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No. 0938-0391

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	03/19/2026

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of facility policies, clinical records, and shower schedules, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 45 residents reviewed (Resident 72).Findings include:The facility policy for the flow of care dated April 15, 2025, indicated that care will be provided to residents, as needed 24 hours a day to attain and maintain the highest level of functioning. The provision of targeted care needs shall be documented on Care Tracker/Point of Care/ADL Flow Records. The charge nurse and/or the unit manager will be responsible for evaluating compliance with flow of care expectations and providing education or intervention as needed to assure the needs are met on an ongoing basis. Step 11 in the flow of care for evening shift includes providing baths and showers. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 72 , dated January 19, 2026, indicated that the resident was able to make himself understood and was able to understand others, required assistance from staff for daily care needs including showering, and had a diagnosis of dementia. Care plan for Resident 72 dated September 17, 2025, indicated that the resident had a self-care performance deficit related to dementia, he requires staff participation with bathing, and was to get showers twice weekly on daylight shift. A review of the nurse aide bathing documentation for Resident 72 dated December 2025, January 2026, February 2026, and March 2026, revealed that the resident preferred Wednesday and Saturday evening showers and the resident may refuse showers. If he refuses, educate and document the refusal and then offer a bed bath. Documentation revealed that the resident received bed baths on December 6, 10, 13, 17, 24, 27, and 31, January 24. There was no evidence that the resident was offered or refused a shower on these dates. Review of the bathing documentation also revealed that on January 7, 14, 17, and 21, and February 11 and 25, the shower was documented as not applicable. There was no evidence that the resident was offered, provided or refused a shower on these dates. There was no documentation that a shower was offered, provided or refused on March 7. An interview with Resident 72 on March 16, 2026, at 10:15 a.m. revealed that the resident was not always offered a shower twice a week and does not recall refusing showers. Interview with the Director of Nursing on March 19, 2026, at 11:09 a.m. revealed there was no documented evidence that Resident 72 was offered or provided showers according to his care schedule during the above-mentioned dates.28 Pa. Code 211.12(d)(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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that central venous catheters were flushed per facility policy for three of 45 residents reviewed (Resident 64, 91, 107).Findings include:The facility's policy regarding flushing central venous (midline) catheters (a thin tube inserted into a vein and used long-term for the administration of fluids and/or medications), dated August 13, 2025, indicated that the catheter was to be flushed before and after it was used to administer medication and was to be documented in the medical record.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 64, dated December 29, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs and was receiving care after joint replacement surgery. Physician's orders for Resident 64 dated March 14, 2026, included for the resident to receive two grams of Cefazolin (an antibiotic) intravenously every eight hours for aftercare following joint replacement surgery for six weeks. Review of the Medication Administration Record (MAR) for Resident 64 dated March 2026, revealed that two grams of Cefazolin was administered every eight hours from March 14 at 8:00 a.m. through March 19 at 8:00 a.m., however there was no documented evidence that the residents PICC (Peripherally Inserted Central Catheter- a long, thin, flexible tube inserted into a peripheral vein, usually in the upper arm, and threaded to a large vein near the heart) was flushed before and after the administration of the antibiotic. Interview with the Director of Nursing on March 19, 2026, at 10:58 a.m. revealed that there was no documented evidence that Resident 64's central venous catheter was flushed before and after the administration of medication. A quarterly MDS assessment for Resident 91, dated March 3, 2026, revealed that the resident was cognitively intact, was independent with his daily care needs and had a diagnosis of pneumonia (infection that inflames the air sacs of the lungs).Physician's orders for Resident 91, dated February 25, 2026, included orders for 1 gram (gm) of Vancomycin (an antibiotic) to be administered intravenously once a day for pneumonia.Review of Resident 91's Medication Administration Records (MAR's) for February and March 2026 revealed no documented evidence that Resident 91's midline catheter was flushed before and after the administration of the antibiotic.A nursing note for Resident 107, dated March 11, 2026, at 5:00 p.m. revealed that the resident was a new admission, was cognitively intact, required assistance for her daily care needs and had a diagnosis of pneumonia.Physician's orders for Resident 107, dated February 12, 2026, included orders for 500 milligrams (mg) of Vancomycin (an antibiotic) to be administered intravenously once a day for pneumonia.Review of Resident 107's MAR for March 2026 revealed no documented evidence that Resident 91's midline catheter was flushed before and after the administration of the antibiotic.Interview with the Director of Nursing on March 18, 2026, at 2:33 p.m. confirmed that there was no documented evidence that Residents 91 and 107's midline catheter was flushed before and after the administration of medication.28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain resident dignity for one of 45 residents reviewed (Residents 27). Findings include:The facility's policy titled personal privacy, dated August 13, 2025, indicated that the facility staff will treat residents in a manner that maintains the privacy of their bodies. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated January 20, 2026, revealed that the resident was sometimes understood, sometimes understood others, was moderately cognitively impaired, and required assistance from staff for daily care needs.Observations of Resident 27 on March 17, 2026, at 3:15 p.m. revealed that he was sitting in a wheeled shower chair while staff pushed him approximately 30 feet from the shower room down the first floor hall to his room. Resident 27 had a folded sheet/blanket across his lap, his chest, back, upper thighs and legs were exposed. Interviews with Nurse Aide 1 and the Regional Clinical Consultant 2 on March 17, 2026, at 3:23 p.m., indicated that he should not have transferred the resident through the hall with only a folded sheet on his lap leaving most of his body exposed. Interview with the Nursing Home Administrator on March 17, 2026, at 3:50 p.m., indicated that staff should have provided for Resident 27's dignity as he was transferred threw the hall, and they did not. 28 Pa. Code 201.29(j) Resident Rights.

