STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395892	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Latrobe	576 Fred Rogers Drive Latrobe, PA 15650

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment for two of 13 residents reviewed (Residents 2, 4), in the East dining room, and in three out of three shower rooms reviewed (East, [NAME] 1 and [NAME] 2). Findings include:The facility's policy titled Resident Environment, dated April 20, 2026, revealed that the policy objective was to provide a safe, clean and homelike environment for residents.Observations of Resident 2 on May 28, 2026, at 10:42 a.m. and at 4:00 p.m. revealed that the resident was sitting up in her bed with the privacy curtain closed. The curtain had multiple areas of stains of different colors and substances.Interview with the Maintenance Supervisor on May 28, 2026, at 4:00 p.m. confirmed that Resident 2's privacy curtain was dirty and not homelike. He explained that staff would contact maintenance that a privacy curtain needed laundry service. Maintenance staff would remove the curtain and then hang a clean curtain.Observations of Resident 4 on May 28, 2026, at 10:32 a.m. and at 2:18 p.m. revealed that the resident was resting in her bed with the facility fan at the foot of her bed. The fan was running and blowing air onto her body. It was noted that the fan had a moderate accumulation of dirt and debris on the grill guard.Observations in the first-floor dining area on May 28, 2026, at 9:45 a.m. revealed that a floor fan was blowing into the kitchen toward a food cart that was in the doorway to the entrance of the kitchen. The food was covered. Observations in the same dining area at 11:45 a.m. revealed that the same fan was now turned and facing into the dining area. There were approximately 10 residents in the dining area and the closest resident was approximately eight feet away from the fan. The residents were not eating at the time. At one point a resident got up and stood in front of the fan to look out the window. The fan was observed to have a very large accumulation of dirt, dust and debris on the grill guard that included a stand of hair that was approximately 13 inches long.Interview with the Assistant Director of Nursing on May 28, 2926, at 1:45 p.m. confirmed that Resident 4's fan and the dining room fan should not have been running in the facility with an accumulation of dirt and debris on them.Observations of shower rooms East, [NAME] 1 and [NAME] 2 at 4:05 p.m., 4:09 p.m. and 4:11 p.m. respectively, revealed that there was a moderate to large amount of a black removable substance noted in the bottom perimeter of the showers, approximately one to ten inches off the shower floor.Interview with the Maintenance Supervisor on May 28, 2026, at 4:15 p.m. confirmed that residents' curtains, fans and shower rooms should always be clean.Interview with the Director of Nursing on May 28, 2026, at 4:37 p.m. confirmed that the resident curtain, fans and shower rooms should have been clean, and they were not.28 Pa. Code 201.29(j) Resident Rights.28 Pa. Code 207.2(a) Administrator's Responsibility.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record reviews, resident and staff interviews, it was determined that the facility failed to provide discharge planning for one of 13 residents reviewed (Resident 2) who planned to be discharged to go home.Findings include:A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 1, 2026, revealed that the resident was cognitively intact, could understand, was understood, was independent with bed mobility and required supervision, and was occasionally incontinent of bladder and continent of bowel.Observations and interview of Resident 2 on May 28, 2026, at 10:42 a.m. revealed that the resident was sitting up in her bed. She explained that she was ready to discharge home about six weeks ago, but feels like she was stuck. She has an apartment, she has care givers, she has family to assist her, and she wanted to discharge weeks ago. She did not want to leave against medical advice, because the facility would contact protective services, and she would not be provided necessary equipment or medications. Resident 2 stated that staff came in to discuss her discharge approximately six weeks ago, but then nothing happened. The social worker was not available because she was on leave. She explained that there was no reason she could not go home, and every day her bill was adding up. Interview with the Director of Therapy on May 28, 2026, at 11:07 a.m., revealed that Resident 2 has poor therapy participation, however she goes on leave of absence with her family without concern. He does not believe that the resident has a place to go, so he was not aware of any future discharge at the time.Interview with the Social Services Director on May 28, 2026, at 2:00 p.m. and 3:35 p.m., revealed that she met with Resident 2 in January, 2026 and the resident did not want to discharge at that time. She was asked to see Resident 2 with another staff member on April 17, 2026. Discharge planning was started at that time and nursing was notified to do oxygen testing. The Social Services Director revealed that she was on leave around April 25, 2026. She confirmed that Resident 2 has an apartment.There was no documented evidence in Resident 2's clinical record to indicate that any discharge planning was completed by Social Services in April 2026, when Resident 2 indicated that she was ready to discharge. A follow-up interview with Resident 2 on May 28, 2026, at 1:31 p.m. revealed that she was being discharged on June 5, 2026.Interview with the Nursing Home Administrator on May 28, 2026, at 3:40 p.m. confirmed that there was no documented evidence of discharge planning in Resident 2's clinical record until May 28, 2026.28 Pa. Code 211.10.Resident care polices