STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395679	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Washington	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)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's facility assessment, staff interview, professional standards, and facility documentation, it was determined the facility failed to conduct and document a comprehensive, evidence-based facility assessment to ensure licensed nursing staff possessed the required training and competencies necessary to provide care and services for residents and Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required. Findings include:Review of the Centers for Medicare and Medicaid Services Memorandum, Revised Guidance for Long-Term Care Facility Assessment Requirements (QSO-24-13-NH) dated June 18, 2024, revealed that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility must provide. Continued review revealed, The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served.The facility assessment dated [DATE], and provided during survey on January 30, 2026, identified that the facility provided specialized services for residents with behaviors, infectious diseases, and have an effective system to identify, collect and use data and information from all departments and monitor performance.The facility could not provide documented evidence that licensed nursing staff received initial or ongoing training or competency evaluations (the ability of staff to demonstrate, through education and skills validation, that they can safely and effectively perform specific clinical procedures) in providing care for residents with behaviors, infectious diseases and have trained staff related to providing feedback of effective systems relate to quality assurance, as required by the facility's own assessment.During an interview o 1/30/26, at 11:40 a.m., the Nursing Home Administrator and the Director of Nursing (DON) confirmed that the facility failed to ensure its facility assessment was operationalized through staff training, competency evaluation, and implementation of policies and procedures related to conduct and document a comprehensive, evidence-based facility assessment to ensure licensed nursing staff possessed the required training and competencies necessary to provide care and services for residents and Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.19 (6)(7) Personnel records.28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2) Management.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Kadima Rehabilitation & Nursing at Washington	1198 W. Wylie Avenue Washington, PA 15301

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of facility policy, documentation, staff interview and review of Centers for Disease Control (CDC) guidelines for Legionella (bacteria that causes disease found in contaminated water) control, and staff interviews it was determined that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility for twelve of twelve months (January 2025 through January 2026). Findings include:Review of the facility policy Legionella Policy dated 1/7/26, with a previous review date of 1/9/25, indicated specific actions should be taken for prevention of Legionella and for investigation should a case occur. Core Elements of the Water Management Plan are:1. Establish Water Management Plan team.2. Describe Center's water system using text and flow diagram.3. Risk assessment with control methods and corrective actions.4. Monitoring control measures.5. Corrective actions.6. Verification and validation.7. Documentation and communication.Review of Department of Health and Human services, Centers for Medicare and Medicaid services (CMS) memo, Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) dated 7/6/18, revealed, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread Legionella and other opportunistic pathogens in water. This policy memorandum applies to Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations. Facilities must have water management plans and documentation that, at minimum, ensure each facility:-Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Nontuberculous Mycobacteria, Burkholderia, Stenotrophomonas, and fungi) could grow and spread in the facility water system.-Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air Conditioning Engineers) industry standard and the CDC toolkit.-Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained.