

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN	STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642
STATE LICENSE NUMBER: 281002	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0623	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to four complaints, completed January 31, 2025, it was determined that Kadima Rehabilitation and Nursing at Irwin, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0623		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0623 SS=D	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	The facility will provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division. The facility cannot retroactively correct the concern identified during annual survey. The facility will send the discharge/transfer list to the state Ombudsman monthly. The Nursing Home Administrator or Designee will re-educate the Director of Social Services on federal tag F0623. The Nursing Home Administrator or Designee will complete an audit monthly for three months to validate the transfer/discharge list is completed and sent to the state Ombudsman monthly. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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F 0623 SS=D	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=D	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 4 Based on a review of facility policy, federal regulation, and staff interview, it was determined that the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for 4 of 12 months (January 2024 through April 2024). Findings include: Review of the facility policy "Admission Transfer and Discharge" 9/21/23 and 9/18/24, indicated no resident will be discharged without timely notification of the resident, responsible party, or authorized representative. Review of Title 42 Code of Federal Regulations §483.15(c)(3) Notice Before Transfer: indicates, before a facility transfers or discharges a resident, the facility must (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 0623		

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F 0623 SS=D	Continued from page 5 representative of the Office of the State Long-Term Care Ombudsman. Federal Regulations further define emergency transfers as, "When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer." During an interview on 1/27/25, at 2:30 p.m., the Nursing Home Administrator confirmed the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for 4 of 12 months (January 2024 through April 2024). 28 Pa. Code 201.18(b)(3)(e)(2) Management.	F 0623		
F 0637 SS=D		F 0637		

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F 0637 SS=D	Continued from page 6 483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 0637	The facility will complete a significant change Minimum Data Set (MDS) assessment for residents with a change in condition. Resident R97 MDS will be updated to reflect the significant change in Hospice services. The Facility will complete a house audit on residents receiving hospice services to validate the MDS was completed and indicates a significant change related to Hospice. The Regional Clinical Consultant or designee will re-educate the Licensed Practical Nurse Assessment Coordinator (LPNAC) on federal regulation 0623, detailing completing a significant change MDS for Hospice residents. The Director of Nursing or designee will complete an audit weekly for four weeks then monthly for three months to validate residents receiving hospice services has a MDS to reflect the significant change.	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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F 0637 SS=D	Continued from page 7	F 0637	The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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F 0637 SS=D	Continued from page 8 Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS- assessments completed indicating a change in condition of a resident requiring change in care) assessment for one of three residents reviewed (Residents R97). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective 10/1/2019, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Review of the facility policy "Resident Assessment/Minimum Data Set" reviewed 9/18/24, indicated the facility will conduct a comprehensive assessment of a resident in a timely manner, within	F 0637		

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F 0637 SS=D	Continued from page 9 14 days after the facility determines that there has been a significant change. The change is a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard clinical interventions. The change impacts more than one area of the resident's health status ad requires interdisciplinary review and or revision of the care plan. A review of the clinical record indicated that Resident R97 was admitted to the facility on 5/22/24, with diagnoses which included dementia (group of symptoms that affects memory, thinking and interferes with daily life), repeated falls, and anxiety. A review of the MDS dated 11/28/24, indicated the diagnoses remain current. A review of a physician order dated 7/5/24, indicated Resident R97 was admitted to hospice care (a special model of care for patients who are in the late phase of an incurable illness and wish to	F 0637		

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F 0637 SS=D	Continued from page 10 receive end-of-life care) on 6/14/24. Review of a care plan dated 7/8/24, indicated Resident R97 was receiving hospice care. Review of Resident R97 ' s MDS assessments revealed a MDS significant change was not completed to include Hospice services. During an interview on 1/31/25, at 10:05 a.m. Licensed Practical Nurse Assessment Coordinator Employee E2 confirmed the facility failed to complete a MDS significant change within 14 days of Resident R97 ' s hospice admission. 28 Pa. Code: 211.5(f) Clinical records.	F 0637		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 11 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The facility will assess, document and notify the physician of increased and decreased Capillary Blood Glucose (CBG) levels for all residents. The facility cannot retroactively correct the concerns identified for residents R51 and R66, however in the future any increased or decreased CBG, the physician will be notified. All diabetic residents' orders will be reviewed to ensure accuracy/need for physician notification. The facility will complete a two week look back of diabetic residents to validate the physicaian was notified of increased or decreased CBG, and resident was assessed for hypoglycemia and documented. The Director of Nursing or designee will re-educate licensed nurses on the facility policy and procedures for Notifying the Physician with resident change in condition, detailing notification of increased or decreased CBG.	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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F 0684 SS=D	Continued from page 12	F 0684	<p>The Director of Nursing or designee will complete an audit three times a week for four weeks then monthly for three months to validate physicians are notified of any increased or decreased blood sugars and residents are assessed for hypoglycemia.</p> <p>The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.</p>	

