

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Kadima Rehabilitation & Nursing at Campbelltown		STREET ADDRESS, CITY, STATE, ZIP CODE 2880 Horseshoe Pike Palmyra, PA 17078	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** Based on clinical record review, policy review, and resident and staff interview, it was determined that the facility failed to provide necessary supervision and services for a resident who had a history of suicidal ideation (thoughts centered around death or suicide) and attempted suicide for one of five sampled residents. This failure resulted in an Immediate Jeopardy situation. (Resident 1) Additionally, the facility failed to ensure that the environment was free from accident hazards in a resident room (Resident 2) and on the nursing unit.</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Suicide Threats, last reviewed September 19, 2024, revealed that resident threats of suicide would be reported immediately to the charge nurse/supervisor. Staff was to remain with the resident until the charge nurse/supervisor arrived to assess the resident. The resident was to be placed on one-to-one observation until the episode resolved if they were capable of self-injury. The one-to-one observation was to continue until the resident was transferred out to another facility for acute intervention or until a nurse assessment determined that the resident was no longer a safety risk. The charge nurse or designee was to immediately notify the resident's physician and responsible party of such threats. The nursing supervisor would assess the resident's physical and mental abilities to act on such threat and implement appropriate precautions. The nurse supervisor would assess the resident to determine if acute interventions were required. All attempts would be made to transfer the resident to a more appropriate setting for emergency intervention and care when they indicated that they had a suicide plan. The Director of Nursing and Administrator would be notified. Social services would be notified to provide psychosocial support as appropriate. If a resident remained in the facility, an assessment of the resident's behavior would be assessed by the interdisciplinary care team within 72 hours of such incident to determine interventions that may be necessary to prevent the reoccurrence of such threats. A revised care plan would be developed to reflect such interventions. A behavioral health professional consultation was indicated whenever the resident made a suggestion of suicide.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], did not have cognitive impairment, and had diagnoses that included suicide attempt, major depressive disorder, generalized anxiety, bipolar disorder (a mental health disorder that causes extreme mood swings), agoraphobia (an anxiety disorder that causes a fear of places or situations that cause panic and a fear of being trapped or helpless) with panic disorder, and insomnia. Review of hospital records dated November 5 and 8, 2024, revealed that the resident was at risk for suicide and required one to one supervision during her hospital admission. On November 18, 2024, a nurse noted that the resident told staff that she was feeling really bad and wanted to hurt herself. There was no evidence that staff remained with the resident, provided one-to-one observation until the episode resolved, assessed to determine if she was no longer a safety risk, transferred to a higher level of care, assessed for acute interventions, reassessed within 72 hours after the resolution of the episode to implement interventions to prevent reoccurrence, or that the resident's care plan was revised to reflect such interventions, per facility policy. On November 19, 2024, the resident's physician noted that the resident reported feeling extremely anxious about the previous hospital stay and change in environment. There was a lack of evidence to support that a behavioral health professional was contacted, per facility policy. On December 11, 2024, staff noted that the resident requested psychological services. On December 12, 2024, staff noted that a referral to the behavioral health services provider had been sent. On February 10, 2025, staff noted the resident reported feeling bad and wished to see a therapist. On February 11, 2025, the resident's practitioner noted that the resident reported increased anxiety and depression, she could not turn her mind off, and felt overwhelmed. The practitioner noted that the resident was followed by psychological services. There was a lack of evidence to support that the resident was ever assessed or followed by psychological services. Review of the behavioral health services provider's documentation revealed no evidence that the resident had been assessed or treated by behavioral health services since admission to the facility on November 15, 2024.</p> <p>On February 13, 2025, the resident's practitioner noted that the resident had suicidal ideation. She reported that her anxiety was still not controlled, she verbalized suicidal ideation, and stated, I just want to die, I do not want to live anymore. The resident was transferred to the hospital for evaluation. The resident returned to the facility on February 14, 2025, at 2:30 a.m. There was a lack of evidence that the facility implemented safety interventions or increased supervision to ensure the resident's safety upon return from the hospital. On February 14, 2025, at 9:00 a.m., staff noted that the resident was found with blood on her bed. She reported taking a sharp object from her roommate, who was sleeping, and sliced her neck multiple times. The resident continued to state that she, wanted to die and did not have anyone to connect with. The resident was transferred out of the facility with emergency medical services.