-Maintains compliance with other applicable Federal, State, and local requirements.Review of the ASHRAE guidance Managing the Risk of Legionellosis Associated with Building Water Systems dated December 2020, indicated the most commonly used supplemental disinfection methods are treatment with chlorine, chlorine-dioxide, copper-silver ions, and monochloramine. The guidance further indicated the recommended levels of residual chlorine are 0.50-3.00 ppm (part per million).Review of the Water Management Program Control Measures did not contain a policy for any specific type of water testing. Review of a water test that had been conducted in 2025, identified a document from a company called Tap score. The document did not include any specific water pathogens that were being tested for.During a phone interview on 1/29/26, at 1:10 p.m., Tapscore support staff Employee E3 stated that the test conducted did not include testing for any water pathogens only for forever chemicals, which did not include any chemical that would be toxic to water pathogens. During an interview on 1/29/26 at approximately 1:22 p.m., the Maintenance Director, Employee E2 confirmed the facility had no documentation of water testing as per the Legionella Policy and that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Infection Control for ten of ten staff members (Employee E9, E10, E11, E12, E13, E14, E15, E16, E17 and E18).Findings include:Review of the Facility Assessment most recently reviewed 1/7/26, listed under the training topics Infection Control Training is identified.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, identified Infection Prevention and Control as a topic for orientation and annual trainings required.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have Infection Control training in-service between 1/17/25, and 1/30/26.Environmental Services Employee E10 had a hire date of 2/22/06, failed to have Infection Control training in-service between 2/22/24, and 1/30/26. Registered Nurse Employee E11 had a hire date of 11/4/19, failed to have Infection Control training in-service between 11/4/24, and 1/30/26. Activity Director Employee E12 had a hire date of 5/22/23, failed to have Infection Control training in-service between 5/22/24, and 1/30/26.Nurse Aide Employee E13 had a hire date of 10/21/98, failed to have Infection Control training in-service between 10/21/24, and 1/30/26.Central Supply Employee E14 had a hire date of 9/23/24, failed to have Infection Control training in-service between 9/23/24, and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have Infection Control training in-service between 1/17/25, and 1/30/26.Nurse Aide Employee E16 had a hire date of 9/11/24, failed to have Infection Control training in-service between 9/11/24, and 1/30/26.Nurse Aide Employee E17 had a hire date of 11/25/24, failed to have Infection Control training in-service between 11/25/24, and 1/30/26.Nurse Aide Employee E18 had a hire date of 11/27/24, failed to have Infection Control training in-service between 11/27/24, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on Infection Control for ten of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and a staff interview, it was determined the facility failed to post contact information, Adult Protective Services (APS), State Agency, and a statement the resident may file a complaint with the State Agency as required, in the building in one of one location where postings are (first floor nursing unit). Findings include: The facility must post, in a form and manner accessible and understandable to residents, resident representatives; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. During observations completed on 1/29/26, at approximately 11:30 a.m., in the lobby, hallways in and around the nursing units, revealed the facility did not have the required elements (agency name, address, email address, and phone number) of Adult Protective Services (APS), State Agency statement that the residents may file a complaint with the State Agency posted or accessible to residents or resident representatives. During rounds and an interview with the Nursing Home Administrator (NHA) on 1/30/26, at 9:00 a.m., the NHA confirmed the facility failed to post required information for Adult Protective Services (APS), State Agency statement the residents may file a complaint with the State Agency as required, in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on two of two nursing units (North and South Nursing Units). Findings include:During an observation on 01/28/2026, from 10:12 a.m., through 11:25 a.m., the following was identified:Residents R44 and R41(room [ROOM NUMBER]) window air conditioner unit not covered to prevent cold air from entering, Resident R112 stated that she had told them cold air was coming in but was not fixed. Resident R112's personal fan had a white dusty substance covering the filtering area.Residents R77 and R2 (room [ROOM NUMBER]) air conditioner window unit was left with gaps in covered area allowing cold air to enter.Resident R61(room [ROOM NUMBER]) unit was loose from window and uncovered allowing cold air to enter room.Residents R35 and R25 (Room141) air conditioner window unit is observed with a flannel shirt to prevent cold air from entering and window blind is broken.Resident R30 and R71(Room137) air conditioning window unit has gaps in plastic allowing cold air to enter.Residents R76 and R39 (room [ROOM NUMBER]) has a towel under air conditioner unit and has gaps in plastic allowing cold air to enter.Additional resident rooms with broken blinds include:Residents R20, R51 and R43 room [ROOM NUMBER])Residents R36 and R8(Room132)Residents R53 and R38(Room133)Residents R31 and R32 (Room134)Residents R33 and R23 (Room136)Residents R42 and R4(Room140)Residents R5 and R63 (Room117) has a plastered unfinished wall under the window Residents R71 and R59 (Room138) has loose floor strip at entrance, causing a potential tripping hazardResidents R54 and R10 (Room116) has area around electrical plug that has unfinished plasterResidents R3, R1 and R14 (Room143) has unfinished plaster area around the heater, and their bathroom wall has broken wall areasResident R71 and R59 (Room138) bathroom walls are chipped During an interview on 1/28/26, at 11:25 a.m., Maintenance Director Employee E2 confirmed the above findings and that the facility failed to provide a safe, clean, comfortable, and homelike environment on two of two nursing units (North and South Nursing Units).28 Pa. Code: 207.2(a) Administrator's responsibility.28 Pa. Code: 201.29(k) Resident rights.