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F 0684 SS=D	Continued from page 13 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for two of four residents reviewed (Residents R51 and R66). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious	F 0684		

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F 0684 SS=D	Continued from page 14 health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.	F 0684		

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F 0684 SS=D	Continued from page 15 Review of facility policy "Nursing Care of the Diabetic Resident" reviewed 9/21/23 and 9/18/24, indicated the facility will recognize, assist, and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident and include vital signs, level of consciousness, assessment of the skin, emotional/mood changes, and pain/discomfort. Document results of any fingerstick blood glucose monitoring, interventions to stabilize blood glucose levels, and notification to physician. Review of facility policy "Notification of Condition Change: Physician" reviewed 1/31/24 and 1/9/25, indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident 's condition. Document assessment data, attempted or actual correspondence with physician, and physician ' s response in the medical record.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
STATE LICENSE NUMBER: 281002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 16 Review of facility policy "Documentation" reviewed 1/31/24 and 1/9/25, indicated nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate. Review of facility "Hypoglycemic Protocol" reviewed 1/31/24 and 1/9/25, indicated if resident 's blood glucose is less than 70 administer rapidly absorbed simple carbohydrate such as four ounces (oz) of juice, five or six oz of regular soda, or tube of glucose gel. Repeat blood glucose in 10-15 minutes and repeat protocol if still less than 70. If resident is symptomatic, notify physician. Review of the clinical record indicated Resident R51 was admitted to the facility on 8/23/24, with diagnoses that included hypoglycemia, diabetes, and high blood pressure. Review of Resident R51' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 11/20/24, indicated	F 0684		

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F 0684 SS=D	Continued from page 17 the diagnoses remain current. Review of Resident R51 physician ' s order revealed the following orders - On 9/29/24, indicated Glucose Gel 40% (used to treat low blood sugar) give one applicatorful as needed for hypoglycemia of less than 70. - On 10/4/24, inject Novolog (begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and last between two to four hours) per sliding scale, if below 70 follow hypoglycemic protocol. - On 11/4/24, indicated to inject Novolog six units before meals. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: - On 11/3/24, at 12:00 p.m. the CBG was noted to be 55. - On 1/4/25, at 10:45 a.m. the CBG was noted to be 448.	F 0684		

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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
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F 0684 SS=D	Continued from page 18 - On 1/21/25, at 8:36 a.m. the CBG was noted to be 429. Review of the care plan dated 8/25/24, indicated the following interventions: Accuchecks as ordered, call MD per order, monitor resident for signs and symptoms of hyper-/hypoglycemia, provide insulin/meds as per resident ' s individual order. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of a clinical record indicated Resident R66 was admitted to the facility on 10/12/21, with diagnoses that included diabetes, high blood pressure, and depression. Review of the MDS dated 11/19/2024, indicated	F 0684		

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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
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F 0684 SS=D	Continued from page 19 the diagnoses remain current. Review of Resident R66 physician 's orders revealed the following orders: - On 3/7/24, indicated Accuchecks two times a day. - On 5/8/24 through 7/17/24, inject insulin Aspart (begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and last between two to four hours) six units before meals. - On 7/23/23 through 8/9/24, inject Basaglar (reaches the bloodstream several hours after injection and tends to lower glucose levels up to 24 hours) 16 units one time a day. - On 7/17/24 through 7/30/24, inject Fiasp (insulin Aspart) six units before meals. - On 7/30/24 through 8/2/24, inject Fiasp ten units before meals. - On 8/2/24 through 9/6/24, inject Fiasp 12 units before meals. - On 8/9/24, indicated Basaglar 20 units one time a day.	F 0684		

