STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on facility policy, observation and staff interview, it was determined that the facility failed to provide a safe, clean, and comfortable environment for one of three nursing unit shower rooms. (Second floor)Findings include:Review of facility policy Environmental Services, Clean, Safe and Orderly Environment dated 4/28/26, indicated the exterior and interior of the facility will be maintained in clean, safe and orderly manner. Housekeeping, Laundry and Maintenance services will provided properly with precautions taken to prevent infection and cross contamination. Observations on 5/7/26, at 1:30 p.m. revealed the second-floor shower room had 5 ceiling tiles that were brown and one ceiling tile that was brown and caving in. During an interview on 5/7/26, at 3:50 p.m. Nursing Home Administrator confirmed the second floor shower room ceiling tile and that she was not aware of its condition and unsafe environment. 28 Pa. Code 201.14(a)Responsibility of licensee28 Pa. Code 201.18(b)(1)(e)(2.1) Management

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility policy and documents, and interviews with staff, it was determined that the facility staff failed to implement policies and procedures to notify the administrator and local law enforcement in a timely manner after a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on one of three nursing units (Third Floor Nursing Unit).Findings include: Review of facility policy Abuse Protection dated 4/28/26, indicated our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Mandated staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, etc.; training is provided as time of hire, annually and as needed. The reporting and filing of accurate documents relative to incidents of abuse; reporting to State agencies as required, analyze and implement necessary changes to prevent future occurrences of abuse. Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned. Review of facility policy Accidents and Incidents dated 4/28/26, indicated all accidents and incidents occurring on our premises must be investigated and reported to the administrator. The charge nurse should conduct initial assessment and provide any emergency interventions. If necessary, call 911 (emergency services) for evaluation and possible transfer to Hospital/Medical Center. Review of facility policy Security dated 4/28/26, indicated the facility will provide security services as needed. In the absence of specific security staff, the Maintenance Department will be responsible for facility security. The following items are not permitted on facility property: all types of firearms or personal knives, dangerous chemicals, explosives, including blasting caps, any object that could be used for the purpose of injury or intimidation. Good judgment is also important for safety and health in the workplace. The following guidelines can help reduce the likelihood of problems: call your supervisor immediately regarding any unusual behavior or incident. Ask any unauthorized visitor to leave. An unauthorized visitor is anyone who does not have permission to visit the work are or who is not working in the facility at the time. All visitors must check in at the front desk. The facility doors will be locked at night after visiting hours. Call 911 if there is a serious concern for your safety or the safety of co-workers or residents. If you become aware of either a prowler or break-in, call 911. Review of the facility Emergency Preparedness Program and Plan - Workplace Violence/Active Shooter dated 4/28/26, indicated in order to preserve life and address the reality of an active shooter event, these guidelines have been established to guide our response to this event to maximize survivability. Most importantly, quickly determine the most reasonable way to protect your own life. Run if there is an accessible escape path, attempt to evacuate the premises. Call 911 when you are safe. Hide if evacuation is not possible, find a place where the active shooter is less likely to easily find you. Dial 911, if possible, to alert police to the active shooter's location. Fight, take action against the active shooter - as a last resort, and only when your life is in imminent danger. Recovery: account for all residents, staff and visitors. Review of a facility submitted document dated 5/3/26, stated, After midnight, an individual who is no longer employed by the facility brought food to her sister. A firearm was exposed in the presence of staff on the third floor and discharged . Staff immediately secured the facility until police arrived. All residents on the third floor were immediately accounted for and assessed, with no injuries identified. Law enforcement was notified and responded. Review of an undated witness statement, completed by Licensed Practical Nurse (LPN) Employee E3 stated, On 5/2/26 at 2315 (11:15 p.m.) I pulled in, 2 CNA (Certified Nurse Aide) at pillar talking and said hello to me. IDK (I didn't know) anything happened. At (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0400 (4:00 a.m.) Registered Nurse (RN) Employee E5 Came on 2, pulled Nurse Aide (NA) Employee E12 to side told her and said don't tell anyone. She then told me and NA Employee E6. Me and NA Employee E6 took a break, NA Employee E6 seen and asked RN Supervisor Employee E2 why no police called. RN Supervisor Employe E2 stated she is going to do this quietly and call Assistant Director of Nursing (ADON) and Director of Nursing (DON). RN Supervisor Employee E2 told NA Employee E6 to be supervisor and take her badge if she could do better. But she, RN Supervisor Employee E2, will be doing this quietly. Review of a witness statement dated 5/3/26, completed by RN Employee E5 stated, I was the nurse on the first floor cart. The supervisor [RN Supervisor Employee E2] informed a staff member and myself that she had a bullet slug in her hand. And told us she was told an ex-employee pulled a hand gun out in the 3rd floor dining room and accidentally discharged a gun that went into the dining room