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	06/30/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, facility documentation, incidents submitted to the local State field office, and staff interviews it was determined that the facility failed to submit a report of an allegation of staff to resident abuse and physical restraint for one of three residents reviewed (Resident R1).Findings include: Review of the facility policy Abuse Reporting and Investigation dated 4/14/26, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse (mental, physical, sexual, involuntary seclusion or misappropriation of resident property), neglect or exploitation. The Department of Health will be notified of the alleged event by the Administrator or designee via the Electronic Event Reporting System (ERS) per regulation. Review of the admission record indicated Resident R1 admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/13/26, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and stroke (damage to the brain from an interruption of blood supply). Review of Resident R1's care plan dated 6/5/26, indicated resident has a behavior problem related to putting self on the floor. Review of facility provided witness statement, undated, and signed by Assistant Director of Nursing (ADON) Employee E1 indicated on Friday, 6/12/26, at approximately 11:40 p.m. they received a call from Registered Nurse (RN) Supervisor Employee E2 of an allegation made by Resident R2 against Nurse Aide (NA) Employee E3. Resident R2 reported they had a photo of the roommate Resident R1, appearing to be secured to a Geri-chair with a white bed sheet. They stated this occurred during the overnight shift on Thursday and claimed NA Employee E3 was responsible. Review of alleged abuse allegations submitted to the State field office did not include the allegation of abuse and physical restraint incident involving Resident R1 reported on 6/12/26. Interview on 6/29/26, at 1:22 p.m. with the Director of Nursing and Nursing Home Administrator confirmed the facility failed to submit a report of an allegation of staff to resident abuse and physical restraint for one of three residents reviewed (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (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