

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  11/07/2024
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 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46336</p> <p>Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of three units (Second-floor, and Third-floor).</p> <p>Findings include:</p> <p>Review of the facility policy Resident Environment dated 7/1/24, indicated the facility will provide an environment that is safe, clean, comfortable, and homelike. A homelike environment de-emphasizes the institutional character of the setting.</p> <p>Observation on 11/4/24, at 9:35 a.m. Resident R44 had two square floor tiles missing from the right side of the bed.</p> <p>Observation on 11/4/24, at 11:42 a.m. the Second-floor dining room had seven trays stacked with old dishes from breakfast on the table against the far wall. There were five residents eating their lunch at this time. One mechanical lift, and two unused wheelchairs were stored in one corner of the dining room, and two additional unused wheelchairs in the opposite corner.</p> <p>Observation on 11/4/24, at 10:42 a.m. Resident R56 had multiple divots (small holes/depressions) in the floor tiles to the right side of the bed.</p> <p>Observation on 11/4/24, at 10:54 a.m. the Third-floor dining room had four mechanical lifts, two unused wheelchairs were stored in one corner of the dining room, and two additional unused wheelchairs in the opposite corner.</p> <p>Observation on 11/4/24, at 11:42 a.m. Resident R16 was outside the doorway of the dining room in a Broda chair (specialty wheelchair that allows for mobility and positioning support) that had a dried, sticky substance on the wheels, brakes, arm rests, and frame of the wheelchair.</p> <p>Interview on 11/4/24, at 11:42 a.m. Nurse Aide (NA) Employee E1 confirmed the Broda chair had a dried, sticky substance on the wheels, brakes, arm rests, and frame of the wheelchair.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/7/24, at 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment for two of three units (Second-floor, and Third-floor).</p> <p>28 Pa. Code: 201.14 (a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18 (a)(b)(1)(3) Management.</p> <p>28 Pa. Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policies, facility documents, clinical records, and resident and staff interviews, it was determined that the facility failed to make certain residents were free from neglect for one of three residents (Resident R53).</p> <p>Findings include:</p> <p>Review of facility policy Abuse: Protection From Abuse dated 7/1/24, indicated residents have the right to be free from neglect and abuse.</p> <p>Review of the admission record indicated Resident R53 admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review of Resident R53's Minimum Data Set (MDS- a periodic assessment of care needs) dated 9/23/24, indicated the diagnoses of anxiety, depression, and high blood pressure.</p> <p>Review of Resident R53's witness statement dated 10/24/24, indicated the resident had to go to the bathroom in the middle of the night. I sat on the toilet and saw diarrhea in my brief. It was indicated she pulled the call bell, and Nurse Aide Employee E6, came and when she asked for assistance with changing her brief, NA, Employee E6 stated change it yourself and walked away.</p> <p>Review of Resident R53's roommate witness statement, dated 10/24/24, stated Resident R53 went to the bathroom around 2 a.m. When she pulled the call bell, NA, Employee E6 came to get the resident off the toilet. It was indicated she heard Resident R53 tell NA, Employee E6 that she had an accident and needed her brief changed. NA, Employee E6 flicked her hand, and said change it yourself. and walked out of the room.</p> <p>During an interview on 11/5/24, at 9:41 a.m. Resident R53 indicated she had problem with diarrhea, and she pushed the call bell for assistance. Resident R53 state a nurse aide came in and told her she was not going to help her. Resident R53 stated she was trying to make it to bathroom, but it started coming out.</p> <p>Interview with the Director of Nursing on 11/6/24, at 10:08 a.m. confirmed the facility failed to make certain residents were free from neglect for one of three residents (Resident R53).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</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** 41984</b></p> <p>Based on review of facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to initiate a thorough investigation for incident or accidents for one of six residents (Resident R70).</p> <p>Findings include:</p> <p>The facility Accident and Incident-Investigating and Reporting policy dated 7/1/24, indicated all accidents or incidents occurring on the premises must be investigated and reported to the administrator.