wall. RN Supervisor Employee E2 went upstairs and dug the slug from the wall. The ex-employee had left the building by this time. Review of a witness statement dated 5/3/26, completed by NA Employee E6 stated, I witnessed nothing, we heard what happened at 4:00 (a.m.) and we were upset we should of been told and police should of been called when it happened this is a serious matter. Review of a witness statement dated 5/3/26, completed by LPN Employee E7 stated, During night shift around midnight RN Supervisor Employee E2 was talking about something happened on 3rd floor. She pulled me aside and showed me a piece of metal. I said whats that. She proceeded to tell me about the aide's sister on the 3rd floor having a gun and it went off. The person had left. I asked if she dialed 911 and she said no. She said she was going to call someone. I did see hole in wall when going upstairs to use microwave. Review of a typed statement indicated, On May 3, 2026, at approximately 0920 (9:20 a.m.) the DON and Nursing Home Administrator (NHA) conducted a recorded conversation with Resident R3. Resident R3 stated that he heard a loud noise which he believed sounded like a gunshot. He reported getting out of bed into his wheelchair to investigate. Resident R3 stated that he observed an unfamiliar female individual near the elevator. He reported that the individual walked back from the elevator and, at that time, he observed what appeared to be a pistol secured at her waist. He stated that the individual then returned to the elevator and left the area. Review of a typed statement indicated, On May 3, 2026, at approximately 0927 (9:27 a.m.) the DON and NHA conducted a recorded conversation with Resident R2. Resident R2 stated that he was seated in the dining room, seated in his usual location, using his phone and watching television. He reported that his back was against the wall and that he was facing the parking lot. Resident R2 stated that he heard a loud explosion and observed smoke. He reported that he was unsure of what had occurred until staff entered the area. Resident R2 indicated that the time of the incident was approximately 12:30 a.m., which he stated he verified by the time displayed on his phone and dining room clock. Resident R2 verbalized that he does not feel scared and continues to feel safe at the facility. Review of a typed statement indicated, On May 3, 2026 at 1335 (1:35 p.m.) the DON and Registered Nurse Supervisor spoke with NA Employee E1 via phone. During this discussion, NA Employee E1 stated that she wished to exercise her right to remain silent and declined to provide a statement, indicating that doing so may incriminate her. The DON informed NA Employee E1 that she was being placed on suspension pending investigation. NA Employee E1 then activated a recording device on her phone. The DON advised that permission to record the conversation was not granted, and the conversation ended at that time. Review of a witness statement dated 5/4/26, completed by NA Employee E8 stated, I was in the med office getting my charger when I heard a loud noise. When I came out it was smoky and smelled weird. I started looking around to make sure nobody was injured after a resident said it was a gun shot and he seen someone leaving with a gun. I don't know that girls name or know her. She had on purple with braids. I'm also unsure on how she got in the building. Review of a witness statement dated 5/4/26, completed by NA Employee E9 stated, I was on 1st floor not sure what has occurred. Just know officers arrived around 6:30 a.m. - 7:00 a.m. clocked out and went home on 5/3/26. During an interview on 5/7/26, at 9:23 a.m. the NHA stated, People have always had to have a code to come in. Visitors and vendors didn't know the code, but employees (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knew the code. Agency employees usually don't know the code, but facility employees do. On Sunday, I came in, the DON came in and Maintenance came in. We disabled the previous entrance code and made a brand new one. Only myself and the Maintenance Director know what the code is. Everyone must be buzzed in now. Everyone can leave the building with a different code. The front entrance door does open when pushed in emergencies, that's the way it's designed. We have ordered visitor passes for visitors to wear while they are in the building. They already have to sign in, so the passes will have their name and date, something to identify them. NA Employee E1 is the sister. She [visitor/former employee] worked for us as an aide, she was hired in December, stopped coming to work in March. We didn't terminate her, we kept her on our roster. She may have told Human Resources she wanted to go per diem (as needed). She was not scheduled for any shifts. If you don't pick up any shifts for a month when you're per diem, you are automatically terminated. On 4/16/26 she was officially out of our system as an employee. LPN Employee E3 had no reason not to think she would be here. She had brought lunch up for her sister [NA Employee E1], she wasn't on the deployment sheet. She showed LPN Employee E3 her pistol in her purse. LPN Employee E3 said you can't have this in here, she said it's not loaded, then a gunshot went off. Then she immediately took off. NA Employee E1 was apologetic. When police arrived, no one would state who the shooter was. RN Supervisor Employee E2 is the one who notified me at 6:15 a.m. I had to direct her to call 911. The detective stated he was notified at 6:30 a.m. When I got here, first responders were already here. Two officers, a lieutenant, and the detective were here. During an interview on 5/7/26, at 12:59 p.m. LPN Employee E10 stated, If I was here and something like that happened, I would notify someone right away, check on everyone and make sure they're safe, definitely call 911. I'd let the supervisor know, then the administrator. We get annual education, including emergency preparedness. During an interview on 5/7/26, at 1:03 p.m. Resident R3 stated, I was lying in bed, I heard this noise, I knew it was a gun