STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395590	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Lititz	125 South Broad Street Lititz, PA 17543

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on a review of the facility's policies, clinical records review, and staff interviews, it was determined that the facility failed to ensure resident was free from neglect for one of the two residents reviewed. (Resident CL1).Findings include:A review of the facility's policy titled Abuse Reporting and Investigation, revealed ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled using technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Types of abuse include Verbal Abuse, Sexual Abuse, Physical Abuse, Involuntary Seclusion, Mental Abuse, Neglect, and Misappropriation of Resident Property.A review of the facility's policy titled Medication Administration, with a revision date of November 2024, revealed that medications are administered, as prescribed, in accordance with good nursing principles and practices and only by person legally authorized to do so to comply with Federal Laws governing Medication Administration and in order to ensure the safe, accurate and timely administration of medications.Clinical records revealed Resident CL1 had a diagnosis of as follows: Chronic Lymphocytic Leukemia (Cancer of the white blood cell), Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), and generalized anxiety. Further review revealed the resident's medical condition continues to decline. The resident was placed on Hospice care (A compassionate, team-based care approach for terminally ill patients with a focus on comfort, dignity, and quality of life) in July 2025.Clinical records revealed Resident CL1 had a fall in the facility, which resulted in a left femur (The longest and strongest bone in your body, running from the hip to the knee) fracture on November 24, 2025. The resident was sent to the hospital for evaluation, but it was determined that the resident was not a candidate for surgery, Resident CL1 was returned to the facility on November 25, 2025.A review of Resident CL1's physician's order dated November 26, 2025, revealed an order for Morphine Sulfate (A powerful opioid analgesic used to manage moderate to severe pain) oral solution 100/5 ml. Give 0. 5 ml every 2 hours for pain. An additional order was made on November 27, 2025, for lorazepam (to treat anxiety), give 1 tablet by mouth every 6 hours for terminal restlessness at 12:00 a.m., 6:00 a.m., 12 noon, and 6:00 a.m.A review of November 2025, Medication Administration Record (MAR) revealed Resident CL1 was not administered with Morphine Sulfate on November 27, 2025, at 8:00 p.m., 10:00 p.m., November 28, 2025, at 12:00 a.m., and 2:00 a.m. Additional MAR review revealed the resident was also not administered Ativan (lorazepam) on November 28, 2025, at 12:00 a.m.A review of the nursing progress notes dated November 28, 2025, at 8:16 a.m., revealed that the agency nurse, Employee E3, reported that the daughter was upset and was insisting on giving the residents' Ativan and Morphine medication. Further review of the same notes revealed Per [Employee E3's name], she/he stated she/he was uncomfortable with administering both doses together due to no signs of restlessness per assessment.A review of the facility's investigation statement from the Director of Nursing, dated November 28, 2025, revealed as follows: It was reported to me that the 3-11 nurse [nurse name] did not administer scheduled Morphine to the resident. The nurse was assigned to residents and in charge of the medication cart until 1:00 a.m. After investigating, it was discovered that the 8 pm, 10 pm, and 12 am doses were not administered.An interview with the Nursing Home Administrator conducted on December 17, 2025, at 2:00 p.m., confirmed that Resident CL1's morphine and Ativan medication orders were not followed. the NHA reported that the agency nurse was not to return to the facility.The facility failed to ensure Resident CL1 was free from neglect by intentionally not administering ordered medication to treat pain and terminal restlessness. 28 Pa. Code 201.18(e)(1) ManagementPreviously cited 7/18/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 7/18/25 28 Pa Code 211.5(f) Clinical RecordsPreviously cited 7/18/25

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to timely provide wound treatment on an identified skin impairment on a resident's ankle for one of the two residents reviewed (Resident CL2). Findings include:A review of the facility's policy titled Skin and Wound Management Policy, revised on April 3, 2025, revealed Residents identified with skin impairments will have appropriate interventions implemented to promote healing. Wound location, characteristics, and a physician's order for treatment are documented in the medical records. The same policy revealed Residents are provided with appropriate prevention and treatment to encourage integrity and healing.Clinical record review revealed Resident CL2 was admitted to the facility from the hospital on November 12, 2025, post fall and diagnosis of Rhabdomyolysis (A serious condition where damaged muscle tissue breaks down, releasing harmful substances [Myeloglobin] into the bloodstream).Hospital records review revealed Resident CL2 also had a diagnosis of left quadricep (a large group of muscles located at the front of the thigh that are essential for movement, and balance), and right peroneal nerve compression (Occurs when the peroneal nerve, which runs by the knee, gets pinched, causing pain, numbness, and weakness leading to footdrop). The resident had an order to wear a left knee brace and right extremity AFO (Ankle Foot Orthosis- a supportive device worn on the lower leg and foot to control motion, provide stability with walking).A review of the resident's admission skin assessment dated [DATE], revealed no skin impairment observed on the bilateral feet.A review of the skin care plan developed on November 13, 2025, revealed the following interventions: turning and repositioning at least every 2 hours, pressure reduction mattress, offload heels, and monitor and report any reddened areas to the physician.A review of the nursing progress notes dated November 30, 2025, at 1:40 p.m., revealed the resident was observed with a .01 cm (centimeter) circular open area on the left ankle and redness on the right ankle. The area was cleaned, and a 4 x 4 dressing was applied.Clinical records review failed to reveal that the physician was notified of the identified skin impairments on the bilateral ankle until December 3, 2025. There were no documented treatments made on the resident's bilateral ankle from December 1, 2, and 3, 2025. A review of the wound NP's (Nurse Practitioner) consult dated December 3, 2025, revealed Deep Tissue Pressure Injury (DTPI- Persistent non-blanchable deep red, maroon or purple discoloration) to the left lateral ankle measuring 0.3 x 0.6 cm. The right ankle was identified as an unstageable pressure ulcer (Obscured full-thickness skin and tissue loss) measuring 2.2 x 0.8 cm., no drainage, with 26-50% eschar (a dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound). A wound treatment to apply skin protectant wipe or spray and leave open to air was made by the wound NP. A review of the resident's Treatment Administration Record (TAR) revealed skin prep treatment to the bilateral ankle was not initiated until December 5, 2025, two days after the wound treatment order was made.An interview with the corporate nurse, Employee E2, on December 17, 2025, at 2:00 p.m., confirmed physician was not notified of the identified skin impairment on the resident's bilateral ankle on November 30, 2025. Employee E2 also confirmed treatment order made by the wound NP on December 3, 2025, was not initiated until December 5, 2025.The facility failed to ensure Resident CL2's identified wound impairment to both ankles was timely followed up and communicated with the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 7/18/2528 Pa Code 211.5(f) Clinical RecordsPreviously cited 7/18/25