STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: **283802**	**463 N HUNTER HIGHWAY** **DRUMS, PA 18222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance, and Revisit survey completed on January 16, 2025, it was determined that Kadima Rehabilitation & Nursing at Luzerne corrected the federal deficiency cited during the survey of November 15, 2024, but continued to be out of compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0684 SS=E		F 0684		

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 0684 SS=E	Continued from page 1 483.25 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	1. Resident 29 was assessed and there were no adverse effects noted. MD/RP aware. 2. 14 days look back was completed to ensure medications with orders for parameters were followed. 3. Licensed Nursing staff were re-educated on the Medication Administration policy with a focus on medication parameters. The DON will complete spot checks of medications with parameters in the orders to ensure parameters are followed. 4. The DON or designee will conduct an audit of medications with parameters weekly x 4 weeks then monthly x 2 months to ensure parameters are followed. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0684 SS=E	Continued from page 2 Based on review of clinical records, select facility policy, and staff interview it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication for one of 15 sampled residents. (Resident 29). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills,	F 0684		

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F 0684 SS=E	Continued from page 3 understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. Review of the facility policy titled "Medication Administration" last reviewed by the facility on September 16, 2024, revealed that medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are administered in accordance with written orders of the attending physician. A review of the clinical record revealed Resident 29 was admitted to the facility on October 19, 2023, with diagnoses to include atherosclerotic heart disease (build-up of fats, cholesterol, and other	F 0684		

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F 0684 SS=E	Continued from page 4 substances in and on the artery walls which causes obstruction of blood flow), hypertension (high blood pressure) and dementia with mild psychotic disturbance (chronic disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning experiencing hallucinations and delusions). A review of the physician's order dated November 5, 2024, revealed an order for Amlodipine Besylate (medication used to treat high blood pressure) Oral Tablet 2.5 mg, give 1 tablet by mouth one time a day for HTN (hypertension). HOLD for SBP<110 (systolic blood pressure less than 110), DBP<60 (diastolic blood pressure less than 60), or HR<60 (heart rate less than 60). Review of the Medication Administration Record (MAR) for November 2024, December 2024, and January 2025, revealed Resident 29's Amlodipine Besylate was administered on the following dates nineteen (19 times) outside of the physician ordered	F 0684		

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F 0684 SS=E	Continued from page 5 parameters: November 6, 2024 no blood pressure or heart rate documented November 7, 2024 no blood pressure or heart rate documented November 9, 2024 BP 100/60 HR 84 November 10, 2024 BP 100/60 HR 84 November 12, 2024 BP 112/62 HR 58 November 13, 2024 BP 112/62 HR 58 November 14, 2024 BP 112/62 HR 58 November 15, 2024 BP 112/62 HR 58 November 16, 2024 BP 92/64 HR 54 November 18, 2024 BP 130/74 HR 54 November 21, 2024 BP 110/62 HR 50 November 24, 2024 BP 118/60 HR 58 November 28, 2024 BP 140/70 HR 56 November 29, 2024 BP 140/70 HR 56 December 2, 2024 BP 124/70 HR 52 December 16, 2024 BP 116/62 HR 56 January 4, 2025 BP 98/52 HR 70 January 5, 2025 BP 102/60 HR 70 January 11, 2025 BP 100/50 HR 50	F 0684		

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F 0684 SS=E	Continued from page 6 During an interview on January 15, 2025, at 12:10 PM the Director of Nursing (DON) confirmed that nursing staff failed to follow acceptable standards of nursing practice during medication administration resulting in multiple medication errors. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies.	F 0684		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 7 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Resident 25 was educated on risks of consumption of non-prescription medications and care plan was updated with interventions to prevent recurrence. 2. New admissions will be educated on risks of consumption of non-prescription medications. The outside medication policy was revised to include illegal substances that are prohibited from entrance to the facility. This policy will be sent to all residents and responsible parties to ensure compliance. 3. Licensed Nursing staff were re-educated on providing risk education to residents following non-compliant episodes and applying effective interventions to care plans post incident.as well as the changes and revisions to the new outside medication policy The DON will review incident reports for effective intervention implementation and education. 4. The DON or designee will conduct an audit of incidents weekly x 4 weeks then monthly x 2 months to ensure effective interventions are	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0689 SS=D	Continued from page 8	F 0689	care planned and necessary education is completed. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	

