

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  03/21/2026
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)
F 0801  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.  Based on staff interview, it was determined that the facility failed to employ a full-time qualified dietary services manager in the absence of a full-time qualified dietitian. Findings include: In an interview conducted on March 21, 2026, at 10:44 a.m., the Director of Nursing confirmed that there was not a full-time dietitian employed at the facility and that the facility did not employ a qualified dietary manager in the absence of a full-time dietitian. 28 Pa. Code 201.18(b)(3) Management.42 CFR S483.60(a)(2) Qualified Dietary Staff Previously cited 6/6/25

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
---	-------	-----------