</p> <p>Review of clinical record indicated Resident R70 was admitted [DATE], with diagnoses which included chronic atrial fibrillation (heart condition that causes the upper chambers of the heart to beat irregularly and often very fast), bipolar disorder and major depressive disorder. A review of Resident R70's Minimum Data Set (MDS-a periodic assessment of resident care needs), dated 8/7/24, indicated diagnoses remained current.</p> <p>Review of Resident R70 nurse progress notes dated 10/3/24 at 1:16 p.m. Resident R70 was found by the elevator in the basement by a nurse aide around 7:30 - 8:00 pm. She was brought back to her room. Confused could not say why she went down there. Will check alarms and monitor.</p> <p>During an interview on 11/7/24, at 8:45 a.m. Director of Nursing (ADON) confirmed the facility did not conduct a investigation on Resident R70 as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code: 211. 10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(3) Nursing services.</p>		

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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41984</p> <p>Based on review of resident records, admission documentation and staff interview, it was determined that the facility failed to maintain admission documentation for two of three residents (Resident R11, R67).</p> <p>Findings include:</p> <p>Review of Resident R11 was admitted [DATE] with diagnoses that include parkinsonism (neurodegenerative diseases that cause similar motor symptoms, such as rigidity, tremors, and slow movement), adjustment disorder with depressed mood and convulsions.</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of Resident R11 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 6/18/24 indicated the resident was assessed as having a BIMS score of 5, which indicates severe impairment.</p> <p>Review of Resident R11's clinical record revealed no admission packet.</p> <p>Review of Resident R67 was admitted [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction affect left non-dominant side, cognitive communication deficit and hypertension.</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of Resident R67 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 7/8/24 indicated the resident was assessed as having a BIMS score of 10, which indicates severe moderately impaired.</p> <p>(continued on next page)</p>		

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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R67's admission packet dated 6/28/24 indicated a no signature from POA (power of Attorney).</p> <p>During an interview with Nursing Home Administrator on 11/6/24 at 11:30 a.m. confirmed Resident R67 was cognitively impaired and should not have signed facility paperwork and R11 never had his admission paper work completed as required.</p> <p>28 Pa Code: 201.18(b)(2) Management.</p> <p>28 Pa Code: 201.24(a) Admission policy.</p> <p>28 Pa Code: 201.19(i) Residents rights.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41984</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four out of five residents sampled with facility-initiated transfer (Residents R41, R58, R69, R70).</p> <p>Findings include:</p> <p>Review of Resident R41's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with muscle weakness, high blood pressure, and insomnia (difficulty falling or staying asleep).</p> <p>Review of Resident R41's clinical record revealed that the resident was transferred to the hospital on 9/28/24, and returned to the facility on [DATE].</p> <p>Review of Resident R41's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility.</p> <p>Review of Resident R58's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with anxiety, high blood pressure, and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.)</p> <p>Review of Resident R58's clinical record revealed that the resident was transferred to the hospital on 9/23/24, and returned to the facility on [DATE].</p> <p>Review of Resident R58's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility.</p> <p>Review of Resident R69's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with lewy bodies (type of dementia that causes a decline in mental abilities over time), parkinsonism (brain conditions that cause slowed movements, rigidity stiffness and tremors)and repeated falls.</p> <p>Review of Resident R69's clinical record revealed that the resident was transferred to the hospital on 4/23/24, and returned to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R69's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility.</p> <p>Review of Resident R70's admission record indicated she was originally admitted on [DATE], with diagnoses that included bipolar, major depressive disorder and atrial fibrillation(heart condition that causes the upper chambers of the heart to beat irregularly and often very fast).