

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 07/18/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0567</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 manage his or her financial affairs.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon interview, it was determined the facility failed to ensure residents received personal funds upon request in a timely manner for one resident reviewed (Resident 13). Findings include: Interview conducted with Resident 13 on July 15, 2025 at 11:30 a.m. revealed that on June 24, 2025 Resident 13 requested \$700.00 from resident's personal funds. This interview further revealed that the facility's Business Office Manager had no access to residents' personal funds due to not being able to write checks or access the funds. This interview further revealed the facility provided Resident 13 with a check for \$700.00 on July 15, 2025, at approximately 11:15 a.m., 14 days after Resident 13 made the request for funds. Interview with Employee E3 on July 15, 2025, at 12:00 p.m. confirmed Resident 13 requested \$700.00 of resident's personal funds on June 24, 2025. This interview also confirmed that Employee E3 had no access to residents' personal funds and had to request access from the facility's corporate office. This interview also confirmed Resident 13 was provided with a check in the amount of \$700.00 on July 15, 2025. The above information was conveyed to the Nursing Home Administrator on July 16, 2025, at approximately 1:00 p.m. 28 Pa. Code 201.18(e)(1) Management</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>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>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observations and interviews with residents and staff, it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment for two of 12 residents reviewed (Residents 7 and 36). Findings include: Observation on July 15, 2025, at 1:31 p.m. revealed Resident 7's bedside table's locked drawer was unable to be closed and therefore could not be locked. Additionally, the bottom door of the bedside table was falling off the hinges. Observation on July 15, 2025, at 10:22 a.m. of the floor in Resident 36's room and bathroom revealed large areas that appeared dull and faded. Interview with Resident 36 at that time revealed that staff had attempted to scrape the floor, removing some of the wax. Interview with Employee E4 on July 18, 2025, at 10:30 a.m. confirmed that staff had attempted to remove something from the floor in Resident 36's room and removed the wax. Employee E4 indicated that the floor needed to be stripped, but Employee E4 has not had the time to do it. The above information was presented to the Nursing Home Administrator on July 18, 2025, at 1:00 p.m. 28 Pa. Code 204.5(f) resident rooms</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on a review of facility policy and interviews with resident and staff, it was determined that the facility failed to ensure residents were free from misappropriation of property for one of 12 residents reviewed (Resident 7). Findings include: Review of facility policy, Abuse Protection, effective August 28, 2018, indicated that the resident has the right to be free from misappropriation of property. Interview with Resident 7 on July 15, 2025, at 12:09 p.m. indicated that the resident was missing approximately \$65 which was in a wallet that was to have been locked in the supervisor's office while the resident was hospitalized . Resident 7 indicated that the missing money was reported to the staff, but Resident 7 was not aware of any investigation. Interview with the Nursing Home Administrator (NHA) on July 18, 2025, at 12:46 p.m. revealed that the NHA was aware of the allegation of missing money, but no investigation had been done. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition28 Pa. Code 201.18(b)(1) Management</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>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon review of facility policy and procedure and facility documentation, it was determined the facility failed to ensure a thorough investigation was completed for an allegation of abuse for one of one resident reviewed (Resident 43). Findings include: Review of facility policy and procedure titled Abuse Protection, effective 2018, revealed Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Further review of this policy revealed Investigation - timely and thorough investigations of all reports and allegations of abuse to include injuries of unknown origin. Further review of this policy revealed Regardless of how minor an accident or incident may be, including injuries of 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. Injuries of unknown origin will be evaluated for potential or suspected abuse. An investigation is implemented and witness statements are obtained. Review of facility documentation revealed that Resident 43 made an allegation of physical abuse on May 27, 2025. The allegation stated that Resident 43 was hit in the mouth on May 26, 2025, by a facility employee. Further review of facility documentation revealed two statements were obtained of nurses working in the facility at the time of the alleged occurrence. Further review of facility documentation failed to reveal evidence that any statements were obtained from Resident 43 or other staff members working at the time of the alleged occurrence. A perpetrator was identified; however, no statement was obtained from the alleged perpetrator. Further review of facility documentation failed to reveal evidence as to a conclusion to the investigation and no PB 22 was filed for the alleged perpetrator. Interview with the Nursing Home Administrator on July 16, 2025, at 11:00 a.m. revealed that no PB 22 had been completed or filed for the alleged perpetrator and further revealed that the investigation was not thoroughly completed. 