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F 0684 SS=D	Continued from page 20 - On 9/6/24 through 12/20/24, inject insulin Aspart 12 units before meals. Review of Resident 66's eMAR revealed that the resident's CBG's were as follows: - On 6/13/24, at 4:46 p.m. the CBG was noted to be 455. - On 6/18/24, at 7:20 a.m. the CBG was noted to be 440. - On 6/18/24, at 4:05 p.m. the CBG was noted to be 496. - On 6/19/24, at 7:13 a.m. the CBG was noted to be 425. - On 6/20/24, at 8:12 a.m. the CBG was noted to be 426. - On 7/23/24, at 7:45 a.m. the CBG was noted to be 406. - On 7/24/24, at 4:26 p.m. the CBG was noted to be 413 - On 7/25/24, at 7:29 p.m. the CBG was noted to be 483. - On 7/26/24, at 3:46 p.m. the CBG was noted to be 418.	F 0684		

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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN STATE LICENSE NUMBER: 281002		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
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F 0684 SS=D	Continued from page 21 - On 7/30/24, at 5:03 p.m. the CBG was noted to be 434. - On 7/31/24, at 3:21 p.m. the CBG was noted to be 414. - On 8/6/24, at 11:11 a.m. the CBG was noted to be 426. - On 8/6/24, at 3:12 p.m. the CBG was noted to be 418. - On 8/25/24, at 3:20 p.m. the CBG was noted to be 413. - On 10/11/24, at 9:59 a.m. the CBG was noted to be 435. - On 10/11/24, at 8:37 p.m. the CBG was noted to be 417. Repeat CBG at 8:38 p.m. was 417. Review of the care plan dated 10/13/21 and 4/19/22, indicated the following interventions: Accuchecks as ordered, call MD per order, monitor resident for signs and symptoms of hyper-/hypoglycemia, provide insulin/meds as per resident ' s individual order. Review of Resident R66's eMAR and clinical	F 0684		

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F 0684 SS=D	Continued from page 22 progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. During an interview on 1/17/25, at 9:00 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, failed to document an assessment or interventions used related to blood glucose, and failed to follow physicians orders for Residents R51 and R66. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0684		
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 23 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	The facility will ensure ongoing communication with the dialysis centers for residents. The facility cannot retroactively correct the concern identified for resident R2. The facility will complete a house audit on all residents who receive dialysis to validate there that a dialysis communication form is completed pre and post treatment between the facility and dialysis center. The Director of Nursing or Designee will re-educate licensed nurses, including new hires and agency of the facility policy and procedures for dialysis care, detailing ensuring the communication form is completed pre and post dialysis treatment between the facility and dialysis center for each scheduled dialysis day. The Director of nursing or Designee will complete an audit three times a week for four weeks then monthly to validate the dialysis form is completed for residents who receive	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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F 0698 SS=D	Continued from page 24	F 0698	dialysis. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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F 0698 SS=D	Continued from page 25 Based on review of clinical records and staff interviews, it was determined that facility staff failed to maintain ongoing communication with the dialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of four residents reviewed (Resident R2). Findings include: Review of the facility policy "Dialysis Care" reviewed 9/18/24, indicated residents ordered dialysis will be monitored and documentation will be maintained in the medical record. All resident 's receiving dialysis will be assessed before and after dialysis treatment and for compliance with their individualized plan of care. Review of the clinical record indicated Resident R2 was re-admitted to the facility on 7/15/24, with diagnoses that included end-stage renal disease (ESRD - the kidneys permanently fail to work), high blood pressure, and depression.	F 0698		

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F 0698 SS=D	Continued from page 26 Review of the Minimum Data Set (MDS - periodic assessment of care needs) date 1/15/25, indicated the diagnoses remain current. Review of a physician ' s order dated 3/31/24, indicated Resident R2 was to receive dialysis three days a week on Tuesday, Thursday, and Saturday, obtain vitals pre and post dialysis. Review of a care plan dated 8/24/20, indicated to keep open communication with the dialysis center. Review of the dialysis communication forms from 1/20/24 through 1/30/25, revealed 84 communication forms out of 156 scheduled treatments were observed. Review of the dialysis communication forms from 1/20/24 through 1/30/25, revealed thirty-four forms not fully completed before treatment, after treatment, or both. During an interview on 1/31/25, at 09:20 a.m. the	F 0698		