</p> <p>Review of the clinical record indicated Resident R16 was transferred to hospital on 3/27/24 and returned to the facility on [DATE], also 6/29/24 returned 6/30/24.</p> <p>Review of Resident R70's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the residents specific needs at the receiving facility.</p> <p>During an interview on 11/6/24 at 2:15 p.m. the Assistant Director of Nursing (ADON) confirmed that the facility failed to provide the necessary information for Resident R41, R58, R69, R70.</p> <p>28 Pa. Code 201.29(a)(c.3)(2) Resident rights</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41984</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for four out of five residents (Residents R41, R58, R69, R70).</p> <p>Findings include:</p> <p>Review of Resident R41's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with muscle weakness, high blood pressure, and insomnia (difficulty falling or staying asleep).</p> <p>Review of Resident R41's clinical record revealed that the resident was transferred to the hospital on 9/28/24, and returned to the facility on [DATE].</p> <p>Review of Resident R41's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the transfer to hospital on 9/29/24.</p> <p>Review of Resident R58's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with anxiety, high blood pressure, and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.)</p> <p>Review of Resident R58's clinical record revealed that the resident was transferred to the hospital on 9/23/24, and returned to the facility on [DATE].</p> <p>Review of Resident R58's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of Resident R69's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with lewy bodies (type of dementia that causes a decline in mental abilities over time), parkinsonism (brain conditions that cause slowed movements, rigidity stiffness and tremors)and repeated falls.</p> <p>Review of Resident R69's clinical record revealed that the resident was transferred to the hospital on 4/23/24, and returned to the facility on [DATE].</p> <p>Review of Resident R69's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident R70's admission record indicated she was originally admitted on [DATE], with diagnoses that included bipolar, major depressive disorder and atrial fibrillation(heart condition that causes the upper chambers of the heart to beat irregularly and often very fast).</p> <p>Review of the clinical record indicated Resident R70 was transferred to hospital on 3/27/24 and returned to the facility on [DATE], also 6/29/24 returned 6/30/24.</p> <p>Review of Resident R70's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE] and 6/29/24.</p> <p>During an interview on 11/6/24 at 2:15 p.m. the Assistant Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for four out of five residents (Residents R41, R58, R69, R70).</p> <p>28 Pa. Code 201.29(a)(c.3)(2) Resident rights.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41984</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for three of five resident hospital transfers (Resident R58, R69, R70).</p> <p>Findings include:</p> <p>Review of Resident R58's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with anxiety, high blood pressure, and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.)</p> <p>Review of Resident R58's clinical record revealed that the resident was transferred to the hospital on 9/23/24, and returned to the facility on [DATE].</p> <p>Review of Resident R58's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 9/23/24.</p> <p>Review of Resident R69's admission record indicated she was originally admitted on [DATE], with diagnoses that included neurocognitive disorder with lewy bodies (type of dementia that causes a decline in mental abilities over time), parkinsonism (brain conditions that cause slowed movements, rigidity stiffness and tremors)and repeated falls.</p> <p>Review of Resident R69's clinical record revealed that the resident was transferred to the hospital on 4/23/24, and returned to the facility on [DATE].</p> <p>Review of Resident R69's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/23/24.</p> <p>Review of Resident R70's admission record indicated she was originally admitted on [DATE], with diagnoses that included bipolar, major depressive disorder and atrial fibrillation(heart condition that causes the upper chambers of the heart to beat irregularly and often very fast).</p> <p>Review of the clinical record indicated Resident R70 was transferred to hospital on 3/27/24 and returned to the facility on [DATE], also 6/29/24 returned 6/30/24.</p> <p>Review of Resident R70's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/27/24 and 6/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/6/24, at 2:15 p.m. Assistant Director of Nursing (ADON) confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for three of five resident hospital transfers as required (Resident R58, R69, R70).</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.</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  11/07/2024