shot. I was like, What the hell? I jumped up in my wheelchair. I got to my doorway and I saw a lady standing at the elevator. I never saw her before. She started walking towards me and I saw her fiddling with her gun in her waistband. She walked past me and went towards the nurses station and said to someone, I'm gonna take the steps just as she said that the elevator opened. At first it didn't really bother me, the first day or so, but now every time I hear a loud noise, I get freaked out and I'm real jumpy. I got freaked out when you knocked on the door. I talked to the Social Worker yesterday and I told her about what was going on. A psychiatrist came yesterday and I talked to them. I'm on Cymbalta, I get phantom limb pain, so she upped that dose and added something for sleeping. I'm having trouble sleeping since the incident, that's new for me. All of these symptoms are new, I never felt jumpy or anxious before. It's weird because I've been around guns my whole life and been through a lot. You think you're in a safe environment and you wouldn't expect something like that, so I'm not sure if that's what's going on in my head. I pride myself in being a badass, this is different for me. During an interview on 5/7/26, at 1:20 p.m. Resident R4 stated, I heard the shot, I thought I was dreaming, it woke me up out of a silent sleep. I heard people running around so I figured something had happened. She wasn't supposed to be in the building, let alone with a gun. During an interview on 5/7/26, at 1:22 p.m. Resident R5 stated, I heard the shot. It was down at the desk, you could see a 38 mm (millimeter) in the wall. I know because I used to shoot when I was a kid. It hit the tray cart in the dining room, the metal door was dented. There were cops all over the place in the morning when I got up. Must have been about 15 officers down in that dining room. If I had been down there, I would have knocked the gun out of her hand, put her on the ground, and held her down till the cops got here. I'd put my elbow in the back of her head. I would have protected the residents here. I'll take you down there right now and show you the bullet holes. During an observation on 5/7/26, at 1:24 p.m. on the Third Floor Nursing Unit, the bullet entrance hole was observed to be patched and painted. The bullet exit hole in the Third Floor Dining Room was also observed to be patched and painted. During an interview on 5/7/26, at 1:26 p.m. Resident R2 stated, I heard a big boom, didn't realize it was a gunshot at first. I don't remember hearing anyone yelling or coming in the dining room. You're not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to have guns here, it's on the front door. I was in the dining room by myself. I think someone checked on me. In the morning I talked to the police. I still feel safe in the building. They need to beef up security. This happened around 12:30 a.m., the police didn't come until I woke up in the morning. The facility has not explained what changes have been made to prevent it from happening again, but they should. During an interview on 5/7/26, at 1:47 p.m. LPN Employee E11 stated, If something like this happened while I was here, I would notify someone right away, especially 911. We do get education on emergency preparedness, usually annually. During a telephonic interview on 5/7/26, at 3:57 p.m. RN Supervisor Employee E2 stated, I was downstairs getting oxygen tanks in the basement, I work on the 1st floor. I didn't know what had gone on. A lady who used to work there, hired and fired multiple times, she was very angry, came in and said, Do you feel safe? I said, Yeah I'm fine. She said, Do you love me? here to find out, she shot her gun at a resident. I didn't know about this until later, I found out at 2:00 a.m. because a resident told me about it, the one who was in the dining room. Another resident described the gun as about the size of your hand, he saw the gun. He said that kind is a repeating one. That was kind of scary. I found the slug on the floor and gave it to the police. The hole in the wall was about the size of your pinkie, a 50 cent piece at the exit. I was very distraught, that was too close to the patients. That girl was disgruntled. I called the DON around 4:00 a.m. People were screaming at me. The girl said she pushed on the door and said, I can come in at any time. I did notify the police when I stopped throwing up, around 4:00 a.m. I feel safer with a buzzer at the door. That girl said, I can come in any of the doors, I know all the codes, I can lean on the glass. She let herself in. Only two people were nearby. LPN Employee E3 saw the gun. The girl said, I brought my sister lunch and she did have a plate of food. It took me so long to notify the police of the incident because I was getting the facts from other patients, that one gentleman who told me the gun was the size of his hand. I was also trying to gather evidence. I found the shell casing and put that in my pocket. I wanted to hand it to the police. I showed them where the shot had gone through. During a telephonic interview on 5/7/26, at 4:13 p.m. LPN Employee E3 stated, There was a CNA that I didn't know was DNR'd (do not rehire) from the facility until she said it. I asked why, she gave some reason, I don't remember. She said, Wanna see my gun? and pulled it right out, don't know where she pulled it out of. Next thing I know she's showing it. I just stood there and didn't say much. When she went to put the clip in she said, Don't worry, it's not loaded. As I said, That's how people get killed that's when the gun went off. It happened so fast. I'm still in shock about the whole thing. I can't get past it. Other nurses are saying, I would have called the cops good for you, why didn't you? I don't care if it was four hours late. After the gun went off the girl said, I'm getting the fuck out of here hurried up and left. One of the residents saw the gun, that was Resident R3. He said he came out of his room and said, Did you do the gunshot? I wasn't saying a word to anybody. She got on the elevator and I sure