored either 1:1 or Q15 minutes check after assessed. Psych should be consulted. During an interview on 10/27/25, at 11:08 a.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R96). 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 Saxonburg Boulevard Cheswick, PA 15024	
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 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 policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meetings (Quarter Three of 2025). Findings Include: The facility Quality Assurance/Performance Improvement policy dated 9/4/25, indicated the facility will conduct quality assurance/improvement and assessment committee meeting at least quarterly to identify areas of service that are non-complaint, or with potential for improvement. Review of Quality assurance and Performance Improvement sign in sheets and attendance records for Quarter Three of 2025, failed to reveal the Infection Preventionist, Director of Nursing, and Medical Director were in attendance. During an interview on 10/31/25, at 12:59 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meetings (Quarter three of 2025), as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.</p>		