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident and staff interviews, and review of facility documents (grievances, resident council, and staffing) review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for ten of sixteen residents (Residents R200, R500, R501, R502, R503, R504, R505, R506, R507, and 508).Findings include: During a group interview, on 1/28/26 at approximately 1:30 p.m., when asked if he felt the facility maintained enough staff to care for resident needs and answer call lights, consensus from the group was no. Residents verbalized frustration relating to care when staff is lower epically with the lack of aides and sometimes nurses in the building. Residents stated it is on all the shifts; the residents stated often the wait time is thirty minutes, though it can go to an hour or longer. Residents stated some of the staff responses when you use your call light are you just rang your light, you ring too much, what do you want now, and staff will come in and turn the light off without taking care of what you need. The residents stated they don't report these events or concerns as they are fearful of retaliation. During the interviews the residents asked and requested multiple that the surveyor promise them to keep their identity confidential. -Resident R505 stated when staffing is not how it should be, there is tension between staff and residents, and she just will get out of the staff's way. I zoom the other way from them. - Resident 507 stated I have to wait for my pain meds, I use my call light and tell them I need my pain medication, I then wait thirty minutes up to two hours to get them. - Resident 502 stated I can't walk, and I can't get to the bathroom by myself, I often have to wait thirty minutes or more to get help. My bigger concern is when my oxygen supply gets low and I get very anxious about running out of oxygen. I just start to yell for help when they don't respond to the call light, but this makes me more anxious and shorter of breath. I asked my family to bring me in a whistle, so I get a response. During a confidential staff interview, when asked if the staff members felt there was sufficient staff to care for resident needs. The staff member stated no, we have gaps in our schedule, we just don't have the number of aides that we should, I think it's mostly because of call offs and times when we are just short staffed. We do take care of every resident but sometimes they have to wait until we can get to them. During a confidential staff interview, when asked if the staff members felt there was sufficient staff to care for resident needs, the staff member stated there are days we are short staffed, we do all work together to take care of everyone, it might take us a little longer on these days. During a confidential staff interview, when asked if the staff members felt there was sufficient staff to care for residents' needs, the staff member stated, you know how it is, there are times when we are short, this is how it is everywhere, it just takes longer to get to everybody on these days. Review of a grievance filed by Resident R200, dated 9/1/25, revealed concerns documented for the aide coming into residents' room when the resident used the call light. Aide stated she would be back to address the residents' needs and never returned. Review of a grievance filed on behalf of Resident R200, dated 9/2/25, revealed concerns documented for wait times. Resident requested her bed linen be changed, after an hour the resident went and got the linens and changed the bed. The aide returned later that day as reportedly told the resident You need to be more patient I have a lot of residents to take care of. Resident stated the aide doesn't need to chastise me and that the aide was unprofessional and as a resident she does not deserve to be spoken to and treated this way. Aide was not to be assigned to resident in the future. Review of resident council minutes, dated 9/6/25, revealed concerns documented for ice pitchers and ice water not being passed. Review of resident council minutes, dated 9/6/25, reveled concerns when staff say they don't have enough workers, showers do not happen. During an interview on 1/30/26, at 10:45 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychosocial well-being. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for five of five nurse aides (NA Employee E13, E15, E16, E17 and E18). Findings include:Review of personnel files revealed that Nurse Aide Employee E13 hire date was 10/21/98, there was no performance evaluation completed.Review of personnel files revealed that Nurse Aide Employee E15 hire date was 7/31/23, there was no performance evaluation completed.Review of personnel files revealed that Nurse Aide Employee E16 hire date was 9/11/24, there was no performance evaluations completed.Review of personnel files revealed that Nurse Aide Employee E17 hire date was 11/25/24, there was no performance evaluations completed.Review of personnel files revealed that Nurse Aide Employee E18 hire date was 11/27/24, there was no performance evaluations completed.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to complete annual performance evaluations for five of five nurse aides (NA Employee E13, E15, E16, E17 and E18).28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.28 Pa Code: 201.14 (a) Responsibility of licensee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to properly store food products in the walk-in cooler and freezer which created the potential for cross contamination (Main Kitchen). Findings include:Review of facility policy Food Storage dated 1/9/26, indicated foods shall be received and stored in a manner that all foods in the freezer and refrigerators will be stored above the floor on shelves to facilitate thorough cleaning.During an observation of the main kitchen on 1/27/26, from 9:00 a.m., through 9:42 a.m., the following was observed:Walk in cooler and freezer had food stored to the ceiling and under the fan encasement allowing potential cross contamination. During an interview on 1/27/26, at 9:42 a.m., Dietary Manager Employee E21 confirmed that the facility failed to properly store food products which created the potential for food borne illness and cross contamination in the Main Kitchen.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(3) Management.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for four of four quarterly meetings (2/12/25, 3/19/25, 4/23/25, 5/28/25, 6/25/25 ,7/30/25, 8/27/25, 9/24/25,10/28/25, 11/18/25, and 12/16/25).Findings Include:Review of Quality assurance and Performance Improvement sign in sheets and attendance records for 2/12/25, 3/19/25, 4/23/25, 5/28/25, 6/25/25 ,7/30/25, 8/27/25, 9/24/25,10/28/25, 11/18/25, and 12/16/25, failed to reveal the Lab Representative and Community Member, one of whom must be the facility's administrator, owner, board member, or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems.During an interview on 1/30/26, at 10:20 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for four of four quarterly meeting (2/12/25, 3/19/25, 4/23/25, 5/28/25, 6/25/25 ,7/30/25, 8/27/25, 9/24/25,10/28/25, 11/18/25, and 12/16/25), as required.

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on resident rights for three of ten staff members (Employees E9, E10 and E15).Findings include:Review of the Facility Assessment most recently reviewed 1/7/26, listed under the training topics Residents rights is identified.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, identified resident rights as a topic for orientation and annual trainings required.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have Resident Rights in-service between 1/17/25, and 1/30/26.Environmental Services Employee E10 had a hire date of 2/22/06, failed to have Resident Rights in-service education between 2/22/25 and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have Resident Rights in-service education between 1/17/25, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on Resident Rights for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395679	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Washington	1198 W. Wylie Avenue Washington, PA 15301

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of personnel records, and staff interview it was determined that the facility failed to ensure that five of five sampled Nurse Aides (NA) received a minimum of 12 hours of in-service education per year (NA Employees E13, E15, E16, E17 and E18). Findings include:Review of facility nurse aide training records revealed that NA Employee E13 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E13 had received a minimum of 12 hours of in-service training yearly.Review of facility nurse aide training records revealed that NA Employee E15 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E15 had received a minimum of 12 hours of in-service training yearly.Review of facility nurse aide training records revealed that NA Employee E16 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E16 had received a minimum of 12 hours of in-service training yearly.Review of facility nurse aide training records revealed that NA Employee E16 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E16 had received a minimum of 12 hours of in-service training yearly.Review of facility nurse aide training records revealed that NA Employee E17 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E17 had received a minimum of 12 hours of in-service training yearly.Review of facility nurse aide training records revealed that NA Employee E18 did not receive 12 hours of in-service training in the last year.The facility was unable to provide documented evidence that NA Employee E18 had received a minimum of 12 hours of in-service training yearly.