as hell wasn't getting on with her. I waited and went down to the first floor and told RN Supervisor Employee E2. I told her what happened and she understood. She went to the phone, I thought she was gonna call somebody, I don't know who she called or texted. Obviously she didn't talk to the NHA or anybody. The cops never came so I was kind of wondering myself why they didn't come. She [RN Supervisor Employee E2] was well aware of it and I really thought she was calling the police after I told her. That scared the crap out of me, there was a resident sitting at the table not very far away from where the bullet came out, I'm not sure if it's still on the wall. I didn't know she was DNR'd, I worked with her a million times, she's a good aide. That's ridiculous. I know people who carry guns all the time, but not into a facility. All I heard was, Well I would have called the cops I believe in going through the chain of command, that's exactly what I did, I don't think I should be in trouble at all. I was told she lawyered up. For what? Every step she took was wrong. Getting in the building, pulling out a gun, and then discharging it. She was acting normal, not aggressive or angry. I trust my supervisor, I believe in chain of command. I think it happened around 11:30 p.m. I guess. It was a blur. I told RN Supervisor Employee E2 about 15 minutes after it happened. I'm not sure how that girl got in the building. During an interview on 5/8/26, at 5:19 p.m. the NHA and DON confirmed that the facility staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failed to implement policies and procedures to notify the administrator and local law enforcement in a timely manner after a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on one of three nursing units (Third Floor Nursing Unit). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to follow a physician order for one of four residents (Resident R1). Findings include: Review of facility policy Medication & Treatment Orders dated 4/28/26, indicated each medication administered will have a corresponding and complete physician's order. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included fracture, left femur, atrial fibrillation (irregular heart rhythm that originates in the heart's upper chambers) and malnutrition. Review of Resident R1s Medicare-5day MDS assessment (minimum data assessment)- periodic assessment of resident care needs) dated 4/27/26, indicated the diagnosis remained current. Review of Resident R1's most recent physician orders indicate Sodium Chloride Injection Solution 0.9 % (Sodium Chloride) Use 60 ml/hr intravenously every shift for AKI, hydration for 1 day, ordered on 4/28/26. Review of Resident R1's Medication Administration Record (MAR) for April indicated blank spaces 4/28/26, it was not started. During an interview on 5/7/26, at 4:15 p.m. Director of Nursing confirmed the physician order was not followed as required. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policy and documents, clinical record review, and resident and staff interviews, it was determined that the facility failed to create an environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit. This failure created an immediate jeopardy situation for all residents.Findings include: Review of facility policy Accidents and Incidents dated 4/28/26, indicated all accidents and incidents occurring on our premises must be investigated and reported to the administrator. The charge nurse should conduct initial assessment and provide any emergency interventions. If necessary, call 911 (emergency services) for evaluation and possible transfer to Hospital/Medical Center. Review of facility policy Security dated 4/28/26, indicated the facility will provide security services as needed. In the absence of specific security staff, the Maintenance Department will be responsible for facility security. The following items are not permitted on facility property: all types of firearms or personal knives, dangerous chemicals, explosives, including blasting caps, any object that could be used for the purpose of injury or intimidation. Good judgment is also important for safety and health in the workplace. The following guidelines can help reduce the likelihood of problems: call your supervisor immediately regarding any unusual behavior or incident. Ask any unauthorized visitor to leave. An unauthorized visitor is anyone who does not have permission to visit the work are or who is not working in the facility at the time. All visitors must check in at the front desk. The facility doors will be locked at night after visiting hours. Call 911 if there is a serious concern for your safety or the safety of co-workers or residents. If you become aware of either a prowler or break-in, call 911. Review of the facility Emergency Preparedness Program and Plan - Workplace Violence/Active Shooter dated 4/28/26, indicated in order to preserve life and address the reality of an active shooter event, these guidelines have been established to guide our response to this event to maximize survivability. Most importantly, quickly determine the most reasonable way to protect your own life. Run if there is an accessible escape path, attempt to evacuate the premises. Call 911 when you are safe. Hide if evacuation is not possible, find a place where the active shooter is less likely to easily find you. Dial 911, if possible, to alert police to the active shooter's location. Fight, take action against the active shooter - as a last resort, and only when your life is in imminent danger. Recovery: account for all residents, staff and visitors. Review of a facility submitted document dated 5/3/26, stated, After midnight, an individual who is no longer employed by the facility brought food to her sister. A firearm was exposed in the presence of staff on the third floor and discharged . Staff immediately secured the facility until police arrived. All residents on the third floor were immediately accounted for and assessed, with no injuries identified. Law enforcement was notified and responded. Review of an undated