NAME OF PROVIDER OR SUPPLIER  Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE  3876 Saxonburg Boulevard Cheswick, PA 15024	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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> 41984</p> <p>Based on facility policy review, clinical and facility record review, facility provided documents and staff interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in elopement (resident exited to an unsupervised and unauthorized location without staff's knowledge) for one of six residents(Resident R70).</p> <p>Findings include:</p> <p>The facility Resident Elopement policy dated 7/1/24, indicated the facility to provide a safe and secure environment for the residents and to be proactive in preventing resident elopement.</p> <p>Review of clinical record indicated Resident R70 was admitted [DATE], with diagnoses which included chronic atrial fibrillation, bipolar disorder and major depressive disorder. A review of Resident R70's Minimum Data Set (MDS-a periodic assessment of resident care needs), dated 8/7/24, indicated diagnoses remained current.</p> <p>Review of Resident R70 nurse progress notes dated 10/3/24 at 1:16 p.m. Resident R70 was found by the elevator in the basement by a nurse aide around 7:30 - 8:00 pm. She was brought back to her room. Confused could not say why she went down there. Will check alarms and monitor.</p> <p>During an interview on 11/7/24, at 8:45 a.m. Director of Nursing (ADON) confirmed the facility did not provide adequate supervision for Resident R70 as required.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 201.29(a)(b)(c)(l)(n) Resident rights.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen equipment and management for three of four residents (Residents R33, R44 and R87).</p> <p>Findings include:</p> <p>Review of the facility policy Oxygen Administration dated 7/1/24, indicated oxygen therapy will be ordered as appropriate using nasal cannula (thin flexible tube that goes around the head and into the nose). Change pre-filled humidification systems at least weekly, along with oxygen tubing.</p> <p>Review of the admission record indicated Resident R33 admitted to the facility on [DATE].</p> <p>Review of Resident R33's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/2/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and depression.</p> <p>Review of Resident R33's current physician orders indicated oxygen at 2 lpm (liters per minute). Change oxygen concentrator filter and oxygen tubing weekly on Wednesday night every week.</p> <p>Observation on 11/4/24, at 10:41 a.m. Resident R33 was in bed with oxygen cannula connected to oxygen concentrator. Concentrator filters were covered with a gray/white fuzzy substance on each side of the concentrator.</p> <p>Interview 11/4/24, at 10:45 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed oxygen concentrator filters were covered with a gray/white fuzzy substance on each side of the concentrator.</p> <p>Review of the admission record indicated Resident R44 admitted to the facility on [DATE].</p> <p>Review of Resident R44's MDS dated [DATE], indicated the diagnoses of anemia, Multiple Sclerosis (immune system eats away at protective covering of nerve cells), and high blood pressure.</p> <p>Review of Resident R44's current physician orders indicated oxygen at 2 lpm. Change oxygen concentrator filter and oxygen tubing weekly on Wednesday night every week.</p> <p>Observation on 11/4/24, at 12:55 p.m. Resident R44 was in bed with oxygen cannula connected to oxygen concentrator.</p> <p>Concentrator filters were covered with a gray/white fuzzy substance on each side of the concentrator.</p> <p>Interview on 11/4/24, at 12:59 p.m. LPN Employee E5 confirmed oxygen concentrator filters were covered with a gray/white fuzzy substance on each side of the concentrator.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission record indicated Resident R87 admitted to the facility on [DATE].</p> <p>Review of Resident R87's MDS dated [DATE], indicated the diagnoses of Non-Alzheimer ' s Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), high blood pressure, and anxiety.</p> <p>Review of Resident R87's current physician orders indicated oxygen at 3 lpm. Change oxygen concentrator filter and oxygen tubing weekly on Wednesday night every week.</p> <p>Observation on 11/4/24, at 9:40 a.m. Resident R87 was in bed with oxygen cannula connected to oxygen concentrator. Oxygen tubing was dated 10/24/24.</p> <p>Interview on 11/4/24, at 9:45 a.m. LPN Employee E5 confirmed oxygen tubing was outdated and was not changed weekly on Wednesday as ordered.