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F 0698 SS=D	Continued from page 27 Director of Nursing confirmed the facility failed to ensure the dialysis communication form was completed pre and post treatment between the facility and dialysis center. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0698		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 28 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The facility will ensure insulin is stored in a safe, secure and orderly manner in accordance with federal and state regulations and facility policies. The insulin pens identified during survey without dates were discarded and immediately replaced. The facility will complete a house audit on all five medication carts to make certain all insulin is stored and dated appropriately. The Director of nursing or Designee will re-educated all licensed nurses, including new hires and agency of the facility policy and proper storage and labeling of insulin. The Director of nursing or Designee will completed an audit three times a week for four weeks and once weekly for three months to ensure insulin pens are stored and dated as indicated. The results of the audit will be forwarded to monthly Quality Assurance and Performance	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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F 0761 SS=D	Continued from page 29	F 0761	Improvement Committee for review and frequency of audits.	

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F 0761 SS=D	Continued from page 30 Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to properly store refrigerated medication in one of three medication carts observed (B unit Short Hall medication cart). Findings include: Review of facility policy "Storage of Medications " reviewed 9/18/24, indicated medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses station. Review of Humalog (Lispro) "Instructions for Use" guidelines revised July 2023, indicate unused pens should be stored in the refrigerator at 36 - 46 degrees Fahrenheit. Unused pens may be used until the expiration date printed on the label, IF the pen has been kept in the refrigerator.	F 0761		

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F 0761 SS=D	Continued from page 31 Review of "Highlights of Prescribing Information" insert for Lantus insulin revised June 2023, indicate 10 ml (milliliter) multi-dose vial and 3 ml single-patient prefilled pen are good for 28 days if unopened at room temperature. During an observation on 1/28/24, at 9:20 a.m. B unit Short Hall medication cart contained 12 insulin pens and one insulin multi-dose vial not dated. This included: - four Novolog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin pens - three Lantus (long-acting type of insulin that works slowly, over about 24 hours) insulin pens - one open Lantus multi-dose vial - one Humulin R (regular-acting insulin that starts to work 30 minutes after injection, peaks in 2-3 hours, and keeps working for 3-6 hours) insulin pen - one Humalog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin	F 0761		

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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
STATE LICENSE NUMBER: 281002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 32 pen - three Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin pens. During an interview on 1/28/25, at 9:20 a.m. Licensed Practical Nurse (LPN) Employee E4 stated she was unsure why so many insulin pens were in the drawer instead of being stored in the refrigerator. During an interview on 1/28/25, at 9:30 a.m. the Director of Nursing confirmed the medications should be dated upon opening and extras not being used should have been stored in the refrigerator per policy. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN STATE LICENSE NUMBER: 281002	STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642
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F 0812 SS=E		F 0812		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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F 0812 SS=E	Continued from page 34 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	The facility will properly monitor equipment in the Main Kitchen in order to prevent the potential for food-borne illness. The facility is unable to correct that temperatures were not recorded on the following dates for the walk in and reach in coolers and freezers, and milk cooler: 1/6/25, 1/13/25, 1/16/25, and 1/18/25. The facility will record temperatures for the walk in and reach in coolers and freezers, and milk cooler. The facility will maintain the temperature logs in the Dining Services Department and kept on file for a period of one year. The Dietary Manager will educate dietary staff, including new hires, on the facility's "Temperature Recording Policy" which states that the Dietary Department will use the Refrigeration and Freezer Temperature Log to record the temperatures of all refrigerators and freezers daily. The forms will be posted in the Dining Services Department and kept on file for a	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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F 0812 SS=E	Continued from page 35	F 0812	<p>period of one year.</p> <p>The Dietary Manager will audit Refrigeration and Freezer temperature logs five times a week for four weeks and then weekly for three months to ensure temperatures for the walk in and reach in coolers and freezers, and milk cooler.</p> <p>The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.</p>	