witness statement, completed by Licensed Practical Nurse (LPN) Employee E3 stated, On 5/2/26 at 2315 (11:15 p.m.) I pulled in, 2 CNA (Certified Nurse Aide) at pillar talking and said hello to me. IDK (I didn't know) anything happened. At 0400 (4:00 a.m.) Registered Nurse (RN) Employee E5 Came on 2, pulled Nurse Aide (NA) Employee E12 to side told her and said don't tell anyone. She then told me and NA Employee E6. Me and NA Employee E6 took a break, NA Employee E6 seen and asked RN Supervisor Employee E2 why no police called. RN Supervisor Employe E2 stated she is going to do this quietly and call Assistant Director of Nursing (ADON) and Director of Nursing (DON). RN Supervisor Employee E2 told NA Employee E6 to be supervisor and take her badge if she could do better. But she, RN Supervisor Employee E2, will be doing this quietly. Review of a witness statement dated 5/3/26, completed by RN Employee E5 stated, I was the nurse on the first floor cart. The supervisor [RN Supervisor Employee E2] informed a staff member and myself that she had a bullet slug in her hand. And told us she was told an ex-employee pulled a hand gun out in the 3rd floor dining room and accidentally discharged a gun that went into the dining room wall. RN Supervisor Employee E2 went upstairs and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 - Many	dug the slug from the wall. The ex-employee had left the building by this time. Review of a witness statement dated 5/3/26, completed by NA Employee E6 stated, I witnessed nothing, we heard what happened at 4:00 (a.m.) and we were upset we should of been told and police should of been called when it happened this is a serious matter. Review of a witness statement dated 5/3/26, completed by LPN Employee E7 stated, During night shift around midnight RN Supervisor Employee E2 was talking about something happened on 3rd floor. She pulled me aside and showed me a piece of metal. I said whats that. She proceeded to tell me about the aide's sister on the 3rd floor having a gun and it went off. The person had left. I asked if she dialed 911 and she said no. She said she was going to call someone. I did see hole in wall when going upstairs to use microwave. Review of a typed statement indicated, On May 3, 2026, at approximately 0920 (9:20 a.m.) the DON and Nursing Home Administrator (NHA) conducted a recorded conversation with Resident R3. Resident R3 stated that he heard a loud noise which he believed sounded like a gunshot. He reported getting out of bed into his wheelchair to investigate. Resident R3 stated that he observed an unfamiliar female individual near the elevator. He reported that the individual walked back from the elevator and, at that time, he observed what appeared to be a pistol secured at her waist. He stated that the individual then returned to the elevator and left the area. Review of a typed statement indicated, On May 3, 2026, at approximately 0927 (9:27 a.m.) the DON and NHA conducted a recorded conversation with Resident R2. Resident R2 stated that he was seated in the dining room, seated in his usual location, using his phone and watching television. He reported that his back was against the wall and that he was facing the parking lot. Resident R2 stated that he heard a loud explosion and observed smoke. He reported that he was unsure of what had occurred until staff entered the area. Resident R2 indicated that the time of the incident was approximately 12:30 a.m., which he stated he verified by the time displayed on his phone and dining room clock. Resident R2 verbalized that he does not feel scared and continues to feel safe at the facility. Review of a typed statement indicated, On May 3, 2026 at 1335 (1:35 p.m.) the DON and Registered Nurse Supervisor spoke with NA Employee E1 via phone. During this discussion, NA Employee E1 stated that she wished to exercise her right to remain silent and declined to provide a statement, indicating that doing so may incriminate her. The DON informed NA Employee E1 that she was being placed on suspension pending investigation. NA Employee E1 then activated a recording device on her phone. The DON advised that permission to record the conversation was not granted, and the conversation ended at that time. Review of a witness statement dated 5/4/26, completed by NA Employee E8 stated, I was in the med office getting my charger when I heard a loud noise. When I came out it was smoky and smelled weird. I started looking around to make sure nobody was injured after a resident said it was a gun shot and he seen someone leaving with a gun. I don't know that girls name or know her. She had on purple with braids. I'm also unsure on how she got in the building. Review of a witness statement dated 5/4/26, completed by NA Employee E9 stated, I was on 1st floor not sure what has occurred. Just know officers arrived around 6:30 a.m. - 7:00 a.m. clocked out and went home on 5/3/26. During an interview on 5/7/26, at 9:23 a.m. the NHA stated, People have always had to have a code to come in. Visitors and vendors didn't know the code, but employees knew the code. Agency employees usually don't know the code, but facility employees do. On Sunday, I came in, the DON came in and Maintenance came in. We disabled the previous entrance code and made a brand new one. Only myself and the Maintenance Director know what the code is. Everyone must be buzzed in now. Everyone can leave the building with a different code. The front entrance door does open when pushed in emergencies, that's the way it's designed. We have ordered visitor passes for visitors to wear while they are in the building. They already have to sign in, so the passes will have their name and date, something to identify them. NA Employee E1 is the sister. She [visitor/former employee] worked for us as an aide, she was hired in December, stopped coming to work in March. We didn't terminate her, we kept her on our roster. She may have told Human Resources she wanted to go per diem (as needed). She was not scheduled for any shifts. If you don't pick up any shifts for a month when you're per