28 Pa. Code 201.18(e)(1) Management</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on facility policy, clinical record review and staff interviews, it was determined that the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman of the transfer or discharge for 4 of 4 (6, 7, 41, and 47) residents reviewed. The facility also failed to provide written information about the bed-hold policy to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours for 3 of 3 residents reviewed (7, 41, and 47). Additionally, the facility failed to reconcile the medications prior to discharge for one of one resident (6). Findings include: Review of facility policy Bed Hold Policy and Procedure revised November 1, 2024, revealed that upon discharge from the facility and admission to a hospital, the social service department or the Administrator's designee will contact, by telephone and in writing, the resident/agent (responsible party) to inform them that the resident was discharged to the hospital. The bedhold letter and bedhold reservation request must be mailed on the date the resident was discharged to the hospital for all residents, regardless of payer. Documentation regarding the contact by telephone and a copy of the bedhold letter and bedhold reservation request sent to the family will be kept on file in the resident's admission folder. Review of Resident 6's clinical record revealed that the resident was discharged to home on June 28, 2025. Further review of the clinical record revealed no evidence that the resident's medications were reconciled prior to discharge. Interview with the Director of Nursing on July 18, 2025, at 11:42 a.m. confirmed that there was no evidence of the medication reconciliation or that a representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge. Review of Resident 7's progress note of February 20, 2025, revealed that the resident was admitted to the hospital for a scheduled surgical procedure. Review of Resident 7's progress note of May 23, 2025, revealed that the resident was admitted to the hospital with a diagnosis of UTI (urinary tract infection) and encephalopathy (disorder or disease of the brain). Review of Resident 7's progress note of June 11, 2025, revealed that the resident was admitted to the hospital with a diagnosis of encephalopathy. Interview with the Director of Nursing on July 18, 2025, at 12:41 p.m. confirmed that there was no evidence that the bed-hold policy was provided to the resident or the resident's representative when the resident was hospitalized. Additionally, there was no evidence that a representative of the Office of the State Long-Term Care Ombudsman was notified of the hospitalizations. Review of Resident 41's clinical record revealed Resident 41 was admitted to an acute care facility on April 18, 2025, with a diagnosis of sepsis. Further review of Resident 41's clinical record failed to reveal evidence that the resident or resident's representative were provided with a copy of the facility bed-hold policy. Additionally, there was no documented evidence that the State Ombudsman was notified of the transfer and admission to the acute care facility. Interview with the Director of Nursing on July 18, 2025, at 11:43 a.m. confirmed that there was no evidence the bed hold policy was provided to Resident 41 or Resident 41's representative and further there was no evidence that the State Ombudsman was notified of Resident 41's transfer and admission to an acute care facility. Review of Resident 47's progress note of May 30, 2025, revealed that the resident was sent to the hospital for evaluation and treatment. Interview with the Nursing Home Administrator on July 18, 2025, at 9:58 a.m. confirmed that there was no evidence that the bed-hold policy was provided to the resident's representative when the resident was hospitalized. Additionally, there was no evidence that a representative of the Office of the State Long-Term Care Ombudsman was notified of the hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon clinical record review, it was determined the facility failed to follow physician's order for weights and pain medication for one of 12 residents reviewed (Resident 4). Findings include: Review of Resident 4's diagnosis list revealed diagnoses including left femur [long bone in upper leg] fracture, shoulder dislocation and obesity. Review of Resident 4's care plan revealed resident is at risk for pain related to left femur fracture and shoulder dislocation. Further review of Resident 4's care plan revealed Resident 4 will adhere to prescribed diet with interventions including weight resident as ordered. Review of Resident 4's physician orders revealed an order for weekly weights for four weeks. Review of Resident 4's Weight Summary revealed Resident 4 was weighed on June 30, 2025. Further review of documentation failed to reveal evidence that Resident 4 was weighed weekly for four weeks as ordered by Resident 4's physician. Further review of Resident 4's physician orders revealed an order for Hydrocodone (pain medication) 7.5 milligrams (mg) to be administered every four hours as needed for severe pain. Review of Resident 4's July 2025 Medication Administration Record revealed Resident 4 received Hydrocodone 7.5 mg on July 9, 2025, for a pain level of 0. Interview with Nursing Home Administrator and Director of Nursing on July 18, 2025, at 2:00 p. m. confirmed that Resident 4 was not weighed weekly for four weeks as ordered by Resident 4's physician and further confirmed Resident 4 should not have received Hydrocodone 7.5 mg for a pain level of 0. 