</p> <p>Clinical Record review revealed that Resident 2 did not have cognitive impairment. In an interview on April 21, 2025, at 12:52 p.m., Resident 1's previous roommate, Resident 2, stated that she has ordered sharp objects online for personal use, these items included a knife, and had been kept on the top of her bedside table. The resident confirmed that Resident 1 obtained a sharp object from her side of the room. During this interview period, the resident's key to her drawer lock was observed in the lock, accessible to anyone who entered the room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on April 21, 2025, at 1:15 p.m., licensed practical nurse (LPN) 1 stated that Resident 2 had a history of ordering sharp objects, such as knives and scissors, that were delivered to her room. LPN 1 confirmed that Resident 1 was found to have cut her neck with scissors that she obtained from her roommate while her roommate was sleeping. Resident 1 stated to LPN 1 that it was an attempted suicide. LPN 1 confirmed that the resident had a history of suicidal ideation and suicide attempts, had expressed feelings of exacerbated depression and anxiety, and thoughts of self-harm. She confirmed that the resident was not placed on one to one observation and was not seen by behavioral health services since admission to the facility.</p> <p>Observation of the back hall on the nursing unit on April 21, 2025, from 1:44 p.m. through 2:10 p.m., and again at 2:20 p.m., revealed an unattended treatment cart that was unlocked. The cart contained various items for resident treatments and button batteries.</p> <p>Observation of two unattended medication carts for the nursing unit on April 21, 2025, at various times between 1:46 p.m. and 3:13 p.m., revealed a pair of scissors stored on top of each medication cart. An ambulatory resident and visitors were present in the area during the observation period. In an interview at 1:49 p.m., LPN 1 stated the scissors are typically stored on the top of the medication carts.</p> <p>In an interview on April 21, 2025, at 4:43 p.m., the Administrator confirmed that there was a lack of evidence to support that the facility had implemented safety interventions or staff education related to the incident involving Resident 1's suicide attempt in order to prevent a reoccurrence of a similar incident.</p> <p>Review of a facility matrix dated April 21, 2025, revealed that nine of 44 residents had a diagnosis of Alzheimer's disease or dementia, and 34 of 44 residents were prescribed psychotropic medications.</p> <p>On April 21, 2025, at 3:21 p.m., the Administrator was notified that the failure to provide adequate safety interventions and supervision for a resident who expressed suicidal ideation constituted an Immediate Jeopardy situation at F689-K, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required.</p> <p>The facility presented an acceptable action plan for removal of the Immediate Jeopardy on April 21, 2025, at 9:03 p.m. The facility's action plan contained the following:</p> <ol style="list-style-type: none"> 1. The facility educated staff onsite regarding the management of a resident who presented with signs of suicidal ideation, which included adequate supervision of the resident, notification to supervisory staff, and implementing immediate interventions. Education also included ensuring that resident accessible areas, which included resident rooms and common areas, were free from accident hazards, and appropriate action when a hazard(s) was identified. 100 percent(%) of all staff will be educated by April 23, 2025. 2. A safety audit of resident areas and any area within resident reach was conducted to determine the presence of accident hazards, such as unlocked medication and treatment carts and sharp objects. This audit was completed on April 21, 2025. Resident and family education will include information regarding items not deemed safe for resident possession and will be completed on April 22, 2025. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. An audit of nine-item patient health questionnaire (PHQ-9, a tool used to identify major depression) scores of all residents in the facility was completed to identify any residents who may have been or was at risk for suicidal ideation or actions. Residents identified to be at risk were reviewed to determine if immediate intervention was required. The audits and resident reviews were completed on April 21, 2025. Updated PHQ-9 interviews would be completed for all residents in the facility. Behavioral health services would be requested to conduct an audit of all residents in the facility to determine any resident who may be at risk for suicidal ideation. These audits and interviews would be completed by April 28, 2025. PHQ-9 interviews will continue to be conducted as scheduled, which included at admission, quarterly, with significant changes in condition, and as needed.</p> <p>4. An assessment of residents who presented with suicidal ideation and were determined to no longer be at risk, will be completed within 72 hours by the interdisciplinary care team. Immediate action and interventions will be implemented as needed, and the supervisor will be notified of the interventions.</p> <p>5. Facility administration was educated on incidents required to be reported to the state agency. 100% of administration will be educated by April 22, 2025.</p> <p>6. Newly admitted residents will be reviewed at morning meetings to determine risk for suicidal ideation and appropriate interventions. Daily review of the 24-hour report will be conducted to identify any resident with suicidal ideation, and interventions will be implemented as indicated.</p> <p>7. Newly hired members of administration will be educated on reporting events to the state agency and the facility's policy entitled, Suicide Threats, by the company's main office. The Administrator assumes responsibility for compliance with reporting incidents to the State Agency.</p> <p>The survey team validated the Immediate Jeopardy was removed on April 21, 2025, at 9:03 p.m., through observation, reviewing the facility training, and staff interviews following the facility's implementation of the plan of removal of the Immediate Jeopardy.</p> <p>The deficient practice remained at an E (pattern with potential for more than minimal harm) scope and severity following the removal of the Immediate Jeopardy.