STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395730	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Lakeside	245 Old Lake Road Dallas, PA 18612

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to ensure a resident's medication regimen was free from unnecessary psychotropic medications and that non-pharmacological interventions and informed consent were implemented prior to initiation of an antipsychotic medication for one of five residents reviewed for unnecessary medications (Resident 2). Findings included:A review of the facility policy titled Psychotropic Medication Use, last reviewed by the facility on November 27, 2024, revealed it is the facility's policy that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The policy states diagnosis alone does not warrant the use of psychotropic medication. Antipsychotic medications will generally only be considered if the following conditions are also met: The behavioral symptoms present a danger to the resident or others, and the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions; paranoia; or grandiosity); or behavioral interventions have been attempted and included in the plan of care, except in an emergency. The policy identifies antipsychotic medications as psychotropic drugs. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 8, 2025, revealed that Resident 2 was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates cognition is severely impaired). A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated October 2024 revealed Resident 2 had no episodes of restlessness or verbal aggression during the month. A review of progress notes dated October 1 through October 31, 2024, revealed no documented episodes of maladaptive behaviors (e.g., aggression or restlessness). A psychiatric consultation note dated October 24, 2024, revealed Resident 2 presented for a four-week follow-up related to previous treatment of severe Alzheimer's dementia. The note documented continued resolution of verbal agitation and physical aggression, with persistence of severe cognitive deficits. The note indicated mood irritability had resolved. A review of the MAR/TAR for November 2024 revealed two episodes of restlessness/verbal aggression documented on November 20, 2024. Progress notes dated November 1 through November 23, 2024, revealed no other documented maladaptive behaviors. A note dated November 22, 2024, at 4:57 AM documented Resident 2 was non-compliant with isolation precautions. A progress note dated November 24, 2024, at 10:13 PM revealed Resident 2 was transported to the emergency department after entering another resident's room and becoming physically and verbally abusive toward staff. Resident 2 was striking out, yelling, and making verbal threats stating he was going to kill staff members. A progress note dated November 25, 2024, at 10:21 AM revealed Resident 2 returned from the emergency department in stable condition, calm and cooperative to care with no new orders. The psychiatric certified registered nurse practitioner (CRNP) was made aware and gave a new order to start Rexulti (brexpiprazole, an antipsychotic medication) 0.5 mg daily for 1 week, then increase to 1.0 mg daily. The physician and resident representative were made aware. A physician's order for Rexulti 0.5 mg daily was initiated on November 26, 2024, and increased to 1.0 mg daily on December 3, 2024, for dementia, mild with agitation. A review of progress note documentation dated November 25 through December 3, 2024, revealed no documented evidence that non-pharmacological interventions were attempted prior to the initiation or escalation of Rexulti. Further review revealed no documented evidence that Resident 2's representative was provided sufficient information to make an informed decision regarding the risks and benefits of initiating an antipsychotic medication. Further review of the clinical record from November 25, 2024, through September 4, 2025, revealed Resident 2 continued to display maladaptive behaviors (increased agitation, verbal aggression, physical aggression, and ambulation without safety interventions) on December 4, 5, 6, 13, 29, and 30, 2024; February 20 and 21, 2025; July 14, 18, and 19, 2025; and August 14 and 24, 2025, despite receiving the

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined that the facility failed to develop and implement discharge planning processes that focused on residents' discharge goals for two out of 15 residents sampled (Residents 5 and 9). Findings include: A review of the facility policy titled Discharge planning, last reviewed by the facility on November 27, 2024, revealed the facility's care planning and interdisciplinary team is responsible for the development of the discharge planning process for residents. The policy indicated the resident, resident representative (as applicable), facility department heads, and any other party deemed necessary to the resident's plan of care will meet to determine the resident's goals, establish discharge needs, and set a projected discharge date . A review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of an admission Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 18 2025, revealed that Resident 5 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13-15 indicates cognition is intact), and indicated in the Q section (a section used for resident goal setting) that the resident's overall discharge plan was unknown, and that there was no active discharge planning already occurring for the resident to return to the community. A review of Resident 5's care plan, initiated on July 11, 2025, revealed the resident wanted to remain in long-term care at the facility, and to honor their wishes of long-term care. A review of a social service progress note dated July 11, 2025, revealed the resident was admitted for long-term care at the facility. A review of a multidisciplinary care conference note dated July 16, 2025, revealed in the social services summary that the resident's discharge goal was long-term care.During an interview with Resident 5 on September 3, 2025, at 11:00 A.M., the resident expressed a desire to return home to live with his parents as his discharge goal. If returning home was not possible, the resident expressed a preference to transfer to another facility where he had previously been admitted prior to his current admission. Resident 5 stated that these goals had been communicated to the social worker since admission. A review of Resident 5's clinical record revealed no documented evidence that the facility developed a plan of care to reflect the resident's stated goals of either returning home or transferring to another facility. During an interview on September 3, 