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	01/23/2026

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 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. Based on a review of the facility's policy, clinical records, hospital records review, and staff interview, it was determined that the facility failed to appropriately monitor and address the bowel movement of one of two residents reviewed (Resident R1).Findings include: A review of the facility's policy titled Bowel Protocol, revised on November 1, 2024, revealed that residents' bowel movements will be monitored daily by the 11-7 nursing supervisor. Residents who have not had a bowel movement for 2 days are identified and considered to be at risk for constipation. Residents will continue to be monitored by nursing for bowel movements following each step: Step one, for residents who have not had a bowel movement for 2 days: Give Prune juice 4 ounces, three doses, or two ounces of bran mixture. If prune juice was ineffective, administer Milk of Magnesia (Used as a laxative to relieve constipation) 30 ml PO in AM on day 3. Step 3: If there are no results from the MOM within 24 hours of administration, administer a Dulcolax Suppository (Provides fast relief for occasional constipation by stimulating bowel muscles, and are inserted rectally for localized action) rectally at bedtime on day 4. Step 4: If there are no results from the Dulcolax suppository after 12 hours (morning day 5, administer a Fleets enema (Involves inserting liquid into the rectum to clear the lower bowel for treating constipation) rectally. Step 5: If no results from enema, identification of pain, or absence of bowel sounds, notify RN Supervisor and physician. A review of the physician's order dated November 4, 2025, revealed the following order: Prune juice 4 ounces every 4 hours as needed for constipation. Magnesium Hydroxide Suspension gives 30 cc once daily as needed for constipation. Bisacodyl suppository 10 mg once daily as needed for constipation. Fleet enema insert 1 applicator rectally once daily as needed for constipation. A review of Resident R1's admission Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated November 11, 2025, revealed that the resident was cognitively intact. The same MDS revealed that the resident requires supervision with toilet transfers and partial/moderate assistance with toilet hygiene. Under the bowel continence section, the resident was assessed (9), indicating that the resident had an ostomy (A surgical procedure that creates an opening in the abdominal wall to divert waste out of the body) or did not have a bowel movement for the entire seven days. Resident 1's admission assessment revealed residents did not have an ostomy. A review of the facility's documents task for bowel movements (BM) revealed that Resident 1 did not have a bowel movement for four days, from November 5, 2025, until November 8, 2025. Nursing progress notes dated November 7 and 8, 2025, failed to reveal that the facility followed its BM protocol and provide an assessment which includes abdominal examination, and checking of bowel sounds, to determine constipation. A review of the nursing progress notes dated November 9, 2025, at 10:44 p.m., revealed Resident complained of nausea and diarrhea. Vitals were checked. The same note revealed unsure of how many BM (bowel movement) residents had. Nursing progress notes dated November 9, 2025, failed to reveal residents were comprehensively assessed to determine if the reported diarrhea was fecal seepage (A liquid stool passing which can result from (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER: Kadima Rehabilitation & Nursing at Lititz		STREET ADDRESS, CITY, STATE, ZIP CODE: 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	constipation) Further review of the facility's documents task for (BM) revealed that Resident 1 continued with no bowel movement for five days, from November 10, 2025, until November 14, 2025. Another five days with no BM from November 18, 2025, until November 22, 2025. There was no documented evidence that the facility had followed their BM protocol, assessed the resident's bowel status and followed the physician's order to administer medications as needed for constipation for the above dates. An interview was conducted with the Director of Nursing on January 23, 2026, at 10:00 a.m. The DON reported that an alert is sent by the EMR (electronic medical records) if a resident has not had a documented bowel movement in two days. The alert is communicated by the supervisor to the nursing staff to implement the facility's bowel protocol. The DON confirmed that there was no documented evidence that facility had followed its BM protocol for Resident 1. The facility failed to ensure Resident 1's bowel movement was appropriately monitored; resident was comprehensively assessed for presence of constipation and followed physician's medication order for constipation as needed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 7/18/25, 12/17/25 28 Pa Code 211.5(f) Clinical RecordsPreviously cited 7/18/2,12/17/25

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, hospital records, and staff interviews, it was determined that the facility failed to timely and appropriately provide behavioral services for one of two residents reviewed (Resident1).Findings include: A review of Resident 1's diagnosis list includes altered mental status, urinary tract infection (UTI- A common bacterial infection occurring anywhere in urinary system, most frequently in the bladder), depression (A mood disorder causing persistent sadness, loss of interest, and function impairment), and anxiety (A disorder that involve repeated episodes of sudden feeling of intense anxiety and fear of terror that reach a peak within minutes). A review of Resident R1's admission Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated November 11, 2025, revealed that the resident was cognitively intact. A review of the nursing progress notes dated November 18, 2025, at 1:55 p.m., revealed that the medication nurse was informed by the therapist regarding several marks on the resident's neck. The residents denied harming themselves and were unsure how the marks on the neck happened. The resident denied feeling suicidal. The resident was placed on a suicide watch, monitored every 15 minutes, and had the removal of cords and other items that can cause harm to the resident. The facility contacted the crisis intervention team. A review of the social service notes dated November 18, 2025, at 1:53 p.m., revealed Crisis Intervention came to assess the resident and found that the resident was not in a state of crisis. The resident denied harming themselves. A review of the psychiatry (A medical doctor specializing in