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide 12 hours of in-service trainings yearly for five of five nurse aides.28 Pa. Code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 201.20(c) Staff Development.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy and clinical records and staff interviews, it was determined that the facility failed to provide the opportunity to formulate an advance directive (written instructions for when the individual is incapacitated) or conduct periodic review of instructions, for two of six residents reviewed (Resident R8, and R36).Findings Include: A review of the facility policy Advance Directives last reviewed 17/26 with a prior review date of 1/9/25, indicated procedures for periodic review of DNROrders will occur at least annually. This facility will allow revocations or amending DNR orders by the resident, the attorney in fact, the representative or treating physician. Such changes will be documented in the medical record. Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2023, 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:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R8 was originally admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/12/25 and admission records, indicated diagnoses of hypothyroidism (thyroid gland creates less than the normal amount of thyroid hormone. The result is the slowing down of many bodily functions), anxiety, and depression. A BIMS score of 14. A review of the clinical record revealed that Resident R8 provided power of attorney (POA) (residents sister) for health care documents to the facility, that included an advance directive dated 1/3/02. On 2/23/22 facility documentation of Healthcare Determinations page reveals the resident does not have an advanced directive and no copy of the advanced directive has been provided to the facility. There is no evidence that periodic advanced directive review occurred with Resident R8 or the power of attorney. During an interview on 1/30/26 at approximately 10 a.m. the Social Service Director Employee E1 confirmed that Resident R8 and the POA have been invited to the care conferences. The POA has not responded to the mailed invitations to attend and has not been visiting the resident for some time. The facility was unable to provide documentation to show if the resident or the POA attended the care conferences in the past twelve months, the documentation reveals code status had been reviewed at the conference by the staff in attendance. Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/18/25 and admission records, indicated diagnoses of diabetes mellitus (high blood sugar), hypertension (high blood pressure), and depression. A BIMS score of 13. A review of the clinical record failed to reveal an advance directive, evidence that a periodic advanced directive review occurred or documentation that Resident R36 was given the opportunity to formulate an Advanced Directive. During an interview on 1/30/26 at approximately 10 a.m. the Social Service Director Employee E1 confirmed that Resident R36 and family had been invited to the care conferences. The facility was unable to provide documentation to show if the resident or the family attended the care conferences in the past twelve months, the documentation reveals code status had been reviewed at the conference by the staff in attendance. During an interview on 1/30/26 at 10:30 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide the opportunity to formulate an advance directive (written instructions for when the individual is incapacitated) or conduct periodic review of instructions. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to make certain, residents who voice grievances can do so without fear of discrimination or reprisal for twelve of sixteen residents (R77, R200, R201, R500, R501, R502, R503, R504, R505, R506, R507, and 508).Findings include: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. A review of the facility policy Grievances last reviewed 1/7/26 with a prior review date of 1/9/25, indicated Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. During a group interview, on 1/28/26 at approximately 1:30 p.m., consensus from the group revealed the residents have a fear of reprisal if they complain or file a grievance related to call light response time and staff attitude. The residents stated they fear they will be retaliated against, by being pointed out as the person who complains or is never satisfied, they have seen it happen to others. During the interviews the residents asked and requested multiple that the surveyor promise them to keep their identity confidential. Review of the facility grievance policy, there is no wording contained in the policy, indicating the grievance can be anonymously completed and submitted. Review of the facility grievance form, there is no wording contained on the form, indicating the grievance can be anonymously completed and submitted. Review of a grievance filed by Resident R77, dated 8/8/25, revealed concerns related to the food being undercooked, cold