</p> <p>Interview on 11/7/24, at 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide appropriate respiratory care related to oxygen equipment and management for three of four residents (Residents R33, R44 and R87).</p> <p>28 Pa. Code: 201.14 (a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18 (a)(b)(1)(3) Management.</p> <p>28 Pa. Code: 201.20(a)(b)(c)(d) Staff development.</p> <p>28 Pa. Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for five of five residents (Resident R41, R43, R44, R59, and R77).</p> <p>Findings include:</p> <p>Review of facility policy Trauma Informed Care dated 7/1/24, indicated the facility will provide individualized and personalized care to the residents. Upon admission, screening for trauma will occur by the social worker. This information will be provided to the interdisciplinary team as needed, for care, treatment, and diagnosis. When information about past trauma becomes available the interdisciplinary team will incorporate this information into the resident's care.</p> <p>Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review of the facility's Social Service History assessment dated [DATE], failed to assess and identify triggers that may be stressors or prompt recall of a previous traumatic event.</p> <p>Review of Resident R41's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/5/24, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), insomnia (difficulty falling and staying asleep, and anxiety).</p> <p>Review of Resident R41's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>Review of the clinical record indicated Resident R43 was admitted to the facility on [DATE].</p> <p>Review of the facility's Social Service History assessment dated [DATE], failed to assess and identify triggers that may be stressors or prompt recall of a previous traumatic event.</p> <p>Review of Resident R43's MDS dated [DATE], indicated diagnoses of PTSD, depression, and muscle weakness.</p> <p>Review of Resident R43's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>Review of the clinical record indicated Resident R44 was admitted to the facility 12/23/21.</p> <p>Review of Resident R44's MDS dated [DATE], indicated diagnoses of PTSD, anemia, Multiple Sclerosis (immune system eats away at protective covering of nerve cells), and high blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R44's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>Review of the clinical record indicated Resident R59 was admitted to the facility 4/27/20, and readmitted [DATE].</p> <p>Review of facility's Social Service History assessment dated [DATE], indicated that resident had a history of PTSD.</p> <p>Review of Resident R59's MDS dated [DATE], indicated diagnoses of PTSD, depression, and personality disorder.</p> <p>Review of Resident R59's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE].</p> <p>Review of the facility's Social Service History assessment dated [DATE], indicated the resident had a history of substance abuse, physical abuse, and sexual abuse.</p> <p>Review of Resident R77's MDS dated [DATE], indicated diagnoses of PTSD, depression, and anxiety.</p> <p>Review of Resident R77's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them.</p> <p>During an interview on 11/5/24, at 12:34 p.m. the Social Service Director, Employee E2 indicated residents are assessed for trauma upon admission and triggers are identified. It was indicated if residents were abused, then the resident's triggers are included in the care plan.</p> <p>During an interview on 11/6/24, at 10:40 a.m. Social Service Director Employee E2 confirmed that the facility failed to identify PTSD triggers in order to eliminate or mitigate any triggers that may cause re-traumatization for five of five residents (Resident R41, R43, R44, R59, and R77).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on observations, and staff interview it was determined that the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to provide care for a resident requiring subcutaneous injections (insertion of medication beneath the skin) which led to an emergency room visit for one of seven residents (Resident 48).</p> <p>Findings include:</p> <p>Review of the facility's current Licensed Practical Nurse (LPN) Job Description indicated Drug Administration Function: Ensure that an adequate supply of floor stock medications, supplies, and equipment is on hand to meet the nursing needs of residents. Safety and Sanitation: Ensure that all personnel performing tasks that involve potential exposure to blood or body fluids participate in appropriate in-service training programs prior to performing such tasks. Equipment and Supply Functions: Participate in the development and implementation of the procedure for the safe operation of all nursing service equipment.</p> <p>Review of the admission record indicated Resident R48 admitted to the facility on [DATE].