STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395758	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Harmony	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect by failing to provide incontinence care in a timely manner for one of four residents reviewed (Resident R105).Findings include: Review of facility policy Abuse: Protection From Abuse dated 4/14/26, indicated the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to: nutrition, medication, therapies, and activities of daily living. The absence of reasonable accommodations of individual needs and preferences may resulted in resident neglect. Review of the clinical record indicated Resident R105 was admitted to the facility on [DATE]. Review of Resident R105's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/1/26, indicated diagnoses of high blood pressure, Peripheral Vascular Disease (PVD - circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Section H0300: Urinary Continence indicated the resident was coded 3 always incontinent of urine. Review of Resident R105's care plan dated 10/24/25, indicated the resident has bladder incontinence related to impaired mobility, possible adverse effects related to medications received and age related functional declines. Interventions include check resident as required for incontinence. Wash, rinse, and dry perineum (the anatomical region between the genitals and the anus). Change clothing as needed after incontinence episodes. Review of a facility submitted document dated 2/26/26, indicated the following: On this date, 2/26/26, this DON (Director of Nursing) was notified by staff of a concern regarding a resident's care. The reporting staff member stated that during rounds, the resident, Resident R105, was found saturated with urine and reported that he had not received incontinent care from the CNA (Certified Nurse Aide) assigned to him the prior shift. Review of a witness statement dated 2/26/26, completed by Nurse Aide (NA) Employee E18 stated, Today 2/25/26, I came in for my 10:30 p.m. - 6:30 a.m. shift and was assigned the back section of Northwest. I began my first round at arrival and upon entering Resident R105's room he was sitting up along with his roommate and both still had dinner trays in front of them, which was a sure sign they hadn't been checked sine dinner. I asked Resident R105 who his aide was and he stated NA Employee E19 and added that he hadn't been changed since 1 p.m. when a different aide was here. Resident R105's brief and insert and bed pad were all completely saturated just like the other day when she had him. Review of a typed verbal witness statement dated 2/26/26, completed by the DON, indicated Resident R105 stated, The resident reported over the past several days there were 2 days when he did not see staff regularly. He specifically recalled that on Sunday and Wednesday, he was assisted in his wheelchair in the morning and then returned to bed before the end of the day shift. He stated that the next time he was changed was by the night shift (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA and identified his CNA on afternoon shifts these days as being NA Employee E19. When asked about staff response to his call light, Resident R105 stated that he did not use the call bell during this time. He noted that staff had entered and exited his room periodically to bring meal trays, water, snacks, etc.; however, incontinent care was not provided during those times. Review of a witness statement dated 2/26/26, completed by NA Employee E19 stated, On 2/25/26 I was working on Northwest 2 p.m. - 10 p.m. and was responsible for the care of several residents, including Resident R105, Resident R11 and another resident who was experiencing persistent vomiting. I was attending to the vomiting resident, providing them with the necessary care and support while also having to mop the entire room due to infection control reasons . Dinner trays came at about 4:40 p.m. We passed dinner, I went into Resident R105's room during dinner to pick up trays after they were done and we picked up the rest of the floor's trays. I do not recall seeing anyone's lights on. After helping do rounds with the agency girl for her x2 residents I went to Resident R11's room and had a full bed change for him, like normal. Resident R105 did not at any point then (or ever really) ring to be changed, but recently he only wants done later on in the night . I then went down to room [ROOM NUMBER] to ask the resident if he was ready when I noticed him vomiting and rushed to get a hoyer (a mechanical lift), the gurney bed, and find help to spot. He got put on the bed, I cleaned all the linens and clothes up into linen bags for laundry, put his chair aside to wash later and completed his shower. He vomited again during the shower and after I was in the room trying to find someone to help transfer him back to bed . I was in a rush to attend to that resident so I may have forgotten to check on Resident R105 when his light was on when I was taking another resident to the shower room. However, passing by the beauty shop I asked the agency girl to cover my lights and she said ok, when I came out his light was off so I assumed she assisted him. When I answer lights I do what they want. I don't turn off the bell and leave so I assume that's what she did since Resident R105 didn't ring again the rest of the night. Multiple times nurses went into his room and didn't inform me of anything from Resident R105, and I was so wrapped up in the other resident's chaos that I genuinely had forgotten to ask the agency girl what he rang for. I did not receive any notification or feedback from my colleagues that Resident R105 still needed to be changed. When I exited the shower, Resident R105's light was not ringing, which led me to believe that his needs had been met. During an interview on 4/29/26, at 12:32 p.m. the DON confirmed that the facility failed to make certain each resident was free from neglect by failing to provide incontinence care in a timely manner for Resident R105. 28 Pa. Code: 201.14(a) Responsibility of licensee28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.