and noodles overflowing in the bowl. When interviewed by food service, the resident stated someone else filled out the form for them and the food is fine just too much in the bowls. The form has a section for the resident's name and name of concerned party and person filing the concern including phone number, all sections contain the resident's name (no other person listed as completing the form). Review of a grievance filed by Resident R201, dated 8/14/25, revealed concerns related to staff after filing an incident report. I don't like how she makes me feel like I'm the problem because of my mental health issues. Review of a grievance filed on behalf of Resident R200, dated 9/2/25, revealed concerns documented for wait times. Resident requested her bed linen be changed, after an hour the resident went and got the linens and changed the bed. The aide returned later that day as reportedly told the resident You need to be more patient I have a lot of residents to take care of. Resident stated in her grievance, the aide doesn't need to chastise me and that the aide was unprofessional and as a resident she does not deserve to be spoken to and treated this way.During an interview on 1/30/26, at 10:45 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to make certain, residents who voice grievances can do so without fear of discrimination or reprisal. 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) Resident rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to initiate a thorough investigation for potential abuse for one of three residents (Residents R400). Findings include:Review of the facility policy Abuse Protection last reviewed on 1/7/26. with a previous review date of 1/9/25, indicated that each resident has a right to be free from abuse, corporal punishment, neglect, etc. The reporting and filing of accurate documents are required and necessary.Review of clinical record indicated Resident R400 was admitted [DATE], with diagnoses which included a stroke with left sided weakness (non-dominant side), heart flutter, epilepsy and kidney disease. A MDS (Minimum Data Set-a periodic assessment of resident care needs), dated 9/17/25, indicated diagnoses remained current. Review of facility provided documentation indicated a submitted event that indicated Resident R400 allegation of abuse from the Activity Director Employee E20, which had been submitted as per regulation, however, further review of the facility provided documentation did not include a thorough investigation which identified Resident R401 as the resident who instigated the situation and also further identified other staff verbally abusing the Resident R400 with threats of calling the police and telling Resident R400 he could not come to the Activity instead of attempting to de-escalate the situation. Review of other residents witnessing the situation identified Resident R401 as the instigator and the other staff as being verbally abusive towards Residents R400 by stating the threats and not allowing his attendance at the activity.During an interview on 1/ 28/26, at 1/29/26, at 11:20 a.m., the Nursing Home Administrator and Director of Nursing confirmed the facility did not conduct complete investigation on Resident R400's allegations as required.28 Pa. Code: 201.14(a) Responsibility of licensee28 Pa. Code: 201.18(b)(1)(3) Management28 Pa. Code: 211. 10(d) Resident care policies28 Pa. Code: 211.12(d)(3) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for one of two residents (Resident R18).Findings include: Review of facility's policy MDS/RAI/Care Planning dated 1/6/26, indicated the facility will develop a written plan of care individualized for each resident, which identifies through an assessment process his/her strengths, problems and needs. Review of the clinical record face sheet revealed that Resident R18 was admitted to the facility on [DATE], with a diagnosis that included PTSD (Post Traumatic Stress Disorder). Review of a psychiatry note dated 12/10/25, indicated Resident R18 had a diagnosis of chronic PTSD with extensive trauma history. Review of Resident R18's care plan dated 9/9/25, failed to reveal a care plan with goals and interventions for PTSD. During an interview on 1/30/26, at 11:00 a.m. the Director of Nursing confirmed that the facility failed to ensure that a comprehensive resident care plan was complete for resident care needs for Resident R18. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility assessment, facility policy, employee file and staff interview, it was determined that the facility failed Prevention of Abuse and Neglect in-service education for two of ten employees (Employees E9and E15) Findings include:Review of the Facility Assessment most recently reviewed 1/7/26, listed under the training topics Abuse Training is identified.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, identified abuse as a topic for orientation and annual trainings required.