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 6/7/2024, 6/3/2025</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on review of clinical records and interview with staff, it was determined that the facility failed to ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standard, to promote healing for one of two residents (Resident 17). Findings include:Review of Resident 17's wound consult of July 16, 2025, revealed resident was seen for an unstageable pressure ulcer (wound covered by eschar [hardened, dry, black or brown dead tissue] or necrotic tissue [dead tissue]) of the right medial (inner side) ankle. Treatment recommendations were made to cleanse with NSS (normal saline solution), apply medical grade honey, calcium alginate (type of wound dressing) to base of wound, secure with bordered foam, change daily and prn (as needed).Review of Resident 17's physician's orders and July 2025 Treatment Administration Record revealed that the recommendation had not been acted upon, and the treatment changed as recommended.The information that the wound recommendation had not been addressed was presented to the Director of Nursing at 11:45 a.m. on July 18, 2025.483.25 Treatment/Svcs to Prevent/Heal Pressure UlcersPreviously cited 6/7/2428 Pa. Code 211.5(f) Clinical recordsPreviously cited 6/3/25, 6/7/2428. Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 6/7/24</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on review of facility policy, review of clinical records, and interviews with staff, it was determined that the facility failed to ensure that acceptable parameters of nutritional status were maintained for two of five residents reviewed (Residents 1 and 47). Findings include: Review of facility policy, Weight Monitoring and Weight Loss Intervention, revised November 2025, indicated that all residents will be weighed on admission, readmission, and at least monthly. Review of Resident 1's clinical record revealed that the resident was admitted on [DATE]. An admission weight was obtained on May 29, 2025, and a mini nutritional assessment completed on that day determined that the resident was at risk for malnutrition. Further review of the clinical record revealed no other weights were obtained. Review of Resident 47's clinical record revealed that the resident was admitted on [DATE]. The only weight documented for the resident was recorded as May 19, 2025, prior to the resident's admission. Further review of the clinical record revealed no further weights were obtained. This information was presented to the Nursing Home Administrator and Director of Nursing at 1:33 p.m. on July 18, 2025. 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 6/7/24</p>

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>Based upon clinical record review, review of facility documentation, and staff interview it was determined the facility failed to ensure proper care and treatment after a fall resulting in actual harm when a resident experienced severe pain after a fall and subsequent fracture due to the facility not providing interventions or monitoring the resident's pain for one of one resident reviewed (Resident 52). Findings include: Review of Resident 52's diagnosis list revealed diagnoses including Dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Peripheral Vascular Disease (PVD - poor circulation of the extremities) and osteoarthritis (degenerative joint disease). Review of Resident 52's care plan revealed Resident 52 was at risk for falls and has acute and chronic pain. Review of Resident 52's progress notes dated May 8, 2025, revealed [At] 4:30 a.m. resident screamed out from room and found lying flat on the floor rolled in blankets. Last observed resident in bed five minutes prior to the incident. On assessment [resident] was alert, no obvious bruising and swelling noted on head, all extremities were moving, no shortening or obvious deformity noted. Skin assessment, open area on the left leg below the knee seen, slight bleeding noted, cleaned, dressed. Helped in bed with three (person) assist. Neuro checks started and vitals were WNL [within normal limits]. Notified hospice, notified MD, and DON [director of nursing]. New order for x-ray of femur [long bone in upper leg] stat [immediately]. Hospice suggested to give Tylenol PRN but resident declined. Tried to notify the family but left message as directed to voicemail. Further review of Resident 52's progress notes dated May 8, 2025, at 10:19 a.m., approximately six hours post fall, revealed notified [mobile x-ray company] to obtain a STAT (immediately or at once) x-ray today. Xray tech will be in sometime today. ASAP (As Soon As Possible). Further review of Resident 52's progress note dated May 8, 2025, at 1:09 p.m., approximately nine hours post fall, revealed entered residents room to attempt administration of PRN [as needed] Tylenol for visible pain noted, upon entering resident holding right leg grimacing, pale in color with golf size ball above the knee and swelling to left side of right knee, resident would not allow writer or aide to get close to the right leg. RN sup [supervisor] and DON [Director of Nursing] notified for further assessment. Further review of Resident 52's progress notes dated May 8, 2025, at 2:20 p.m., approximately ten hours post fall, revealed Nurse placed call to hospice to notify of visible injury to right knee/femur told they were already aware no further instructions call placed to daughter voicemail left for a call back regarding sending resident out, resident appears in distress holding right leg grimacing stating please do something PRN Tylenol given, BP [blood pressure] 70/44, HR [heart rate] 76, R [respirations] 22. Further review of Resident 52's progress notes dated May 8, 2025, at 6:30 p.m., 14 hours post fall, revealed right leg x-ray completed showing acute fracture of the distal femoral metaphysis comminuted and displaced. [Resident's] right leg is swollen