diem, you are automatically terminated. On 4/16/26 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 - Many	she was officially out of our system as an employee. LPN Employee E3 had no reason not to think she would be here. She had brought lunch up for her sister [NA Employee E1], she wasn't on the deployment sheet. She showed LPN Employee E3 her pistol in her purse. LPN Employee E3 said you can't have this in here, she said it's not loaded, then a gunshot went off. Then she immediately took off. NA Employee E1 was apologetic. When police arrived, no one would state who the shooter was. RN Supervisor Employee E2 is the one who notified me at 6:15 a.m. I had to direct her to call 911. The detective stated he was notified at 6:30 a.m. When I got here, first responders were already here. Two officers, a lieutenant, and the detective were here. During an interview on 5/7/26, at 12:59 p.m. LPN Employee E10 stated, If I was here and something like that happened, I would notify someone right away, check on everyone and make sure they're safe, definitely call 911. I'd let the supervisor know, then the administrator. We get annual education, including emergency preparedness. During an interview on 5/7/26, at 1:03 p.m. Resident R3 stated, I was lying in bed, I heard this noise, I knew it was a gun shot. I was like, What the hell? I jumped up in my wheelchair. I got to my doorway and I saw a lady standing at the elevator. I never saw her before. She started walking towards me and I saw her fiddling with her gun in her waistband. She walked past me and went towards the nurse's station and said to someone, I'm gonna take the steps just as she said that the elevator opened. At first, it didn't really bother me, the first day or so, but now every time I hear a loud noise, I get freaked out and I'm real jumpy. I got freaked out when you knocked on the door. I talked to the Social Worker yesterday and I told her about what was going on. A psychiatrist came yesterday and I talked to them. I'm on Cymbalta (a medication used to treat depression), I get phantom limb pain (the real sensation of pain in a limb or body part that has been amputated or is missing), so she upped that dose and added something for sleeping. I'm having trouble sleeping since the incident, that's new for me. All of these symptoms are new, I never felt jumpy or anxious before. It's weird because I've been around guns my whole life and been through a lot. You think you're in a safe environment and you wouldn't expect something like that, so I'm not sure if that's what's going on in my head. I pride myself in being a badass, this is different for me. During an interview on 5/7/26, at 1:20 p.m. Resident R4 stated, I heard the shot, I thought I was dreaming, it woke me up out of a silent sleep. I heard people running around so I figured something had happened. She wasn't supposed to be in the building, let alone with a gun. During an interview on 5/7/26, at 1:22 p.m. Resident R5 stated, I heard the shot. It was down at the desk, you could see a 38 mm (millimeter) in the wall. I know because I used to shoot when I was a kid. It hit the tray cart in the dining room, the metal door was dented. There were cops all over the place in the morning when I got up. Must have been about 15 officers down in that dining room. If I had been down there, I would have knocked the gun out of her hand, put her on the ground, and held her down till the cops got here. I'd put my elbow in the back of her head. I would have protected the residents here. I'll take you down there right now and show you the bullet holes. During an observation on 5/7/26, at 1:24 p.m. on the Third Floor Nursing Unit, the bullet entrance hole was observed to be patched and painted. The bullet exit hole in the Third Floor Dining Room was also observed to be patched and painted. During an interview on 5/7/26, at 1:26 p.m. Resident R2 stated, I heard a big boom, didn't realize it was a gunshot at first. I don't remember hearing anyone yelling or coming in the dining room. You're not supposed to have guns here, it's on the front door. I was in the dining room by myself. I think someone checked on me. In the morning I talked to the police. I still feel safe in the building. They need to beef up security. This happened around 12:30 a.m., the police didn't come until I woke up in the morning. The facility has not explained what changes have been made to prevent it from happening again, but they should. During an interview on 5/7/26, at 1:47 p.m. LPN Employee E11 stated, If something like this happened while I was here, I would notify someone right away, especially 911. We do get education on emergency preparedness, usually annually. During a telephonic interview on 5/7/26, at 3:57 p.m. RN Supervisor Employee E2 stated, I was downstairs getting oxygen tanks in the basement, I work on the 1st floor. I didn't know what had gone on. A lady who used to work there, hired and fired multiple times, she was very angry, came in and said, Do you (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 - Many	feel safe? I said, Yeah I'm fine. She said, Do you love me? here to find out, she shot her gun at a resident. I didn't know about this until later, I found out at 2:00 a.m. because a resident told me about it, the one who was in the dining room. Another resident described the gun as about the size of your hand, he saw the gun. He said that kind is a repeating one. That was kind of scary. I found the slug on the floor and gave it to the police. The hole in the wall was about the size of your pinkie, a 50 cent piece at the exit. I was very distraught, that was too close to the patients. That girl was disgruntled. I called the DON around 4:00 a.m. People were screaming at me. The girl said she pushed on the door and said, I can come in at any time. I did notify the police when I stopped throwing up, around 4:00 a.m. I feel safer with a buzzer at the door. That girl said, I can come in any of the doors, I know all the codes, I can lean on the glass. She let herself in. Only two people were nearby. LPN Employee E3 saw