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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 by not maintaining ceiling heating ventilation and air conditioning units (HVAC), and not providing a clean wheelchair for one of 45 residents reviewed (Residents 5). Findings include: The facility's policy titled resident rights, dated August 13, 2025, indicated that the resident has a right to a safe, clean, comfortable and homelike environment.Observations on March 16, 2026 at 9:58 a.m. of the East Hall heating and air conditioning unit revealed that the unit had a thick layer of dust accumulated on the filters and that it was making a rattling noise. Observations of the [NAME] 1 hall heating and air conditioning unit on March 16, 2026 at 10:42 a.m. revealed that the unit had a thick layer of dust on the filters.Observations of the [NAME] 2 hall heating and air conditioning unit revealed that there was a thick layer of dust on the filters and that the filters were hanging out of the unit.Interview with the Maintenance Director on March 18, 2026 at 9:22 a.m. revealed that the heating and air conditioning units needed cleaned. He stated that he cleans them monthly, however, that the filters needed vacuumed. Observations of Resident 5's wheelchair on March 19, 2026, at 12:41 p.m. revealed that the metal frame and the top of the back rest cushion had a large amount of brownish/white removable dust on it.Interview with the Maintenance Assistant 3 on March 19, 2026, at 12:50 p.m. indicated that he thought housekeeping cleaned the chairs. Interview with the Nurse Aide 4 on March 19, 2026, at 12:58 p.m. confirmed that Resident's 5's wheelchair was dirty and should have been cleaned. He revealed that the facility used to have a staff member that was responsible for hosing them down outside, but about a year or two ago he left, and now I don't see anyone doing that anymore.Interview with Housekeeping Employee 5 on March 19, 2026, at 1:07 p.m. indicated that they clean frequently used touch points, night stands, bed frames, over the bed lights window ceils, trash cans and the bathroom. She indicted that if she was deep cleaning a room and saw a wheelchair was dirty then she would clean it.Interview with the Van Driver/Floor Technician 6 on March 19, 2026, at 1:15 p.m. indicated that he drove the van and was responsible for cleaning and maintaining the floors, he indicated that he thought possibly that the night nurse aides cleaned the chairs. Interview with the Assistant Director of Nursing on March 19, 2026, at 1:25 p.m. confirmed that the maintenance department and housekeeping share the responsibility of maintaining the cleanliness of the facility wheelchairs. She indicated that the removable dust, dirt and debris on Resident 5's wheelchair should not have been there, and it should have been cleaned. 28 Pa. Code 201.29(j) Resident Rights.28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for two of 45 residents reviewed (Resident's 65 and 72). Findings include:The facility's policy regarding care plans, dated [DATE], indicated that nursing staff and/or the interdisciplinary team were to initiate and/or update care plans for the resident as warranted. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 65, dated February 3, 2026, indicated that the resident was moderately cognitively impaired, required extensive assistance from staff for daily care tasks, and had diagnoses that included cerebral palsy and intellectual disorders.A review of Resident 65's clinical record revealed that from the date of her admission, [DATE], until [DATE], the resident was a Full Code (provide cardiopulmonary resuscitation (CPR). On [DATE], her code status was changed to Do Not Resuscitate (do not provide cardiopulmonary resuscitation). On February 17, 2026, the resident experienced shortness of breath, congestion and an increased heart rate. The resident's mother was updated regarding her change in condition and verbally changed her daughters No Code status to Full Code. The resident was transferred to the hospital where she was admitted . A review of Resident 65's Provider Orders for Life Sustaining Treatments (POLST) revealed that on [DATE], the Nurse practitioner and resident's mother signed the form stating the resident was a Full Code Physician's orders regarding advanced directives for Resident 65, dated [DATE], indicated that she was a Full Code (provide cardiopulmonary resuscitation if she ceases to breath).Resident 65's current care plan, revised [DATE], indicated that the resident's code status was Do Not Resuscitate.Interview with the Licensed Practical Nurse Assessment Coordinator 7 on [DATE], at 10:29 a.m. confirmed that resident 65's care plan was not updated when her health status changed and/or when the POST was signed on [DATE].Interview with the Director of Nursing on [DATE], at 10:45 a.m. confirmed that Resident 65's care plan was not updated to reflect the current code status which is a full code, and it should have been. A quarterly MDS assessment for Resident 72 dated [DATE], indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included dementia. Care plan for Resident 72 dated [DATE], indicated that the resident