

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Harmony		STREET ADDRESS, CITY, STATE, ZIP CODE 191 Evergreen Mill Road Harmony, PA 16037	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to notify the physician of missed medication and increased behaviors for one of four residents (Resident CRR2) and failed to notify a resident's responsible party for an increase in medication dosage for one of three residents (Resident R1).</p> <p>Review of the facility's policy Notification Change in Condition Responsible Party dated 2/1/24, indicated the responsible party or guardian is to be notified of changes in condition or occurrences to ensure that the resident 's responsible party or guardian is notified of changes and /or occurrences and action and pertinent information are documented. When any one of the following instances occurs, the resident's responsible party or guardian will be notified including but not inclusive to: There is a significant change in the resident's physical, mental or psychosocial status. An incident has occurred, (including falls, altercations, injuries, elopements, medication errors, etc.).</p> <p>Refusal of medications, treatments, labs. The nurse must document the name of the person notified, the date and time in the nurse's notes.</p> <p>Review of the facility's policy Notification of Condition Change Physician Notification dated 2/1/24, indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident's condition. Document assessment data the attempted or actual correspondence with physician, and physician's response in the medical record.</p> <p>Review of Resident CRR2 indicated an admitted [DATE].</p> <p>Review of Resident CRR2's Minimum Data Set (MDS) dated [DATE], indicated the diagnosis of hypertension (high blood pressure), hyperlipidemia (high fat in the blood), and dementia (impairment of memory and thinking). Section C0200 indicated 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 intact; 8-12: moderately impaired; 0-7: severe impairment. Resident CRR2 received a score of three indicating severe impairment.</p> <p>Review of Resident CRR2's admission elopement indicated resident was at risk for elopement.</p> <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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident CRR2's progress note dated 11/5/2024, at 07:48 indicated resident approached this nurse stating, I don't want your food, I don't want any of your pills. I want that doctor here right now. You people are keeping me from Altoona. I want my sister. If I don't get to Altoona, I am going to hurt somebody. Resident was pacing the hallway, very agitated. He went back into his room and sat on the bed staring at the door. Supervisor and DON notified of resident's agitated state.</p> <p>Review of CRR2's progress notes indicate on 11/5/24, at 8:59 a.m. resident is refusing to take any and all medications.</p> <p>Review of progress note dated 11/5/2024, at 9:45 a.m. indicated resident in the hallway walking back to room from nurse's station. Resident informed this nurse that the man that is in his room is not helping him to get to Altoona and he wants him out of there. The resident stated, If you don't get him out I will. I don't want him in my house. While speaking, he was making a fist and clearly showing this nurse that he is agitated. He was assured that the roommate was not going to hurt him and that this nurse would talk to the supervisors about removing him from the room. Resident shook head.</p> <p>Review of progress note dated 11/5/2024 at 11:45 a.m. indicated resident remains agitated. Sitting on the bed staring at the door. Resident is unapproachable at this moment. Resident refused lunch and is continuing to ramble about seeing a doctor to get back to Altoona. Resident states, Call the Altoona police and send me to the prison. Either way I am going to Altoona. My sister is . I want the doctor here, they won't call my sister, I need to go to Altoona. Resident reassured that he may call his sister whenever he wants to. Resident stated, Get out of my room until you get the doctor and a ride to Altoona hospital. Someone's gonna get hurt.</p> <p>During an interview completed on 11/22/24, at 12:05 p.m. Director on Nursing confirmed that the physician was not notified of Resident CRR2's refusal of medications and increase in behaviors.</p> <p>During an interview completed on 11/22/24, at 12:20 p.m. the Assistant Director of Nursing (ADON) stated it is poor documentation and confirmed that failed to notify the physician of missed medication and increased behaviors for one of four residents (Resident CRR2).</p> <p>Review of Resident R1's clinical record indicate an admitted [DATE].</p> <p>Review of Resident R1's minimum Data Set (MDS) dated [DATE], indicates the diagnosis of hypertension (high blood pressure), urinary tract infection, and dementia (impairment of memory and thinking) Section C0200 indicated 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 intact; 8-12: moderately impaired; 0-7: severe impairment. Resident R1 received a score of seven indicating severe impairment.</p> <p>Review of physician orders dated 11/18/2024, indicate Remeron Oral Tablet 30 MG (Mirtazapine-medication used to treat depression and can also help with sleep) Give 1 tablet by mouth every hour of sleep.</p> <p>Review of progress note on 11/18/2024, at 4:40 p.m. indicate Nurse Practitioner (NP) in to see resident and ordered to increase Mirtazapine to 30mg PO QHS for anxiety/insomnia. Resident aware and will continue to be monitored.