</p> <p>Review of Resident R48's Minimum Data Set (MDS) dated [DATE], indicated the diagnosis of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), schizophrenia (delusions and hallucinations that blur the line between what is real and what isn't), and anxiety.</p> <p>Review of Resident R48's physician order dated 9/3/24, indicated Lantus (long-acting insulin) inject 80 units subcutaneously two times a day.</p> <p>Review of Resident R48's current care plan indicated diabetes medication as ordered by doctor. Monitor and document for side effects and effectiveness.</p> <p>Review of Resident R48's progress note dated 10/5/24, at 12:43 p.m. Resident was getting her insulin coverage for a glucose of 305 and the needle became dislodged into her abdomen. The physician was called and ordered Resident R48 to be sent out to emergency room . Report given to Emergency Medical Services (EMS) and the emergency room .</p> <p>Review of Resident R48's progress note dated 10/5/24, at 6:03 p.m. indicated resident returned from hospital at 6:00 p.m. No new orders. Resident was x-rayed at the hospital and no needle was found. Needle syringe was further investigated after resident departed facility to emergency room it was found to have been a syringe with a retractable needle (after the administration of the syringe contents, the hypodermic needle retracts to the inside of the barrel of the syringe).</p> <p>Interview on 11/5/24, at 11:27 a.m. LPN Employee E7 indicated It was a new needle system. We weren't trained on it. They were getting new needles, three different types of needles. They appeared the same as the old needles, but the needle disappeared, and I was worried, so I sent her out to the emergency room .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/5/24, at 11:00 a.m. the Nursing Home Administrator confirmed that the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to provide care for a resident requiring subcutaneous injections which lead to an emergency room visit for one of seven residents (Resident 48).</p> <p>28 Pa. Code: 201.14 (a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18 (a)(b)(1)(3) Management.</p> <p>28 Pa. Code: 201.20(a)(b)(c)(d) Staff development.</p> <p>28 Pa. Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>46337</p> <p>Based on clinical record review and staff interviews it was determined the facility failed to report abnormal lab results to the ordering physician timely for one of three residents reviewed. (Resident R58)</p> <p>Findings Include:</p> <p>Review of the facility Notification of Condition Change: Physician policy dated 7/1/24, revealed a change in a resident's condition will be reported to the physician in a timely manner, including abnormal lab values.</p> <p>Review of Resident 58's Physician orders revealed an order dated 11/3/24, for a urine culture (test of urine to determine if there is a Urinary Tract Infection).</p> <p>Review of Resident 58's Laboratory report for the urinalysis revealed the report was final and was reported on 11/4/24. The results had abnormal lab values.</p> <p>Interview with Infection Preventionist, Employee E8 on 11/6/24, at 9:50 a.m. indicated lab results are signed off after it is reviewed by a physician. It was indicated notification to the physician, lab results, and any new orders are documented in the resident's clinical record.</p> <p>Review of Resident R58's clinical record on 11/6/24, at 1:30 p.m. failed to include evidence Resident R58's physician was notified of the abnormal lab results.</p> <p>Interview with the Nursing Home Administrator on 11/6/24, at 1:34 p.m. confirmed the facility failed to report abnormal lab results to the ordering physician timely for one of three residents reviewed. (Resident R58).</p> <p>28 Pa. Code 211.12(c)(d) (1)(3)(5) Nursing services.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on facility policy, observations, and staff interviews it was determined that the facility failed to provide adaptive feeding devices for one of four residents (Resident R11).</p> <p>Findings include:</p> <p>Review of the facility policy Adaptive Eating Devices dated 7/1/24, indicated adaptive eating devices are pieces of equipment used by patients to enable them to achieve or maintain their highest level of eating independence. It was indicated the director of dining ensures that the patient meal identification states in the alert field the specific adaptive device needed or another system is in place.</p> <p>Review of the admission record indicated Resident R11 admitted to the facility on [DATE].</p> <p>Review Resident R11's active physician order dated 6/11/24, indicated the resident is to have weighted utensils and divided plate.</p> <p>Review of Resident R11's MDS dated [DATE], indicated the diagnoses of high blood pressure, Parkinson's Disorder (a movement disorder of the nervous system that worsens over time), and dysphagia (difficulty swallowing).