the gun. The girl said, I brought my sister lunch and she did have a plate of food. It took me so long to notify the police of the incident because I was getting the facts from other patients, that one gentleman who told me the gun was the size of his hand. I was also trying to gather evidence. I found the shell casing and put that in my pocket. I wanted to hand it to the police. I showed them where the shot had gone through. During a telephonic interview on 5/7/26, at 4:13 p.m. LPN Employee E3 stated, There was a CNA that I didn't know was DNR'd (do not rehire) from the facility until she said it. I asked why, she gave some reason, I don't remember. She said, Wanna see my gun? and pulled it right out, don't know where she pulled it out of. Next thing I know she's showing it. I just stood there and didn't say much. When she went to put the clip in she said, Don't worry, it's not loaded. As I said, That's how people get killed that's when the gun went off. It happened so fast. I'm still in shock about the whole thing. I can't get past it. Other nurses are saying, I would have called the cops good for you, why didn't you? I don't care if it was four hours late. After the gun went off the girl said, I'm getting the fuck out of here hurried up and left. One of the residents saw the gun, that was Resident R3. He said he came out of his room and said, Did you do the gunshot? I wasn't saying a word to anybody. She got on the elevator and I sure as hell wasn't getting on with her. I waited and went down to the first floor and told RN Supervisor Employee E2. I told her what happened and she understood. She went to the phone, I thought she was gonna call somebody, I don't know who she called or texted. Obviously she didn't talk to the NHA or anybody. The cops never came so I was kind of wondering myself why they didn't come. She [RN Supervisor Employee E2] was well aware of it and I really thought she was calling the police after I told her. That scared the crap out of me, there was a resident sitting at the table not very far away from where the bullet came out, I'm not sure if it's still on the wall. I didn't know she was DNR'd, I worked with her a million times, she's a good aide. That's ridiculous. I know people who carry guns all the time, but not into a facility. All I heard was, Well I would have called the cops I believe in going through the chain of command, that's exactly what I did, I don't think I should be in trouble at all. I was told she lawyered up. For what? Every step she took was wrong. Getting in the building, pulling out a gun, and then discharging it. She was acting normal, not aggressive or angry. I trust my supervisor, I believe in chain of command. I think it happened around 11:30 p.m. I guess. It was a blur. I told RN Supervisor Employee E2 about 15 minutes after it happened. I'm not sure how that girl got in the building. On 5/7/26, at 5:47 p.m., the NHA and DON were made aware that Immediate Jeopardy (IJ) was called due to the failure to create an environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit. The NHA was provided an Immediate Jeopardy template, and a corrective action plan was requested. On 5/7/26, at 8:06 p.m. an acceptable Corrective Action Plan was received which included the following interventions: The facility will create an environment free of avoidable accidents. The facility cannot retroactively correct the concern identified for the incident that occurred on 5/3/26. The DON and or designee will assess all residents for injuries, psychosocial needs and mental harm related to incident and if necessary provide needed treatment, update resident care orders and care plans. This will be completed by 5/8/26. The NHA and or designee will notify families and physicians of incidents, and this will be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 - Many	completed by 5/8/26. The NHA and Regional team will review and update the facility policy on weapons in the facility by 5/7/26. At this time, the facility investigation is unable to determine the root cause of how the visitor/former staff member entered the facility due to an open investigation with the police and we are unable to speak with this person. The NHA or designee will continue to investigate if any staff let visitor/former employee into the facility and will take action as appropriate. The facility has locked the front entrance of the facility and all visitors and staff will have to be let in by a staff member and complete screening at the front entrance prior to work or visiting. This will be implemented by 5/8/26. The NHA and or designee will educate all staff on the facility for weapons, visitation, visitor screening and active shooter policy prior to their next scheduled shift, education to be completed on 5/8/26. The NHA or designee will develop a visitor and staff screening process to prevent weapons from entering the facility. The process will include a staff member letting visitors/staff enter the facility and sign in at front desk. The sign in sheet will include asking the staff/visitor if they have any weapons, if yes, they will not be permitted to visit or work, and asked to leave the facility immediately. This will be implemented by 5/8/26. This incident as all other incidents will be reviewed at the monthly Quality Assurance and Performance Improvement Committee for review and recommendations as necessary. On 5/8/26, at 2:00 p.m. it was confirmed 112 residents were present at the facility during the incident. 112/112 residents had a skin assessment performed with no injuries noted. 113/113 residents were assessed on 5/7/26 for psychosocial needs and mental harm. One resident was identified as having mental harm related to the incident. Two additional residents were identified as potential witnesses to the incident. 3/3 resident physician orders were verified to include behavior monitoring related to discharge of firearm. 