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F 0812 SS=E	Continued from page 36 Based on a review of facility policies and documents, and staff interviews, it was determined that the facility failed to properly monitor equipment in the Main Kitchen creating the potential for food-borne illness. Findings include: A review of facility policies "Equipment Temperature Logs" dated 9/18/24, indicated that the Dietary Services Manager will use the Refrigeration and Freezer Temperature Log to record the temperatures of all refrigerators and freezers daily. The forms will be posted in the Dining Services Department and kept on file for a period of one year. A review of the "Equipment Temperature Log, To Be Taken daily by the Dietary Services Manager" documents dated 12/1/24 through 1/27/25 did not include documentation that temperatures were taken on the following days for the walk in and reach in coolers and freezers, and milk cooler:	F 0812		

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F 0812 SS=E	Continued from page 37 1/6/25. 1/13/25. 1/16/25. 1/18/25. During an interview on 1/27/25, at 9:50 a.m., the Nursing Home Administrator and Dietary Services Manager E1 confirmed the above findings, and that the facility failed to monitor equipment temperatures creating the potential for food-borne illness. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.	F 0812		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 38 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	The facility will ensure that all insulin pens in compartments will be stored appropriately in bags to prevent cross contamination in accordance to state and federal regulations. The insulin pens identified in survey that were not stored appropriately were discarded and replaced and stored in bags to prevent cross contamination. The facility will conduct a house audit on residents with insulin pens to ensure that all residents with insulin pens are bagged and stored appropriately to prevent cross contamination. The Director of Nursing or designee will re-educate all licensed nurses, including new hires and agency on Federal Regulation F0880 detailing facility policy on proper bagging of insulin pens. The Director of Nursing or designee will complete an audit 3 times weekly for 4 weeks and then monthly for 3 months to ensure insulin pens are	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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F 0880 SS=E	Continued from page 39 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	bagged appropriately. Results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement committee for review and frequency of audits.	

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F 0880 SS=E	Continued from page 40	F 0880			

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F 0880 SS=E	Continued from page 41 Based on observations and interview, the facility failed to store medications in a safe and sanitary manner for one of three medication carts reviewed (A unit Long Hall, and B unit Short Hall). Findings: Review of facility policy "Infection Control Plan, Program, and Committee" reviewed 9/18/24, indicated the facility maintains a structured Infection Control Program focused on prevention and management of infections. During an observation on 1/28/25, at 9:10 a.m., A unit Short Hall medication cart contained six of six insulin pens in compartments unbagged, posing the risk of cross-contamination. During an interview at that time, Licensed Practical Nurse (LPN) Employee E3 confirmed the insulin pens were unbagged. During an interview on 1/28/25 at 10:00 a.m. the	F 0880		

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F 0880 SS=E	Continued from page 42 Director of Nursing confirmed the facility failed to prevent the risk of cross-contamination by storing insulin pens unbagged in the medication carts for A unit Long Hall medication carts. 28 Pa code 201.14(a) Responsibility of licensee 28 Pa code 211.12(d)(1) Nursing services	F 0880			

Pennsylvania Department of Health

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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025	
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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility will ensure state-required nurse aide ratios are met for all shifts. The facility cannot correct that nurse aide staffing ratios were not met on the cited dates. The facility will ensure that nurse aide staffing ratios are met every shift. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5520 and ensuring nurse aide staffing ratios are met each shift. Daily shift staffing ratios will be reviewed at daily staffing meeting. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects to not meet staffing ratios on a given shift, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist as needed. The Nursing Home Administrator/designee will audit	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

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P 5520	Continued from page 2	P 5520	<p>staffing daily for four weeks and monthly for three months to ensure nurse aide staffing ratios are being met.</p> <p>The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.</p>	

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P 5520	Continued from page 3 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one of one nurse aide (NA) per 10 residents during the day shift for 9 of 21 days, one NA per 11 residents during the evening shift for 13 of 21 days, and one NA per 15 residents during the night shift for 12 of 21 days. Findings include: Review of the nursing schedules and census information for the weeks of 11/03/24 through 11/09/24, 12/22/24 through 12/28/24 and 1/26/2025 through 2/01/25, revealed the following NA staffing shortages: Day shift: 12/22/24 census 106 30.00 actual hours 33.92 hours required. 12/23/24 census 106 30.00 actual hours	P 5520		