was taking antipsychotic (medication used for the treatment and management of symptoms associated with various psychiatric disorders) medication for management of dementia with behaviors. An intervention dated [DATE], included that the resident was to be checked every 15 minutes related to physical aggression. There was no documented evidence that 15-minute checks were being completed. Care plan for Resident 72 dated [DATE], indicated that the resident was at risk for inappropriate verbal and physical aggressive behaviors related to dementia and an intervention dated [DATE], included that the resident was to have one-on-one observation(continuous monitoring of a patient by a staff member to ensure safety) related to increased anxiety. There was no documented evidence that one-on-one observation was being completed. An interview with the Director of Nursing on [DATE], at 11:09 a.m. confirmed that Resident 72 was no longer receiving checks every 15 minutes and was no longer receiving one-on-one observation, however the care plan was not revised when these interventions were resolved and should have been. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that bowel protocols were followed as ordered by the physician for one of 45 residents reviewed (Resident 3).Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated January 7, 2026, revealed that the resident was cognitively impaired and was frequently incontinent of bowel movements. Physician's orders for Resident 3, dated January 2, 2026, included orders for the resident to receive 4 ounces of prune juice as needed for no bowel movement in two days and was to be administered every shift until the resident had a bowel movement; 30 milliliters of Milk of Magnesia as needed for no bowel movements for three days; a 10 milligram bisacodyl suppository rectally as needed for no bowel movement for four days; and a Fleets enema to be given rectally as needed if the resident did not have a bowel movement in 12 hours after the bisacodyl suppository.Review of Resident 3's bowel records for February 2026 revealed that there was no documented evidence that the resident had a bowel movement from February 2 through 6 and February 15 through 20, 2026. Review of the February 2026 MAR's for Resident 3 revealed that staff did not initiate or follow the bowel protocol as ordered by the physician. Interview with the Director of Nursing on March 19, 2026, at 10:58 a.m. confirmed that the physician's orders for bowel medications were not followed for Resident 3. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free of accident hazards as possible by transporting a resident without leg rests for one of 45 residents reviewed (Resident 42). Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated December 12, 2025, revealed that the resident was cognitively impaired and required extensive assistance from staff for care. Observations on March 18, 2026 at 9:30 a.m. revealed that Nurse Aide 8 pushed resident 42 from her room out into the hallway with her legs dangling and no leg rests on the chair.Interview with Nurse Aide 8 on March 18, 2026 at 9:30 a.m. revealed that she pushed Resident 42 without leg rests because she could not find any in the resident's closet.Interview with the Director of Nursing on March 18, 2026 at 11:35 a.m. confirmed that Resident 42 should have had leg rests on her wheelchair while being transported. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of facility policies, manufacturer's prescribing information, facility's medications not to be crushed list, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent. Findings include: The facility's policy regarding medication administration, dated August 13, 2025, revealed that medications were to be administered in accordance with good nursing principles and practices and in order to ensure the safe, accurate and timely administration of medications. All drugs, devices and related materials will be administered in accordance with federal and state laws and regulated.The facility's list of medications not to be crushed, revised August 13, 2025, revealed that metformin extended release (ER), Myrbetriq ER, and propranolol hydrochloride (HCL) were not be crushed.Physician's orders for Resident 32, dated January 17, 2025, included an order for the resident to receive 20 milligrams (mg) Propranolol hydrochloride (HCL) three times a day, an order dated October 30, 2025 for the resident to receive 500 mg Metformin hydrochloride extended release (ER) two times a day, and an order dated December 13, 2025 for the resident to receive 25 mg Myrbetriq one time a day.Observations of medication administration for Resident 32 on March 19, 2026, at 08:45 a.m. revealed that Licensed Practical Nurse 9 prepared the resident's medication, including propranolol HCL, metformin ER, and Myrbetriq ER, by crushing them and then proceeded to administer the crushed medications to the resident. Interview with Licensed Practical Nurse 9 on March 19, 2026, at 08:50 a.m. revealed that she was unaware that she should not crushed the propranolol HCL, metformin ER, or the Myrbetriq ER and that the medication package should have indicated do not crush for any