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/21/24, at 1:23 p.m. the ADON Employee E1 confirmed that Resident R1 has a BIMS score of 7 and that her responsible party was not notified of an increase in her medication we will have to educate the nurse and that the facility failed to notify a resident's responsible party for an increase in medication dosage for one of three residents (Resident R1).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, clinical records, observations, and staff interviews it was determined that the facility failed to make certain each resident received adequate supervision which resulted in one elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of four residents (Resident CRR2) and failed to consistently document in the clinical record regarding post-incident response after an elopement for two of four residents (Resident R1 and CRR2).</p> <p>Findings include:</p> <p>Review of the facility's policy Elopement Prevention dated 2/1/24, indicated cognitively impaired residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.</p> <p>Review of the facility's policy Notification Change in Condition Responsible Party dated 2/1/24, indicated the responsible party or guardian is to be notified of changes in condition or occurrences to ensure that the resident ' s responsible party or guardian is notified of changes and /or occurrences and action and pertinent information are documented. When any one of the following instances occurs, the resident ' s responsible party or guardian will be notified including but not inclusive to: There is a significant change in the resident ' s physical, mental or psychosocial status. An incident has occurred, (including falls, altercations, injuries, elopements, medication errors, etc.). Refusal of medications, treatments, labs. The nurse must document the name of the person notified, the date and time in the nurse ' s notes.</p> <p>Review of the facility's policy Notification of Condition Change Physician Notification dated 2/1/24 indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident ' s condition. Document assessment data attempted or actual correspondence with physician, and physician ' s response in the medical record.</p> <p>Review of Resident R1's clinical record indicate an admitted [DATE].</p> <p>Review of Resident R1's minimum Data Set (MDS) dated [DATE], indicates the diagnosis of hypertension (high blood pressure), urinary tract infection, and dementia (impairment of memory and thinking).</p> <p>Review of Residents R1's facility provided information labeled privileged and confidential-not part of the medical record-do not copy indicated at approximately 2:30 p.m. when the second shift staff were arriving it was noted that the resident was standing at the end of the driveway.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R1's progress notes failed to have documentation regarding the incident of elopement the last documentation discovered in the clinical record was dated 11/1/24, followed by documentation completed on 11/2/24 at 3:00 p.m. that indicated progress note late entry: Head to toe assessment completed on resident, which revealed no redness, bruising, or open areas, able to move all extremities at baseline, vital signs stable, neuro checks within normal limits. Resident has no complaints of pain or discomfort.</p> <p>During an interview on 11/21/24, at 11:47 a.m. the Director of Nursing stated, I don't know why the nurse didn't document on Resident R1.</p> <p>Review of Resident CRR2 indicated an admitted [DATE].</p> <p>Review of Resident CRR2's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), hyperlipidemia (high fat in the blood) and dementia.</p> <p>Review of Resident CRR2's admission elopement indicated resident was at risk for elopement.</p> <p>Review of Residents CRR2's facility provided information labeled witness statements dated 11/5/24, indicated at approximately 2:00 p.m. the nurse went back to resident CRR2's room to complete a 15-minute check and he was not in his room. At approximately 2:05 p.m. it was noted that the window in CRR2's room was open, and the screen was forcefully pushed out. Search was immediately expanded to the outside grounds of facility. Local authorities were notified, and communication from the local authorities stated they had located the resident and were going to bring him back to facility.</p> <p>Review of Resident CRR2's progress notes failed to have documentation regarding the incident of elopement the last documentation discovered in the clinical record was dated 11/5/24 at 11:45 a.m. followed by a note dated 11/5/24, at 3:10 p.m. indicating a head-to-toe assessment completed. Noted superficial abrasion to top back of scalp 1cm x 1 cm no active bleeding, right elbow light bruising 3cm x 3 cm, right hip superficial abrasion 5cm x 5 cm no active bleeding, left knee superficial abrasion 0.5 x 0.5cm no active bleeding. Full range of motion to all extremities. Denies any pain at this time with movement. Denies chest pain or headache.</p> <p>During an interview on 11/21/24 at 1:20 p.m. the Director of nursing stated upon asking if Resident CRR2 had adequate supervision replied I can't say I disagree to there being a lack of supervision and that facility failed to make certain each resident received adequate supervision that resulted in one elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of four residents (Resident CRR2) and failed to document in the clinical record regarding post-incident response after an elopement for two of four residents (Resident R1 and CRR2).</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services.</p>		