</p> <p>During an observation on 11/4/24, at 12:04 p.m. Resident R11's lunch tray failed to include weighted utensils and a divided plate.</p> <p>During an interview on 11/4/24, at 12:05 p.m. Nurse Aide, Employee E9 confirmed Resident R11 failed to have weighted utensils and a divided plate served with his meal.</p> <p>During an observation and interview on 11/6/24,, Food Service Director, Employee E10 confirmed Resident R11's meal tray or ticket did not have weighted utensils and a divided plate. Food Service Director, Employee E10 confirmed the facility failed to provide adaptive feeding devices for one of four residents (Resident R11).</p> <p>28 Pa Code: 211.6(a) Dietary service.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45577</p> <p>Based on a review of policy, observation and staff interview, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.</p> <p>Findings include:</p> <p>A review of facility policy Sanitation dated 7/1/24, indicated the food service area shall be maintained in a clean and sanitary manner. All equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas.</p> <p>During an observation on 11/4/24, at 9:50 a.m., of the walk-in cooler in the main kitchen, conducted with Food Service Director (FSD) Employee E3, revealed that the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris. FSD Employee E3 confirmed observation by surveyor when viewed.</p> <p>During an interview on 11/4/24, at 9:55 a.m., FSD Employee E3 confirmed that the facility failed to properly maintain kitchen equipment, walk-in cooler, in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services (supportive services for end stage terminal illness) with facility services to meet the needs of each resident for end-of-life care for three of three residents (Resident R18, R38, and R76).</p> <p>Findings include:</p> <p>Review of the facility policy Hospice Care dated 7/1/24, indicated all hospice assessments, plan of care, progress notes and services provided will be maintained on the medical record and integrated with the facility plan of care. Nursing staff will ensure there is a current physician's order, physician progress note regarding Hospice care, Hospice documentation is current and available on the medical record.</p> <p>Review of the admission record indicated Resident R18 admitted to the facility on [DATE].</p> <p>Review of Resident R18's MDS, dated [DATE], indicated the diagnoses of Parkinson's Disease ( a movement disorder of the nervous system that worsens over time), high blood pressure, and Alzheimer's Disease (a brain disorder that gets worse over time, causing a gradual decline in memory, thinking, behavior and social skills). Section O0110 K1. indicated hospice care received while a resident.</p> <p>Review of Resident R18's current physician orders indicated admit to an outside vendor's Hospice Services on 5/22/24. The order failed to include the diagnoses qualifying the resident for Hospice Services.</p> <p>Review of Resident R18's current care plan indicated to obtain physician order and appropriate referral and notify Hospice of any change in condition or medication changes. The care plan failed to identify contact information on how to contact the Hospice Service for Resident R18.</p> <p>Review of the admission record indicated Resident R38 admitted to the facility on [DATE].</p> <p>Review of Resident R38's MDS, dated [DATE], indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), high blood pressure, and atrial fibrillation (irregular heart rhythm). Section O0110 K1. indicated hospice care received while a resident.</p> <p>Review of Resident R38's current physician orders indicated admit to an outside vendor's Hospice Services on 9/14/21. The order failed to include the diagnoses qualifying the resident for Hospice Services.</p> <p>(continued on next page)</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  11/07/2024
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 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R38's current care plan indicated to obtain physician order and appropriate referral and notify Hospice of any change in condition or medication changes. The care plan failed to identify contact information on how to contact the Hospice Service for Resident R38.</p> <p>Review of the admission record indicated Resident R76 admitted to the facility on [DATE].</p> <p>Review of Resident R76's MDS, dated [DATE], indicated the diagnoses of Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), high blood pressure, and depression. Section O0110 K1. indicated hospice care received while a resident.</p> <p>Review of Resident R76's current physician orders indicated admit to an outside vendor's Hospice Services. The order failed to include the diagnoses qualifying the resident for Hospice Services.