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have Abuse training in-service between 1/17/25, and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have Abuse Training in-service education between 1/17/25, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on abuse for two of ten staff members.28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on review of the facility assessment, facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for ten of ten staff members (Employee E9, E10, E11, E12, E13, E14, E15, E16, E17 and E18).Findings include:Review of the Facility Assessment most recently reviewed 1/7/26, listed under the training topics Code of Ethical Conduct is identified.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, identified corporate compliance as a topic for orientation and annual trainings required.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have Compliance and Ethics training in-service between 1/17/25, and 1/30/26.Environmental Services Employee E10 had a hire date of 2/22/06, failed to have Compliance and Ethics training in-service between 2/22/24, and 1/30/26. Registered Nurse Employee E11 had a hire date of 11/4/19, failed to have Compliance and Ethics training in-service between 11/4/24, and 1/30/26. Activity Director Employee E12 had a hire date of 5/22/23, failed to have Compliance and Ethics training in-service between 5/22/24, and 1/30/26.Nurse Aide Employee E13 had a hire date of 10/21/98, failed to have Compliance and Ethics training in-service between 10/21/24, and 1/30/26.Central Supply Employee E14 had a hire date of 9/23/24, failed to have Compliance and Ethics training in-service between 9/23/24, and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have Compliance and Ethics training in-service between 1/17/25, and 1/30/26.Nurse Aide Employee E16 had a hire date of 9/11/24, failed to have Compliance and Ethics training in-service between 9/11/24, and 1/30/26.Nurse Aide Employee E17 had a hire date of 11/25/24, failed to have Compliance and Ethics training in-service between 11/25/24, and 1/30/26.Nurse Aide Employee E18 had a hire date of 11/27/24, failed to have Compliance and Ethics training in-service between 11/27/24, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on Compliance and Ethics for ten of ten staff members.28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility assessment, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for ten of ten staff members (Employee E9, E10, E11, E12, E13, E14, E15, E16, E17and E18).Findings include:Review of S483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at S 483.75.Review of the Facility Assessment most recently reviewed 1/7/26, listed under the training topics QAPI is not identified.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, did not identify QAPI as a topic for orientation and annual trainings required.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have QAPI training in-service between 1/17/25, and 1/30/26.Environmental Services Employee E10 had a hire date of 2/22/06, failed to have QAPI training in-service between 2/22/24, and 1/30/26. Registered Nurse Employee E11 had a hire date of 11/4/19, failed to have QAPI training in-service between 11/4/24, and 1/30/26. Activity Director Employee E12 had a hire date of 5/22/23, failed to have QAPI training in-service between 5/22/24, and 1/30/26.Nurse Aide Employee E13 had a hire date of 10/21/98, failed to have QAPI training in-service between 10/21/24, and 1/30/26.Central Supply Employee E14 had a hire date of 9/23/24, failed to have QAPI training in-service between 9/23/24, and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have QAPI training in-service between 1/17/25, and 1/30/26.Nurse Aide Employee E16 had a hire date of 9/11/24, failed to have QAPI training in-service between 9/11/24, and 1/30/26.Nurse Aide Employee E17 had a hire date of 11/25/24, failed to have QAPI training in-service between 11/25/24, and 1/30/26.Nurse Aide Employee E18 had a hire date of 11/27/24, failed to have QAPI training in-service between 11/27/24, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on QAPI for ten of ten staff members.28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of regulatory requirements, facility policy, facility documents, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Effective Communication for two of ten employees (E9 and E15). Findings include:Review of Federal regulatory requirements for S483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. Review of the Facility assessment dated [DATE], with a previous review date of 1/9/25, did not include Effective Communication in the list of staff training topics.Review of the facility policy Staff Development Program last reviewed on 1/7/26, with a previous review date of 1/9/25, did not include Effective Communication in the list of topics for staff training.Physical Therapy Aide Employee E9 had a hire date of 9/15/16, failed to have Effective Communication in-service between 1/17/25, and 1/30/26.Nurse Aide Employee E15 had a hire date of 7/31/23, failed to have Effective Communication in-service education between 1/17/25, and 1/30/26.During an interview on 1/30/26, at 10:15 a.m., the Director of Nursing confirmed that the facility failed to provide training on Effective Communication for two of ten staff members.28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(c) Staff development.