and hard upon palpation above right knee. Unable to move resident due to pain. Resident on hospice and morphine needed to be signed to take out of emergency cart. Resident in pain and cannot be moved at this time. Daughter is present and would like [resident] evaluated in ER [emergency room]. Review of facility documentation revealed all responsible parties, including the Director of Nursing and Nursing Home Administrator, were informed of Resident 52's ongoing severe pain with documentation or signs of intervention. Further review of facility documentation revealed facility was aware of the delay in services regarding obtaining an x-ray of Resident 52's leg, but no additional assessments, treatments or emergency services were initiated until an x-ray was completed 14 hours post fall. Further review of facility documentation revealed Despite being informed throughout the day of the resident's condition, the DON did not assess the resident nor follow up on the x-ray order. Interview with Nursing Home Administrator and Director of Nursing on July 18, 2025, at 2:30 p.m. confirmed that no appropriate action was taken regarding Resident 52's severe pain for 14 hours post fall. The facility failed to ensure appropriate and timely treatment was provided for a resident in severe pain for 14 hours, causing prolonged and unmanaged pain and actual harm to Resident 52. 28 Pa. Code 201.18(e)(1) Management Previously cited 8/31/2023 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 8/31/2023, 6/7/2024, 6/3/2025</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon review of policy and procedure and clinical record review, it was determined the facility failed to provide transportation to a dialysis center for dialysis for one of one resident reviewed (Resident 8). Findings include: Review of policy and procedure titled Dialysis Care, revised November 2024, revealed The facility will make all transportation arrangements to and from the Dialysis Center. Resident 8 was admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease. Review of Resident 8's clinical progress notes dated June 23, 2025 revealed Resident sent to [hospital emergency department] via ambulance to receive dialysis. Review of Resident 8's clinical progress notes dated July 2, 2025 revealed Patient missed dialysis due to transportation issue. Resident 8 discharged from the facility on July 15, 2025. Interview with the Nursing Home Administrator and Director of Nursing on July 18, 2025 at 2:00 p.m. confirmed the facility had issues with transportation and have since retained a transport company to transport residents to appointments. 28 Pa. Code 201.18(e)(1) Management</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon clinical record review, it was determined the facility failed to ensure pharmacy consultant reviews were completed monthly as required for one of five records reviewed (Resident 3). Findings include: Review of Resident 3's clinical record failed to reveal evidence that Pharmacy Consultant reviews were completed for Resident 3 for the following months - July, September, October, November and December 2024 and January, February, March and June 2025. Review of Resident 7's clinical record indicated that the consultant pharmacist identified an irregularity during the drug regimen review of March 27, 2025. There was no documented evidence of the irregularity or that the physician addressed the irregularity. Review of Resident 17's clinical record indicated that the consultant pharmacist recommended Venlafaxine (antidepressant medication) be assessed for a gradual dose reduction on December 8, 2024. There was no documented evidence that the physician addressed the recommendation. Additionally, the consultant pharmacist identified an irregularity during the drug regimen review of May 30, 2025. There was no documented evidence of the irregularity or that the physician addressed the irregularity. Review of Resident 37's clinical record indicated that the consultant pharmacist identified irregularities during the drug regimen reviews of December 8, 2024, May 30, and June 29, 2025. There was no documented evidence of the irregularities or that the physician addressed the irregularities. Interview with the Nursing Home Administrator on July 18, 2025, at 1:00 p.m. confirmed that no documented evidence exists that the Pharmacy Consultant completed medication reviews for the above-mentioned months and no documented evidence that the physician addressed pharmacy recommendations. 28 Pa. Code 211.9(a)(f)(3) Pharmacy Services</p>		

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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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon clinical record review, review of select facility policies and procedures, and facility documentation, it was determined the facility failed to implement non-pharmaceutical interventions prior to the administration of pain medication for three residents and failed to monitor side effects of pain medication and anti-depressant medication for two residents (Resident 1, Resident 4, Resident 17).</p> <p>Findings include:</p> <p>Review of facility policy "Pain Management Guideline" effective August 2017, indicated that documentation and observation of care and treatment reflects ongoing monitoring of pain levels and interventions (pharmacological and non-pharmacological). The documentation will be reflected on the eMAR (electronic medication administration record) and progress notes.</p> <p>Review of Resident 1's physician's orders included an order for Oxycodone HCl (pain medication) 5 milligrams (mg) to be administered every six hours as needed for moderate to severe pain.