</p> <p>Review of Resident R76's current care plan indicated to obtain physician order and appropriate referral and notify Hospice of any change in condition or medication changes. The care plan failed to identify contact information on how to contact the Hospice Service for Resident R76.</p> <p>Interview on 11/6/24, at 9:24 a.m. Social Service Director Employee E2 confirmed the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services (supportive services for end stage terminal illness) with facility services to meet the needs of each resident for end-of-life care for three of three residents (Resident R18, R38, and R76).</p> <p>28 Pa. Code: 201.14 (a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18 (a)(b)(1)(3) Management.</p> <p>28 Pa. Code: 201.20(a)(b)(c)(d) Staff development.</p> <p>28 Pa. Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.11(d)e Resident care plan.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on facility policies, clinical record review, observation, and staff interviews, it was determined the facility failed to ensure enhanced barrier precautions were ordered and implemented for four of four residents (Resident R26, R41, R44, and R65).</p> <p>Findings include:</p> <p>Review of facility policy Enhanced Barrier Precautions dated 7/1/24, indicated enhanced barrier precautions require the use of gown and gloves only for high-contact resident care activities. High contact resident care activities include device care or use of urinary catheter. It was indicated an enhanced barrier precaution sign is displayed near the entrance of the room or the facility has another system to communicate may be utilized to alert staff of the enhanced barrier precautions. PPE supplies will be available for use (gloves, gown) near the resident's room. A trash can will be placed near the exit of the resident room to dispose of gown and gloves.</p> <p>Review of Center for Disease (CDC) definition for Enhanced Barrier Precautions (EBP, a type of special isolation when providing direct care to a resident): The use of isolation gown and gloves during high-contact resident care activities including catheter and wound care.</p> <p>Review of the clinical record indicated that Resident R26 was admitted to the facility on [DATE].</p> <p>Review of Resident R26's physician order dated 3/3/22, revealed an active order for a foley catheter.</p> <p>Review of Resident R26's physician order failed to include an order for enhanced barrier precautions.</p> <p>During an observation on 11/5/24, at 10:34 a.m. no enhanced barrier isolation signage or PPE were observed outside Resident R26's door. Resident R26 was observed with a catheter.</p> <p>Review of the clinical record indicated that Resident R41 was admitted to the facility on [DATE].</p> <p>Review of Resident R41's physician order dated 7/27/24, revealed an active order for the resident's suprapubic catheter.</p> <p>Review of Resident R41's physician order failed to include an order for enhanced barrier precautions.</p> <p>During an observation on 11/4/24, at 10:23 a.m. no enhanced barrier isolation signage or PPE were observed outside Resident R41's door. Resident R41 was observed with a catheter.</p> <p>Review of the clinical record indicated that Resident R44 was admitted to the facility on [DATE].</p> <p>Review of Resident R44's physician order dated 12/29/23, revealed an active order to change the resident's suprapubic catheter as needed if it becomes dislodged.</p> <p>(continued on next page)</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  11/07/2024
NAME OF PROVIDER OR SUPPLIER  Kadima Rehabilitation & Nursing at Cheswick		STREET ADDRESS, CITY, STATE, ZIP CODE  3876 Saxonburg Boulevard Cheswick, PA 15024	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R44's physician order failed to include an order for enhanced barrier precautions.</p> <p>During an observation on 11/4/24 11:15 a.m. no enhanced barrier isolation signage or PPE were observed outside Resident R44's door. Resident R41 was observed with a catheter.</p> <p>Review of the clinical record indicated that Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's physician order dated 6/3/24, revealed an active order to provide suprapubic catheter care.</p> <p>Review of Resident R65's physician order failed to include an order for enhanced barrier precautions.</p> <p>During an observation on 11/5/24, at 9:01 a.m. no enhanced barrier isolation signage or PPE were observed outside Resident R65's door. Resident R65 was observed with a catheter.</p> <p>During an interview on 11/5/24, at 2:01 p.m. the Infection Preventionist, Employee E8 confirmed that the facility failed to ensure enhanced barrier precautions were ordered for four of four residents (Resident R26, R41, R44, and R65).</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.10 (d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.</p> <p>28 Pa. Code: 211.11(a) Resident care plan.</p>