3/3 care plans were verified to include interventions related to risk for alteration in mood related to hearing/witnessing unintentional gun discharge on 5/3. Review of facility documents on 5/8/26, indicated the facility had notified all resident families of the incident on 5/3/26. The Medical Director was notified of the incident on 5/8/26. The facility's policy Security/Visitor Screening was revised on 5/7/26. The revision included the facility doors will be locked at all times, a staff member will let in visitors and staff and they will be asked to sign in at the front desk and complete screening. If the visitor or staff member possesses an item that is prohibited, they will be asked to leave the facility immediately. On 5/8/26, at 8:27 a.m. it was verified that in order to gain entrance into the facility, a doorbell must be rung at the main entrance. A staff member must enter a code before the main entrance door opens. Upon entering the facility, all visitors and staff are required to sign in at the main entrance and are screened for weapons at that time. Review of facility documents on 5/8/26, revealed the facility had 109 employees and 16 agency employees. 67 employees signed they received formal education on the policies Weapons, Visitation/Visitor Screening and Active Shooter education. 51 employees were noted as they received education via phone as they had not been working in the building. During employee interviews on 5/8/36, from 11:11 a.m. through 2:18 p.m. 24 employees confirmed they had received education on the facility's weapons, visitation/visitor screening policies and active shooter education, as stated above. The Immediate Jeopardy was lifted on 5/8/26, at 4:00 p.m. when the action plan implementation was verified. During an interview on 5/8/26, at 5:00 p.m. the NHA and DON confirmed that the facility failed to create an environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit, resulting in immediate jeopardy for all residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility by failing to create a safe environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit, which created an immediate jeopardy situation for all residents.Findings include: The job description for the Nursing Home Administrator specified the primary purpose of the job position is to manage the Facility with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities To follow all facility policies and apply them uniformly to all employees. The ensure the highest degree of quality care is provided to our residents at all times. The job description for the Director of Nursing specified the purpose of the job is to plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Based on findings identified in this report, the facility failed to create a safe environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit, placing all residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 5/7/26, at 5:47 p.m. the NHA and DON were notified that they failed to effectively manage the facility by failing to create a safe environment free of accidents when a visitor/former employee entered the facility with a loaded handgun and discharged the handgun on the Third Floor Nursing Unit, which created an immediate jeopardy situation for all residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Communication training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Communication training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Resident Rights training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Resident Rights training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Abuse, Neglect, and Exploitation training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Abuse, Neglect, and Exploitation training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide QAPI (Quality Assurance and Performance Improvement) training to four of five direct care facility staff reviewed (Employees E11, E13, E14, and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for Employees E11, E13, E14, and E16 for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide QAPI training to four of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Infection Control training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Infection Control training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Compliance and Ethics training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Compliance and Ethics training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documents, and staff interviews it was determined that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year for three out of three Nurse Aide (NA) Employees (Employee E13, E14, and E15)Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Nurse Aide (NA) Employees E13, E14, and E15. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for Employees E13, E14, and E15 for the year 2025, and confirmed that the facility failed to provide the required 12 hours of annual in-service education for three out of three Nurse Aide Employees. 28 Pa. Code 201.19(7) Personnel policies and procedures28 Pa. Code 201.20(a)(d) Staff development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395538	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Cheswick	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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Behavioral Health training to five of five direct care facility staff reviewed (Employees E11, E13, E14, E15 and E16).Findings include: During an interview on 5/8/26, at 3:33 p.m. the Nursing Home Administrator (NHA) stated that education is conducted by calendar year running January through December, and State Agency requested Employee Education records for Licensed Practical Nurse (LPN) Employee E11, Nurse Aide (NA) Employee E13, NA Employee E14, NA Employee E15, and Registered Nurse (RN) Employee E6. During an interview on 5/8/26, at 4:17 p.m. the NHA stated that the facility was unable to find any education records for the above employees for the year 2025. During an interview on 5/8/26, at 4:55 p.m. Human Resources Director Employee E17 confirmed that the facility failed to provide Behavioral Health training to five of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development