mental health) consults dated November 18, 2025, at 2:47 p.m., revealed the resident had a linear scratch to the neck with no concerns noted. The notes indicated that the resident denied suicidal ideation, homicidal ideation, and auditory and visual hallucination. The physician recommended starting Hydroxyzine (A medication used to treat itching, anxiety, and as a sedative) 25 mg two times daily and follow up in four to six weeks / PRN (as needed) per facility request. Nursing notes dated November 18, 2025, at 6:47 p.m., revealed that the resident's son came in to visit and asked about the safety precautions in place, which were answered by the nursing supervisor. The son disclosed that during the visit, the resident admitted to using a picture frame in the room to hurt themselves. As per the son, the resident reported feeling depressed due to health issues, loss of independence, and increased confusion. A review of the social services notes dated November 19, 2025, at 9:46 a.m., revealed that the granddaughter disclosed that the resident told the son that she/he did try to kill themselves. Crisis intervention was called back and recommended to talk to the residents regarding emergency room evaluation and treatment. The same note revealed the resident denied harming themselves and declined hospitalization. A review of the nursing progress notes dated November 19, 2025, at 3:39 p.m., revealed that suicide precautions were not removed at this time. Granddaughter reported to the social worker that the resident told the son that the resident grabbed the glass from the picture frame and used it to cut their neck. An interview with the Director of Nursing (DON) conducted on January 20, 2026, at 11:00 a.m., revealed that the resident informed the son that she/he tried to hurt themselves with the glass on the picture frame. The DON also reported that slashes were observed in the resident's reading book sleeves. The picture frame was never found in the resident's room. A review of the progress notes documentation after November 18, 2025, failed to reveal that a follow-up consult was made to the behavioral health services after the resident confirmed hurting themselves with the use of the glass in the picture frame to cut their neck, despite the psychiatrist's recommendation to follow up as needed. A review of the nursing progress notes dated November 25, 2025, at 12:41 a.m., revealed the resident was sent to the emergency room after a request (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be hospitalized for abdominal pain and was returned to the facility. A review of the hospital records, After Visit Summary dated November 25, 2025, revealed Diagnoses: Fecal impactions (A condition where a large, hard mass of stool gets stuck in the colon or rectum, preventing normal bowel movement) and suicidal ideations (The thought process of having ideas about possibility of dying by suicide). The same report revealed consult to behavioral intervention team-suicide. A review of the hospital records, emergency room (ER) provider notes, dated November 25, 2025, revealed that in addition to abdominal pain, this patient admitted that she/he attempted to kill themselves two days ago. Further notes review revealed: Patient states that she is depressed about the state of her health. Apparently, she scratched her neck with glass and then attempted to wrap a cord around her neck 3 days ago. She admits she was [too chicken] to really go through with it The ER physician ordered for the patient to be seen by a behavioral health while at the ER. A review of the ER behavioral health consult dated November 25, 2025, revealed that the patient admitted that a few days ago, she/he attempted to kill themselves with a piece of glass and cords but chickened out. The recommendation includes follow up primary care physician and restart with the previous counselor. Nursing notes dated November 30, 2025, at 4:23 p.m., revealed Resident verbalized delusional statements: people were out to do population control and were drugging all food and fluids to kill people, and President [NAME] is going to come get me and bring clean water in a metal tin. Nursing progress notes dated December 9, 2025, at 12:30 a.m., revealed that the resident was pushing a chair up and down the hall at 12:30 a.m. Nursing progress notes dated December 9, 2025, at 4:41p.m., revealed noted to have some increased anxiety mixed with paranoia. Resident refused medications this morning and evening. Residents have been going in and out of room wandering most of the shifts. Nursing progress notes dated December 10, 2025, at 7:01 p.m., revealed Resident stated to therapy that her time was coming up and she was going to die. The same note revealed that the DON (Director of Nursing) spoke to the resident and reported she does not hear voices but has thoughts that tell her Jesus is coming soon and God is going to judge her and have no mercy and that the time is soon. She stated at the same time devil is trying to take her soul, but God continues to protect her, and she hopes he has mercy on her. An interview with the DON and Nursing Home Administrator conducted on January 23, 2026, at 10:00 a.m., revealed that the facility was not aware of a second attempt (wrapping a cord on the neck). The facility reported that the hospital did not communicate its findings and recommendations to the facility. The DON reported that despite a behavioral intervention being completed in the hospital, as documented on the discharge summary, the facility did not ask for the report/recommendations since the resident was sent back to the facility. There was no documented evidence that the primary physician was notified of the residents' increased anxiety, paranoia, and delusions after the transfer to the hospital on November 25, 2025. There was no documented evidence that facility had the resident followed by a behavioral health until December 16, 2025. Resident 1 would not have been seen by the behavioral health team after an admission of cutting neck with a glass on November 18, 2025, if the resident did not request to be sent to the ER for abdominal pain on November 25, 2025, reporting suicidal ideation twice which prompted ER behavioral health consult. The facility failed to ensure Resident R1 was provided with timely behavioral health services after an admission of hurting self on November 18, 2025, failed to timely follow an ER behavioral health recommendation on November 25, 2025, to start counselling after reporting two times suicidal ideation, and notifying primary physician of the resident's increasing behaviors of paranoia, delusion and anxiety. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 7/18/25, 12/17/25 28 Pa Code 211.5(f) Clinical RecordsPreviously cited 7/18/2,12/17/25