</p> <p>Review of Resident 1's clinical record failed to reveal evidence that non-pharmaceutical interventions were attempted prior to the administration of the as needed pain medication and failed to reveal evidence that side effects were being monitored for the use of pain medication.</p> <p>Review of Resident 4's diagnosis list revealed diagnoses including left femur [long bone in upper leg] fracture and left shoulder dislocation.</p> <p>Review of Resident 4's physician orders revealed an order for Hydrocodone & Acetaminophen [pain medication] 7.5-325 milligrams (mg) to be administered every 4 hours as needed for pain.</p> <p>Review of Resident 4's clinical record failed to reveal evidence that non-pharmaceutical interventions were attempted prior to the administration of the as needed pain medication and failed to reveal evidence that side effects were being monitored for the use of pain medication.</p> <p>Review of Resident 4's clinical record failed to reveal evidence that non-pharmaceutical interventions were attempted prior to the administration of the as needed pain medication and failed to reveal evidence that side effects were being monitored for the use of pain medication.</p> <p>Review of Resident 17's physician's orders included an order for Percocet 5-325 mg (oxycodone with acetaminophen) every six hours as needed for moderate to severe pain.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on July 18, 2025, at 1:00 p.m. confirmed that no non-pharmaceutical interventions were attempted prior to the administration of pain medication and no side effects were monitored during the use of the pain medication.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Previously cited 6/7/2024, 6/3/2025</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon interview and observation, it was determined the facility failed to employ a Licensed Dietitian. Findings include:Review of clinical records failed to reveal evidence that a Licensed Dietitian was reviewing or monitoring the nutritional status of residents.Interview with the Nursing Home Administrator on July 18, 2025, at 1:30 p.m. confirmed that the Licensed Dietitian, supposedly employed by the facility, was unavailable. This interview further revealed that a Licensed Dietitian had not been reviewing the nutritional status or providing nutritional services to residents in the facility. 28 Pa. Code 201.18(e)(1) Management</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Bases on observations and interviews with staff, it was determined that the facility failed to store food in accordance with professional standards for food service safety. Findings include: Observations on July 15, 2025, at 9:40 a.m. during a tour of the kitchen with Employee E3, a large build up of ice was noted in the walk-in freezer. Boxes of food were observed to be covered in ice to the point of not being able to identify what the items were. Interview at the time with Employee E3 confirmed that the ice build up had been an on-going problem. The above information was presented to the Nursing Home Administrator at 1:30 p.m. on July 18, 2025. 483.60 Food Procurement, Store/Prepare/Serve - Sanitary Previously cited 6/7/24</p>

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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>Provide and implement an infection prevention and control program.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Bases on observations and interviews with staff, it was determined that the facility failed to handle, store, and process so as to prevent the spread of infection. Findings include: Observations of the laundry area on July 18, 2025, at 11:00 a.m. revealed large trash bags on the floor containing dirty items in front of the dryer. The folding table containing clean items was located approximately four feet from the dirty items. Shelves on the walls contained various maintenance items such as tools and small hardware items. Additional observations revealed no PPE (personal protective equipment) was available for staff to use while sorting and handling contaminated items. Interview with E4 at that time revealed that PPE is used when items are from rooms that are on transmission-based precautions, but the PPE is not available in the laundry area. 483.80 Infection Prevention and Control Previously cited 6/7/2428 Pa. Code 205.2(c)28 Pa. Code 205.26(d)</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon interview and review of facility documentation, it was determined that the facility failed to ensure that a staff person was certified as an Infection Preventionist. Findings include: Review of facility documentation failed to provide evidence that the facility had a qualified staff person certified as an Infection Preventionist. Interview with the Nursing Home Administrator on July 18, 2025, at 1:00 p.m. confirmed that the Director of Nursing was taking the required classes but had not completed the required classes and certification for Infection Prevention. The interview further revealed that the facility had no Infection Preventionist on staff. 28 Pa. Code 201.18(b)(2) Management Previously cited 4/29/2025</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based upon facility documentation, it was determined that the facility failed to ensure nurse aides completed the annual 12-hour in servicing as required. Findings include: Review of facility documentation revealed the facility had one certified nurse aide employed for at least one year. Further review of facility documentation failed to reveal evidence that the nurse aide had completed the required 12-hour annual in servicing as required. Interview with the Nursing Home Administrator and Director of Nursing on July 18, 2025, at 1:00 p. m. confirmed that the nurse aide had not completed the required 12 hours of annual inservicing as required. 28 Pa. Code 201.18(b)(2) Management Previously cited 4/29/2025</p>		