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P 5520	Continued from page 4 33.92 hours required. 12/25/24 census 106 30.00 actual hours 33.92 hours required. 12/26/24 census 106 30.00 actual hours 33.92 hours required. 12/27/24 census 106 30.00 actual hours 33.92 hours required. 12/28/24 census 106 30.00 actual hours 33.92 hours required. 01/26/25 census 106 30.00 actual hours 33.92 hours required. 01/29/25 census 106 30.00 actual hours 33.92 hours required. 01/31/25 census 106 30.00 actual hours 33.92 hours required. Evening shift: 11/08/24 census 107 28.00 actual hours 28.53 hours required. 12/22/24 census 106 28.00 actual hours 28.27 hours required. 12/23/24 census 106 25.50 actual hours	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5520	Continued from page 5 28.27 hours required. 12/24/24 census 106 30.00 actual hours 33.92 hours required. 12/25/24 census 106 30.00 actual hours 33.92 hours required. 12/26/24 census 106 30.00 actual hours 33.92 hours required. 12/27/24 census 106 30.00 actual hours 33.92 hours required. 12/28/24 census 106 30.00 actual hours 33.92 hours required. 01/28/25 census 106 30.00 actual hours 33.92 hours required. 01/29/25 census 106 30.00 actual hours 33.92 hours required. 01/30/25 census 106 30.00 actual hours 33.92 hours required. 01/31/25 census 106 30.00 actual hours 33.92 hours required. 02/01/25 census 106 30.00 actual hours 33.92 hours required. Night shift:	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5520	Continued from page 6 11/07/24 census 109 45.00 actual hours 54.50 hours required. 11/09/24 census 106 52.50 actual hours 53.00 hours required. 12/22/24 census 106 37.50 actual hours 53.00 hours required. 12/23/24 census 106 45.00 actual hours 53.00 hours required. 12/27/24 census 102 30.00 actual hours 51.00 hours required. 12/28/24 census 102 37.50 actual hours 51.00 hours required. 01/27/25 census 107 45.00 actual hours 53.50 hours required. 01/28/25 census 107 45.00 actual hours 53.50 hours required. 01/29/25 census 107 34.50 actual hours 53.50 hours required. 01/30/25 census 107 37.50 actual hours 53.50 hours required. 01/31/25 census 107 30.00 actual hours 53.50 hours required.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
STATE LICENSE NUMBER: 281002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 7 02/01/25 census 107 45.00 actual hours 53.50 hours required. During an interview on 1/29/25, at 10:00 a.m. the Nursing Home Administrator confirmed the above findings, and that the facility failed to provide the minimum of nurse aide's on the above days and shifts as required.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
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P 5530	Continued from page 8 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility will ensure state-required LPN ratios are met for all shifts. The facility cannot correct that LPN staffing ratios were not met on the cited dates. The facility will ensure that LPN staffing ratios are met every shift. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5530 and ensuring LPN staffing ratios are met each shift. Daily shift staffing ratios will be reviewed at daily staffing meeting. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects to not meet staffing ratios on a given shift, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist as needed. The Nursing Home Administrator/designee will audit staffing daily for four weeks and	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN			STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
STATE LICENSE NUMBER: 281002					
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P 5530	Continued from page 9	P 5530	<p>monthly for three months to ensure LPN staffing ratios are being met.</p> <p>Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN STATE LICENSE NUMBER: 281002		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 10 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift on 5 of 21 days, one LPN per 30 residents during the evening shift on 5 of 21 days, and one LPN per 40 residents during the night shift on 3 of 21 days. Findings include: Review of the nursing schedules and census information for the weeks of 11/03/24 through 11/09/24, 12/22/24 through 12/28/24 and 1/26/2025 through 2/01/25, revealed the following LPN staffing shortages: Day shift: 11/09/24 census 106 32.00 actual hours 33.92 hours required. 12/22/24 census 106 30.00 actual hours	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5530	Continued from page 11 33.92 hours required. 12/25/24 census 106 24.00 actual hours 33.92 hours required. 01/26/25 census 107 32.00 actual hours 34.24 hours required. 02/01/25 census 107 32.00 actual hours 34.24 hours required. Evening shift: 11/08/24 census 107 28.00 actual hours 28.53 hours required. 12/22/24 census 106 28.00 actual hours 28.27 hours required. 12/23/24 census 106 25.50 actual hours 28.27 hours required. 01/26/25 census 107 24.00 actual hours 28.53 hours required. 02/01/25 census 107 28.00 actual hours 28.53 hours required. Night shift:	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT IRWIN		STREET ADDRESS, CITY, STATE, ZIP CODE: 249 MAUS DRIVE NORTH HUNTINGDON, PA 15642		
