

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395679	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Washington		STREET ADDRESS, CITY, STATE, ZIP CODE 1198 W. Wylie Avenue Washington, PA 15301	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>39311</p> <p>Based on review of the grievance policy, facility documents, and staff interviews it was determined that the facility policy does not include all required elements and that the facility failed to document, resolve, and provide response to residents and/or their responsible parties for eleven of thirteen residents (Resident R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11).</p> <p>Findings include:</p> <p>Review of the facility policy Grievances dated 1/31/24, indicated the facility will support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution.</p> <p>Further review of the policy Grievances revealed that the policy failed to contain information related to:</p> <ul style="list-style-type: none"> -The right to file grievances anonymously. -Identification of a Grievance Official responsible for overseeing the grievance process. -The right to obtain a written decision regarding his or her grievance; - As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. -Immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law. -Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395679
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction.</p> <p>-Maintaining evidence demonstrating the result of all grievances for a period of no less than three years from the issuance of the grievance decision.</p> <p>Review of the facility provided concern form dated 1/9/25, indicated Resident R2 stated she was missing a night gown. The sections titled Immediate Actions, Summary of Findings, and Corrective Actions were blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern and for the NHA (Nursing Home Administrator) were unsigned.</p> <p>Review of the facility provided concern form dated 1/9/25, indicated Resident R3 stated she was missing clothing since admission, and that the concern was previously reported and she hasn't heard anything about it. The sections titled Immediate Actions, Summary of Findings, and Corrective Actions were blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern and for the NHA were unsigned.</p> <p>Review of the facility provided concern form dated 1/9/25, indicated Resident R4 stated she was missing clothing. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of the facility provided concern form dated 1/15/25, indicated Resident R5 stated he was missing his facial shaver since a room move on 12/12/24. The sections titled Summary of Findings and Corrective Actions were blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern and for the NHA were unsigned.</p> <p>Review of the facility provided concern form dated 1/15/25, indicated Resident R5 stated he was missing his personal food items from his room. The sections titled Immediate Actions, Summary of Findings, and Corrective Actions were blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern and for the NHA were unsigned.</p> <p>Review of the facility provided concern form dated 1/15/25, indicated Resident R6 stated that her room has not been cleaned in two days. Within the Summary of Findings section, it was documented that the Maintenance Director confirmed that Resident R6's bathroom appeared not to have been cleaned. The Corrective Actions section was blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern was unsigned.</p> <p>Review of the facility provided concern form dated 1/17/25, indicated Resident R7 had a concern that staff were loud in her room overnight. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided concern form dated 1/27/25, indicated Resident R7 had a second concern that staff were loud in her room overnight. The section titled Immediate Actions, Summary of Findings was blank. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of the facility provided concern form dated 2/7/25, indicated Resident R8 stated he has not received his scheduled shower on 2/6/25. The section titled Summary of Findings indicated, Resident shower next am - back on 3-11 shower. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of facility provided shower schedules indicated Resident R8 was scheduled on afternoon shift on Mondays and Thursdays.</p> <p>Review of Resident R8's shower record for January 2025, through March 2025, revealed that Resident R8 had documented showers on 1/23/25, 2/7/25, 3/10/25, and 3/17/25.</p> <p>Review of the facility provided concern form dated 2/7/25, indicated Resident R3 stated she did not receive a shower on Wednesday 3-11. The section titled Summary of Findings indicated, Shower schedule reviewed showers remain on 3-11. The questions of Was the Concern Confirmed, Written Decision Requested, and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of facility provided shower schedules indicated Resident R3 was scheduled on day shift on Wednesdays and Saturdays.</p> <p>Review of Resident R3's shower record for January 2025, through March 2025, revealed that Resident R3 had documented showers on 1/29/25, 2/1/25, 2/12/25, and 3/17/25.</p> <p>During an interview on 4/12/25, at approximately 1:15 p.m. the NHA confirmed that the Summary of Findings Shower schedule reviewed showers remain on 3-11 did not provide a conclusion to the grievance.</p> <p>Review of the facility provided concern form dated 2/7/25, indicated Resident R9 had a concern that the overnight nurse aide did not enter his room until 5:00 a.m. The questions of Written Decision Requested and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of the facility provided concern form dated 2/17/25, indicated Resident R10 stated a nurse aide was rough with her. The questions of Written Decision Requested and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of the facility provided concern form dated 2/28/25, indicated Resident R9 had a concern that the wound nurse practitioner and the wound nurse completed his treatment during his breakfast. The sections titled Immediate Actions and Summary of Findings were blank. The questions of Written Decision Requested and Was the resident or concerned party notified of the resolution were unanswered.</p> <p>Review of the facility provided concern form dated 3/4/25, indicated Resident R11 stated he was missing money. The questions of Written Decision Requested and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern was unsigned.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided concern form dated 3/5/25, indicated Resident R8 stated he was missing money. The questions of Written Decision Requested and Was the resident or concerned party notified of the resolution were unanswered. The signature line for the Department Head Related to Concern was unsigned.</p> <p>During an interview on 4/16/25, at approximately 11:00 a.m. the Director of Nursing confirmed that the facility policy does not include all required elements and confirmed that the facility failed to document, resolve, and provide response to residents and/or their responsible parties for eleven of thirteen residents.</p> <p>28 PA. Code:201.18(b)(1)(2) Management.</p> <p>28 PA. Code:201.29(a) Residents Rights.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>Based on review of federal and state laws, facility policies, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to report allegations of abuse and neglect for five of twelve residents (Resident R1, R3, R8, R9 and R10).</p> <p>Findings include:</p> <p>Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies.</p> <p>Review of the facility's policy Abuse Reporting and Investigation dated 1/31/24, indicated anyone who witnesses an incident of suspected resident abuse is to intervene immediately and stop the abuse. They are to report it to the charge nurse or supervisor immediately. The policy further stated the Department of Health will be notified of the alleged event by the Administrator or designee per regulation. Additional notification to the Area Agency on Aging (Protective Services) and local authorities will be completed as appropriate based on the allegation.</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, 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 the clinical record indicated Resident R1 was originally admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/11/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), coronary artery disease (damage or disease in the heart's major blood vessels), and fibromyalgia (chronic disorder that causes pain, fatigue, and trouble sleeping). Review of Section C: Cognitive Patterns indicated Resident R1 had a BIMS score of 15.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a progress note dated 3/5/25 3:46 p.m. indicated, Resident requested I come into her room. I brought an aide with me to be a witness. Resident calmly told me I hope when you are older or your parents end up in this nursing home so you can be mistreated and in pain. I asked resident what I had done in order for her to feel this way. She responded with you talk to me condescendingly. You are talking down to me I assured resident that that wasn't the case and it was my job to keep her safe. I informed her that we can't have medication at the bedside because we need to have documentation of things that she took. Resident agitated. I asked resident if it was okay for me to leave her room. Resident agreed.</p> <p>Review of a progress note dated 3/5/25, at 4:53 p.m. resident cussing/yelling and kicking legs at nurse who was trying to administer insulin and gabapentin. said she wanted to administer herself and was instructed that couldn't happen with how she was acting and with no order stating so. Also slammed gab (gabapentin) medication down and spilled it then demanded a refill, was instructed that couldn't happen due to not knowing how much she had consumed. resident told me to get out and wanted [other staff members]. resident asked (charge nurse) to give her her meds when due instead of me for rest of shift.</p> <p>Review of a progress note dated 3/6/25, at 10:43 a.m. indicated, Resident demanding to [physician] and male nurse at the same time to discuss behaviors of resident. RN (registered nurse) entered room and informed her that this is not going to happen because what has happened is in the past. RN (and) SS (social services) and recommendation made to provide care with 2 people at all times. NP (nurse practitioner) notified and order obtained.</p> <p>Review of a progress note dated 3/19/25, at 11:58 a.m. indicated, delivered afternoon meds to resident with ADON (Assistant Director of Nursing) and administrator outside of room for witness. resident was pleasant but stated after receiving meds and conversing with me that I wasn't allowed in her room anymore and she'd be in contact with her lawyer. I didn't respond and exited said room.</p> <p>During an interview on 4/12/25, at 11:45 a.m. Resident R1 stated that the Medical Director verbally abused her and yelled at her on the morning of 3/6/25. Resident R1 stated she told multiple staff members about her concerns.</p> <p>Review of the facility provided grievances from March and April 2025 failed to reveal a grievance entered on Resident R1's behalf.</p> <p>During an interview on 4/12/25, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that as the facility had taken the step of Resident R1 not being provided care with only one staff member, the facility was aware of Resident R1's allegations of verbal abuse.</p> <p>Review of reports submitted to the local state field office did not include Resident R1's allegation of verbal abuse.</p> <p>Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and weakness. Review of Section C: Cognitive Patterns indicated Resident R3 had a BIMS score of 15.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided concern form dated 2/7/25, indicated Resident R3 stated she has not received her shower on 3-11 (3:00 p.m. to 11:00 p.m. shift).</p> <p>Review of Resident R3's shower record for January 2025, through March 2025, revealed that Resident R3 had documented showers on 1/29/25, 2/1/25, 2/12/25, and 3/17/25.</p> <p>Review of reports submitted to the local state agency did not include Resident R3's allegation of neglect.</p> <p>Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and chronic kidney disease (gradual loss of kidney function). Review of Section C: Cognitive Patterns indicated Resident R8 had a BIMS score of 15.</p> <p>Review of the facility provided concern form dated 2/7/25, indicated Resident R8 stated he has not received his scheduled shower on 2/6/25.</p> <p>Review of Resident R8's shower record for January 2025, through March 2025, revealed that Resident R8 had documented showers on 1/23/25, 2/7/25, 3/10/25, and 3/17/25.</p> <p>Review of reports submitted to the local state agency did not include Resident R8's allegation of neglect.</p> <p>Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes, anemia (too little iron in the body causing fatigue), and chronic pain. Review of Section C: Cognitive Patterns indicated Resident R9 had a BIMS score of 15.</p> <p>Review of the facility provided concern form dated 2/7/25, indicated Resident R9 voiced a concern about not being provided assistance from the overnight nurse aide until 5:00 a.m. The conclusion of the grievance confirmed that the nurse aide did not attend to the resident.</p> <p>Review of reports submitted to the local state field office did not include Resident R8's allegation of neglect.</p> <p>Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes, heart failure, and a seizure disorder. Review of Section C: Cognitive Patterns indicated Resident R9 had a BIMS score of 15.</p> <p>Review of the facility provided concern form dated 2/17/25, indicated Resident R10 stated a nurse aide was rough with her.</p> <p>Review of reports submitted to the local state field office did not include Resident R10's allegation of physical abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/16/25, at approximately 11:00 a.m. the Director of Nursing confirmed that facility failed to implement policies and procedures to report allegations of abuse and neglect for five of twelve residents.</p> <p>28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) (e)(1) Management.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>39311</p> <p>Based on review of facility documents, observations, and resident and staff interviews it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for eight of 16 residents (Residents R1, R3, R5, R8, R9, R10, R12, and R13).</p> <p>Findings include:</p> <p>Review of the facility policy Flow of Care/ADL dated 1/31/24, indicated Care will be provided to residents, as needed 24-hour a day to attain and maintain the highest level of functioning.</p> <p>During an interview on 4/12/25, at 11:12 a.m. Resident R10 stated that staff tell her she pulls the call light too much, they don't care for all her needs, and that she hears the staff speak about being short-staffed.</p> <p>During an interview on 4/12/25, at 11:20 a.m. Resident R13 stated that fresh water isn't passed, and many times she has to get it herself.</p> <p>During an interview on 4/12/25, at 11:37 a.m. Resident R8 stated that the aides are short-staffed and the call lights can be long.</p> <p>During an interview on 4/12/25, at 11:40 a.m. Resident R12 stated that call lights seem like they take a long time.</p> <p>During an interview on 4/12/25, at 11:41 a.m. Resident R5 stated call lights are long at times. A lot time they could use more people.</p> <p>Review of facility grievances filed in January 2025, through March 2025, revealed the following:</p> <p>-On 2/7/25, Resident R3 had voiced a concern about not being assisted to shower. Review of facility provided shower schedules indicated Resident R3 was scheduled on day shift on Wednesdays and Saturdays.</p> <p>Review of Resident R3's shower record for January 2025, through March 2025, revealed that Resident R3 had documented showers on 1/29/25, 2/1/25, 2/12/25, and 3/17/25. No documentation was provided for scheduled shower dates of 1/1/25, 1/4/25, 1/8/25, 1/11/25, 1/15/25, 1/18/25, 1/22/25, 1/25/25, 2/5/25, 2/8/25, 2/15/25, 2/19/25, 2/22/25, 2/26/25, 3/1/25, 3/5/25, 3/8/25, 3/12/25, 3/15/25, 3/19/25, 3/22/25, 3/26/25, and 3/29/25.</p> <p>-On 2/7/25, Resident R8 had voiced a concern about not being assisted to shower. Review of facility provided shower schedules indicated Resident R8 was scheduled on afternoon shift on Mondays and Thursdays.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R8's shower record for January 2025, through March 2025, revealed that Resident R8 had documented showers on 1/23/25, 2/7/25, 3/10/25, and 3/17/25. No documentation was provided for scheduled shower dates 1/2/25, 1/6/25, 1/9/25, 1/13/25, 1/16/25, 1/20/25, 1/27/25, 1/30/25, 2/3/25, 2/6/25, 2/10/25, 2/13/25, 2/17/25, 2/20/25, 2/24/25, 2/27/25, 3/3/25, 3/6/25, 3/13/25, 3/20/25, 3/24/25, 3/27/25, and 3/31/25.</p> <p>-On 2/7/25, Resident R9 had voiced a concern about not being provided assistance from the overnight nurse aide until 5:00 a.m. The conclusion of the grievance confirmed that the nurse aide did not the resident.</p> <p>Review of facility provided Resident Council minutes from January 2025, through March 2025, revealed the following concerns:</p> <p>January 2025: Snacks not being passed to residents and catheter bag not being emptied.</p> <p>February 2025: Snacks and ice water not being passed to residents.</p> <p>March 2025: Nurse aides not providing care, ice water not being passed, long call light response times, not receiving showers, and staff not completing rounds to check on residents.</p> <p>During an interview on 4/16/25, at approximately 11:00 a.m. the Director of Nursing confirmed the facility failed to provide Activity of Daily Living (ADL) assistance for eight of 16 residents.</p> <p>28 PA. Code:201.18(b)(2) Management.</p> <p>28 PA. Code:201.29(a) Resident's Rights.</p>		