medication that is not to be crushed. Interview with the Director of Nursing on March 19, 2026 at 11:35 a.m. revealed that the medication package should have said do not crush, and that the nurse should not have crushed them.Facility policy regarding specific medication administration procedures for oral inhalation administration, dated August 13, 2025 indicated that when administering a steroid inhalers staff are to provide the resident with cup of water and instruct them to rinse their mouth and spit the water out.The Manufacturer's prescribing information for Breo Ellipta, a sterioid inhaler, dated May 2023, indicated that Breo Ellipta can cause serious side effects, including fungal infection in your mouth or throat (thrush). The user should rinse their mouth with water without swallowing after using Breo Ellipta to reduce your chance of getting thrush.Physician's orders for Resident 88, dated September 7, 2025, included an order for the resident to receive 100-25 micrograms per actuation (mcg/act) Breo Ellipta inhalation aerosol powder once a day.Observations of medication administration for Resident 88 on March 17, 2026, at 9:30 a.m. revealed that Licensed Practical Nurse 10 administered the Breo Ellipta inhaler, but did not offer for the resident to rinse his mouth after use.Interview with Licensed Practical Nurse 10 revealed that she did not offer Resident 88 to rinse and spit after administering the Breo Ellipta, and she should have. Interview with the Director of Nursing on March 19, 2026 at 9:58 a.m. revealed that Licensed Practical Nurse 10 should have offered for Resident 88 to rinse his mouth after use of the inhaler.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on a review of the facility policies, the facility's list of medications that are not to be crushed, as well as observations and staff interviews, it was determined that the facility failed to label medications with the appropriate instructions for administration for one of 45 residents reviewed (Resident 32).Findings include:The facility's policy regarding medication administration, dated August 13, 2025, revealed that medications were to be administered in accordance with good nursing principles and practices and in order to ensure the safe, accurate and timely administration of medications. All drugs, devices and related materials will be administered in accordance with federal and state laws and regulated.The facility's list of medications not to be crushed, revised August 13, 2025, revealed that propranolol HCL, metformin hydrochloride (HCL) extended release (ER), and Myrbetriq ER were not be crushed.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 32, dated February 3, 2026, revealed that the resident was cognitively impaired, required assistance from staff for all his daily care needs, and had diagnoses that included diabetes, overactive bladder, and heart disease. Physician's orders for Resident 32, dated January 17, 2025, included an order for the resident to receive 20 milligrams (mg) Propranolol HCL three times a day, an order dated October 30, 2025 for the resident to receive 500 mg Metformin HCL ER two times a day, and an order dated December 13, 2025 for the resident to receive 25 mg Myrbetriq ER on e time a day.Observations of medication administration for Resident 32 on March 19, 2026, at 08:45 a.m. revealed that Licensed Practical Nurse 9 prepared the resident's medication, including propranolol HCL, metformin HCL ER, and Myrbetriq ER, by crushing them and then proceeded to administer the crushed medications to the resident. Interview with Licensed Practical Nurse 9 on March 19, 2026, at 08:50 a.m. revealed that she was unaware that she should not crushed the propranolol HCL, metformin HCL ER, or the Myrbetriq ER and that the medication package should have indicated do not crush for any medication that is not to be crushed and those ones did not. Interview with the Director of Nursing on March 19, 2026 at 11:35 a.m. revealed that the medication package should have said do not crush, however, the pharmacy does not label the medications do not crush until the physician orders that. 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include:The facility's deficiencies and plan of corrections for an annual survey ending December 10, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending March 19, 2026, identified repeated deficiencies related to quality care, IV fluids, and labeling drugs.The facility's plan of correction for a deficiency regarding accurate MDS assessments, cited during the survey ending December 10, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that quality care was provided.The facility's plan of correction for a deficiency regarding development of care plans, cited during the survey ending December 10, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F694, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's IV fluids were administered appropriately.The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending December 10, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that drugs were labeled appropriately.Refer to F684, F694, F761.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.