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P 5530	Continued from page 12 12/23/24 census 106 16.00 actual hours 21.20 hours required. 12/24/24 census 103 16.00 actual hours 20.60 hours required. 01/30/25 census 107 16.00 actual hours 21.40 hours required. During an interview on 1/29/25, at 10:00 a.m. the Nursing Home Administrator confirmed the above findings, and that the facility failed to provide the minimum of LPN's on the above days and shifts as required.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5640	Continued from page 13 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility will ensure that the state minimum staffing requirement of 3.2 PPD is met in order to ensure the health and safety of all residents. Facility is unable to retroactively correct concern of minimum staffing requirement not being met on dates: 11/08, 11/09, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 1/26, 1/29, 1/30, 1/31, and 2/1. Facility will continue to ensure all efforts are exhausted to maintain the minimum staffing requirement of 3.2 PPD on a daily basis to ensure the health and safety of all residents. Facility will continue to acquire agency staff as needed to meet the 3.2 PPD requirement. Recruitment efforts are under way and a plan is in place. Bonuses will be offered to all staff to pick up shifts. Facility Admissions will be limited if staffing requirement cannot be met. Regional Clinical Consultant will re-educate Administrator, Director of Nursing, and staffing coordinator on "Nursing Department Staff" policy	Completion Date: 02/25/2025 Status: APPROVED Date: 02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5640	Continued from page 14	P 5640	<p>which outlines the minimum staffing requirements and steps that are to be taken in order to ensure staffing requirements are met in order to ensure the health and safety of all residents.</p> <p>Administrator or designee will audit staffing levels five times a week for four weeks and then monthly for three months to ensure the minimum staffing requirement of 3.2 PPD is met to ensure the health and safety of all residents.</p> <p>Findings of audits will be reported to monthly Quality Assurance & Performance Improvement (QAPI) for review, recommendations, and frequency of audits.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395382	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
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P 5640	Continued from page 15 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 14 of 21 days (11/08, 11/09, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 1/26, 1/29, 1/30, 1/31, and 2/1). Findings include: Review of the nursing schedules and census information for the weeks of 11/03/24 through 11/09/24, 12/22/24 through 12/28/24 and 1/26/2025 through 2/01/25, revealed that the facility failed to maintain 3.20 hours of general nursing care to each resident in a 24-hour period on the following dates: -11/08/24, Census 107. PPD 3.13. -11/09/24, Census 106. PPD 3.19. -12/22/24, Census 106. PPD 2.32. -12/23/24, Census 106. PPD 2.19. -12/24/24, Census 103. PPD 3.05.	P 5640		

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P 5640	Continued from page 16 -12/25/24, Census 106. PPD 2.45. -12/26/24, Census 106. PPD 2.71. -12/27/24, Census 102. PPD 2.52. -12/28/24, Census 102. PPD 2.66. -01/26/25, Census 107. PPD 2.90. -01/29/25, Census 107. PPD 2.60. -01/30/25, Census 107. PPD 3.02. -01/31/25, Census 107. PPD 2.57. -02/01/25, Census 107. PPD 2.80. During an interview on 1/29/25, at 10:00 a.m. the Nursing Home Administrator confirmed the above findings, and that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 14 of 21 days.	P 5640		



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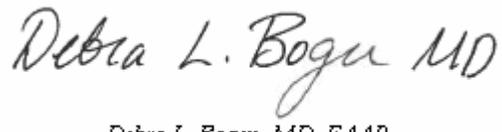
KADIMA REHABILITATION & NURSING AT IRWIN

STATE LICENSE NUMBER: 281002

SURVEY EXIT DATE: 01/31/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY