| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395827 | A. Building<br>B. Wing | 12/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kadima Rehabilitation & Nursing at Pottstown | 3031 Chestnut Hill Road<br>Pottstown, PA 19464 |

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 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166<br><br>Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure correct installation, use, and maintenance of bed rails for one resident (Resident 1)<br><br>Findings include:<br><br>Review of Title 42 Code of Federal Regulations (CFR) S483.25(n) - Bed Rails states, If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements, Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails).<br><br>Review of the facility policy Use of Side Rails dated August 28, 2018, indicated that the resident will be checked frequently for safety.<br><br>Review of the admission record indicated Resident 1 was admitted to the facility on [DATE], with the following diagnoses: chronic respiratory failure with hypoxia (low oxygen levels in the blood), Hemiplegia, unspecified affecting left nondominant side (one-sided paralysis or weakness of the face, arm, or leg), Tracheostomy status (a surgical airway management procedure which consists of making an incision on the anterior front of the neck and opening a direct airway through an incision in the windpipe as a site for a tracheal tube to be inserted; this tube allows a person to breathe without the use of the nose or mouth).<br><br>Review of Resident 1's side rail/restrain enabler evaluation assessment dated [DATE], revealed at this time side rails are indicated to provide safety.<br><br>Interview conducted on December 30, 2024, at 9:41 a.m. with Resident 1 revealed the side rail located next to Resident 1's left hand was not properly secured to the bed and was unusable for turning and repositioning.<br><br>At 9:47 a.m. the Nursing Home Administrator (NHA) accompanied the surveyor to Resident 1's room. The NHA confirmed the bedrail/side rail was not properly secured to the bed and nursing staff should have regularly performed inspections on Resident 1's bedrails/ side rails.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code: 211.10(c)(d) Resident care policies.<br><br>28 Pa. Code: 211.12(d)(1)(5) Nursing services. |