2025, at 11:25 A.M., with Employee 1, the Social Services Director, confirmed Resident 5 is cognitively intact and able to make his own decisions regarding his care and discharge planning and confirmed Resident 5's care plan did not reflect his wishes to return to the community or transfer to another facility. Employee 1, the Social Services Director, was unable to provide documented evidence that the facility was working with Resident 5 towards a discharge plan that met his goals. Following inquiries made during the survey, Resident 5's care plan was updated on September 3, 2025, to indicate the resident would remain in the facility long-term but wished to return home when medically stable, with possible discharge to be considered if feasible. An interview with the Nursing Home Administrator (NHA) on September 3, 2025, at 11:35 A.M. revealed the information regarding Resident 5's discharge planning goals was reviewed, and the NHA acknowledged that the goals identified by the resident were not reflected in the plan of care. A clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental health condition that combines symptoms of psychosis and a mood disorder, such as depression or bipolar disorder) and epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures). A review of a quarterly MDS dated [DATE], revealed that Resident 9 was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact). A review of Resident 9's care plan, initiated on June 27, 2025, indicated the resident would remain at the facility on a long-term basis. Interventions included maintaining the resident's wishes to be in long-term care at the facility. However, a progress note dated July 1, 2025, at 12:00 A.M. documented that Resident 9 was admitted to the facility for strengthening after hospitalization. The progress note reflected Resident 9's statement that she intended to regain strength and then return home to live with her daughter. During an

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, a review of clinical records, resident observation, and staff interviews, it was determined that the facility failed to complete an accurate Minimum Data Set for three of 15 residents sampled (Resident 1, Resident 10, & Resident 11).Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 2024, requires the assessment to accurately reflect the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include dementia (a progressive condition involving cognitive decline, memory loss, and changes in personality and behavior). The Quarterly MDS dated [DATE], documented pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection which makes it difficult to breathe) in Section I2000 (Infections). However, there was no evidence in the clinical record that the resident had pneumonia during the seven-day look-back period. The Registered Nurse Assessment Coordinator (RNAC) confirmed on September 3, 2025, at 10:00AM, that the resident did not have pneumonia during that time and acknowledged the MDS was inaccurate. A clinical records review revealed Resident 10 was admitted to the facility on [DATE], with diagnoses to include Parkinson's Disease without dyskinesia without mention of fluctuations (progressive movement disorder of the nervous system). The initial MDS dated [DATE], section GG-0115 (section related to functional abilities the ability to perform tasks and activities necessary for daily living) documented no impairment in range of motion (the full movement of a joint). A clinical record review of a Physical Therapy Evaluation and Plan of Treatment (dated June 13, 2025) for Resident 10 documented no impairment in range of motion for both upper and lower extremities. Further clinical record review of an Occupational Therapy Evaluation and Plan of Treatment (dated June 12, 2025) for Resident 10 identified a goal to increase R shoulder flexion (bending of a limb or joint) to 30 degrees by July 3, 2025. The Occupational Therapy Evaluation and Plan of Treatment also noted Resident 10 experienced functional limitations (reported level of difficulty) in range of motion for both one upper and one lower extremity. Observation and interview of Resident 10 on September 2, 2025, at 11:00 AM revealed bilateral hands including fingers and wrists with obvious joint deformities. During observation and interview with this surveyor on September 2, 2025, at 11:00 AM, Resident 10 expressed a desire for devices to help her eat meals such as a fork, spoon, cup. Interview with the Registered Nurse Assessment Coordinator (RNAC) and Director of Rehabilitation on September 3, 2025, at 0856, discussed the above findings. The RNAC and Director of Rehabilitation could not confirm the MDS for Resident 10 had been coded accurately regarding range of motion activities and entered a correction to the MDS during the survey time. A clinical records review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses to include Unspecified dementia, moderate with agitation (a term for a collection of symptoms that can be caused by several disorders that affect the brain). Review of the Quarterly MDS assessment dated [DATE], Section N0450 (antipsychotic medication review), documented that a gradual dose reduction (stepwise lowering of medication) for antipsychotic medication was completed on May 29, 2025. Review of physician orders dated May 20, 2025, documented a new order for a decreased dose of Seroquel (an antipsychotic medication). Review of nursing documentation dated May 20, 2025, confirmed the order was received, and the decreased dose was administered beginning May 20, 2025. During an interview on September 4, 2025, at 11:30 AM, the RNAC stated that the date of May 29, 2025, date was entered on the MDS because it was documented on the psychiatric evaluation form and could not confirm that the MDS was coded accurately. During an interview with the Director of Nursing on September 4, 2025, at 11:28 AM, after review of the MDS coding, the facility was unable to provide documentation to support the accuracy of the MDS coding for Resident 10 and Resident 11.28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.12(c)(d)(1)(5) 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 clinical record review, facility policy review, observations, and staff and resident interviews, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one of 15 sampled residents (Resident 10). Findings include: A review of the clinical record revealed Resident 10 was admitted to the facility on [DATE], with diagnoses to include Parkinson's Disease without dyskinesia without mention of fluctuations (progressive movement disorder of the nervous system). Further review of the clinical record indicated Resident 10 had a BIMS score of 13 