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide behavioral health services for one of five residents reviewed which resulted in multiple lacerations to the neck from a suicide attempt, actual harm, to the resident. (Resident 1)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included suicide attempt, major depressive disorder, generalized anxiety, bipolar disorder, agoraphobia (an anxiety disorder that causes a fear of places or situations that cause panic and a fear of being trapped or helpless) with panic disorder, and insomnia. Review of hospital records dated November 5 and 8, 2024, revealed that the resident was at risk for suicide and required one to one supervision during the hospital admission. Review of the care plan revealed that the resident was at risk for mood problems due to suicide attempts prior to admission. The intervention was for behavioral health consultations (consults) as needed. A physician's order dated November 15, 2024, directed staff to obtain psychiatric consults as needed. On November 18, 2024, a nurse noted that the resident told staff that she was feeling really bad and wanted to hurt herself. On November 19, 2024, the resident's provider noted that the resident reported feeling extremely anxious with her previous hospitalization and change in environment. On December 11, 2024, staff noted that the resident requested psychological services. On December 12, 2024, staff noted that a referral to the behavioral health services provider had been sent. On February 10, 2025, staff noted the resident reported feeling bad and wished to see a therapist. On February 11, 2025, the resident's practitioner noted that the resident reported increased anxiety and depression, she could not turn her mind off, and felt overwhelmed. The practitioner noted that the resident was followed by behavioral health services. There was a lack of evidence to support that the resident was ever assessed or followed by a behavioral health provider. Review of the behavioral health services provider's documentation revealed no evidence that the resident had been assessed or treated by behavioral health services since admission to the facility on November 15, 2024. On February 13, 2025, the resident was seen by the provider for continued anxiety and suicidal ideation. The resident stated, I just want to die, I do not want to live anymore. The resident was sent to the hospital for evaluation. The resident returned to the facility at 3:00 a.m., on February 14, 2025. On February 14, 2025, staff noted that the resident was found to have slit her neck multiple times with a sharp object that she obtained from her roommate.</p> <p>In an interview on April 21, 2025, at 1:15 p.m., licensed practical nurse (LPN) 1 stated that Resident 1 had expressed feelings of depression and anxiety. She confirmed that the resident was not seen by behavioral health services since admission to the facility. LPN 1 stated that on February 14, 2025, the resident was observed with multiple lacerations to her neck after she cut her neck with scissors that she obtained from her roommate in an attempt to commit suicide.</p> <p>In an interview on April 21, 2025, at 2:25 p.m., Registered Nurse (RN) 1 stated that there was a lack of documented evidence that the resident was seen by a behavioral health specialist since admission.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>(continued on next page)</p>		

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F 0742 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to maintain medical records that were accurate for three of five sampled residents. (Residents 3, 4, and 5)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder, intermittent explosive disorder, anxiety, depressive disorder, and borderline personality disorder. Review of the care plan revealed that the resident had a problem with mood and the intervention was for staff to obtain behavioral health consultations (consults) as needed. On January 7, 2025, the resident's practitioner noted that she was feeling overwhelmed with placement in a new facility. The practitioner noted that the resident was referred for behavioral health services. On February 3, 2025, staff noted that the resident requested to speak to a mental health provider as she had been feeling manic and depressed. On February 4, 2025, the resident's provider noted that she was seen for anxiety and reported feeling very anxious. The practitioner note indicated that the resident was referred to behavioral health services and would be seen by that nurse practitioner on that date. On February 18, 2025, the resident's practitioner noted that the resident reported speaking with the behavioral health nurse practitioner had been of help to her. Despite the physician's notation that the resident spoke to the behavioral health nurse practitioner and was referred to behavioral health services on January 7, 2025, there was a lack of evidence in the resident's medical record that the resident was seen by behavioral health providers until March 25, 2025.</p> <p>Clinical record review revealed that Resident 4 had diagnoses that included anxiety, intellectual disability, persistent mood disorder, and psychosis. Review of the care plan revealed that the resident used psychotropic medications and the intervention was to follow up with behavioral health consults as needed. Clinical record review revealed that the resident was seen by Vital Health (a behavioral health care provider) on September 17, 2024. The assessment indicated follow-up services would be in six weeks. There was a lack of evidence in the medical record that any behavioral health assessment had been received, reviewed, and added to the resident's record until March 25, 2025, more than six months after the anticipated follow-up. There was a lack of documented evidence in the medical record that scheduled services had been rescheduled.</p> <p>Clinical record review revealed that Resident 5 had diagnoses that included major depressive disorder. Clinical record review revealed that the resident was seen by Vital Health on November 26, 2024. The assessment indicated follow-up services would be in four to six weeks. There was a lack of evidence in the medical record that any behavioral health assessment had been received, reviewed, and added to the resident's record until March 25, 2025, four months after the anticipated follow-up. There was a lack of documented evidence in the medical record that scheduled services had been rescheduled.</p> <p>In an interview at 3:07 p.m., on April 21, 2025, Registered Nurse 1 stated that behavioral health assessments were sent to the facility electronically and they were to be printed out and scanned into the residents' medical records. She confirmed that additional behavioral health care assessments were not available in the residents' medical records.</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services.