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 13 to 15 suggests the individual is cognitively intact) as of June 17, 2025 A review of nursing progress notes documented two occurrences involving Resident 10's son. On June 14, 2025, and again on July 3, 2025, Resident 10's son demonstrated disruptive and hostile behaviors, including verbal aggression and use of vulgar language toward staff while in the presence of Resident 10. Documentation related to the July 3, 2025, incident indicated that law enforcement intervened, the son was handcuffed, and he was escorted from the facility. Following this event, the son was prohibited from entering the building. A review of the comprehensive care planning policy last reviewed by the facility on November 27, 2024, revealed that the facility will develop an individualized care plan for each resident. The policy further described the goals of care will be established through an evaluation of the resident's present state of physical and emotional health and care plans are revised as information about the resident and resident's condition change. A review of Resident 10's comprehensive care plan, in effect through the survey end date of September 4, 2025, revealed no evidence that Resident 10's psychosocial well-being had been evaluated or addressed in relation to the disruptive behaviors of his son or the subsequent restriction preventing his son from entering the building. During an interview on September 3, 2025, at 9:04 AM, the facility Social Worker confirmed that Resident 10's care plan was not updated to include ongoing assessment of psychosocial needs and related goals following these incidents. In an interview on September 4, 2025, at 11:28 AM, the Director of Nursing acknowledged the facility was unable to provide evidence that Resident 10's care plan had been revised to reflect these events. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.10 (d) Resident care polices.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for 1 resident out of 15 residents sampled (Resident 4). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: AssessmentsClinical problemsCommunications with other health care professionals regarding the patientCommunication with and education of the patient, family, the patient's designated support person, and other third parties. A review of the facility policy titled Anticoagulation Policy, last reviewed by the facility on November 27, 2024, revealed it is the policy of the facility that all residents prescribed anticoagulants (a blood thinner) will be monitored closely for therapeutic effectiveness and potential complications. PT/INR (Prothrombin Time/International Normalized Ratio) is a laboratory blood test used to measure how long it takes blood to clot. The PT measures clotting time, while the INR standardizes the result so it can be interpreted consistently across different labs. Providers use PT/INR values to determine if warfarin is working effectively and safely. If the level is too low, the blood can clot and cause strokes or clots in the legs or lungs. If the level is too high, the resident may experience dangerous bleeding. According to policy, PT/INR levels must be obtained as ordered and results promptly communicated to the provider.Further review revealed that all nursing, medical, and pharmacy staff will follow standardized procedures for administration, lab monitoring, documentation, communication, and education. A clinical record review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and hydrocephalus (fluid buildup on the brain).A quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment process conducted at specific intervals to plan resident care) of Resident 4 dated July 11, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 04 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). A physician's order dated June 3, 2025, directed warfarin 7 milligrams (mg) by mouth daily at bedtime. A nurse progress note dated June 3, 2025, documented communication with the physician regarding PT/INR results, with instructions to draw the next PT/INR on June 17, 2025. However, a clinical record review revealed no PT/INR was ordered or obtained on June 17, 2025. The June 2025 Medication Administration Record (MAR) showed Resident 4 received Coumadin (brand name for warfarin) 7 mg from June 3 through June 17, 2025. No warfarin was ordered or administered on June 18 or June 19, 2025. On June 20, 2025, at 7:44 A.M., a physician ordered a STAT PT/INR, followed by a one-time dose of 7 mg warfarin at 8:06 A.M., administered at 9:21 A.M. Later that same day, at 12:49 P.M., the physician ordered warfarin 7 mg daily, with a PT/INR to be drawn on June 24, 2025. A nurse progress note dated June 20, 2025, at 8:19 P.M. documented clarification with the on-call provider that Resident 4 should receive the scheduled 7 mg warfarin dose at 9:00 P.M. despite receiving a one-time dose earlier that day, as the resident had missed previous doses. An interview with the Director of Nursing (DON) on September 4, 2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth , which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that encounters food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Initial tour of the dietary department in the presence of the foodservice director (FSD) on September 2, 2025, at 8:50 AM revealed the following food storage and sanitation concerns with the potential to increase the potential for food-borne illness: Observation of the handwashing area revealed there was no trash can near the sink to dispose of paper towels after washing and drying hands. There were four bags of frozen vegetables and one bag of tater tots on the shelf in the freezer which were not dated. Observation of the dry storage room revealed the metal locking latch of the exit door to the outside was folded back in the door jam which prevented the door from closing. The floor area in front of the door was worn, soiled, and the floor tile was cracked. There was a six inch piece of floor molding missing from the wall to the right of the exit door. Observation of the sink in the janitor closet located in the dietary department revealed the sink contained a plastic bin filled with microfiber cloths, aprons, and a container of cleaning wipes. Interview with the food service director at the time of the observations confirmed the dietary department should be maintained in a sanitary manner and acceptable practices for food storage were to be followed and all food items were to be properly dated to ensure safety and quality and prevent the potential for food contamination and foodborne illness.28 Pa. Code 201.18 (e)(1)(2.1) Management. 28 Pa. Code 211.6 (f) Dietary services.