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F 0689 SS=D	Continued from page 9 Based on a review of clinical records, resident and staff interview it was determined the facility failed to develop and implement effective safety measures to prevent the ingestion of an illegal substance for one resident out of 15 residents sampled. (Resident 25). Findings include: A clinical record review revealed Resident 25 was admitted to the facility on April 19, 2024, with diagnoses that included schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia and bipolar disorder- people with this condition experience periods of extreme energy, irritability, and restlessness and/or periods of depressive episodes, low energy, and hopelessness), chronic pain, and polysubstance use disorder (includes use of drugs such as cocaine, misuse of alcohol, tobacco, or a prescription medicine such as opioids). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated	F 0689		

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F 0689 SS=D	Continued from page 10 standardized assessment process conducted periodically to plan resident care) dated October 28, 2024, revealed that Resident 9 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Review of the resident's clinical record revealed a progress note dated December 9, 2024, at 7:59 PM, indicated Resident 25 exhibited slurred speech, and tremors (involuntary, rhythmic shaking or trembling of a body part)and an inability to hold a can of soda ,which he dropped. Documentation indicated no change in cognition, heart rate was 104 (normal value is between 60 and 100), and blood pressure was 106/84 (normal is less than 120/80). According to the documentation, Resident 25 declined to go to the hospital and stated, "I will be ok in a little while".	F 0689		

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F 0689 SS=D	Continued from page 11 A subsequent progress note dated December 10, 2024, at 2:11 AM, indicated worsening symptoms, including tremors, slurred speech, diaphoresis (sweating), a heart rate of 139, and oxygen saturation of 89% (normal is between 95% and 100%) on room air. The physician ordered transfer to the emergency room. A change in condition note dated December 10, 2024, at 2:11 AM, indicated Resident 25 experienced tremoring, was diaphoretic (sweating), heart rate was 139, oxygen saturation was 89% on room air (normal is between 95% and 100%), and had slurred speech. The physician ordered the resident to be sent to the emergency room for an evaluation. Review of physician Progress Note dated December 10, 2024, indicated that Resident 25 was sent to the emergency room for "an overdose event". According to the progress note, "a visitor from outside the facility brought him in CBD Gummies or so we are told and so the resident	F 0689		

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F 0689 SS=D	Continued from page 12 maintains". The Nursing Home to Hospital Transfer form dated December 10, 2024, revealed that a visitor had given Resident #25 a "marijuana edible gummy" on the evening of December 9, 2024. Review of hospital After Visit Summary dated December 10, 2024, revealed that Resident 25 was evaluated in the emergency room for shortness of breath and diagnosed with behavior change due to substance use. According to the summary, the resident received two naloxone injections (medication used to reverse the life-threatening effects of a known or suspected opiate/narcotic overdose) 2mg at 2:46 AM, and again at 3:14 AM. A review of the resident's care plan failed to identify interventions or a plan to prevent the recurrence of consumption of nonprescribed medications.	F 0689		

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F 0689 SS=D	Continued from page 13 There was no documentation indicating the resident received education regarding the risks of ingesting nonprescribed substances. During an interview on January 16, 2025, at 1:30 PM, the Director of Nursing confirmed that the facility had not implemented interventions to prevent the resident from being provided with or consuming nonprescribed medications. The Director also confirmed that no education regarding the risks of consuming nonprescribed substances had been provided to Resident #25. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12 (d)(5) Nursing services	F 0689		
F 0692 SS=E		F 0692		

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F 0692 SS=E	Continued from page 14 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Residents 12, 18 and 29 have been weighed. A nutritional assessment will be completed and their care plans updated. 2. The facility has hired an RD for 10 hrs/ week to provide onsite support. 3. The licensed staff were re-educated on the Weight/Re weight policy. The RD was re-educated on importance of completing nutritional assessments timely and update the care plans as needed. 4. The RD/ Designee will audit resident weights to ensure resident weights are obtained per policy. The Registered dietician will be notified of any weight changes that are of concern. The results of the audits will be reviewed at QAPI for review and analysis of ongoing education.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

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F 0692 SS=E	Continued from page 15 determined the facility failed to assess, evaluate, monitor nutritional parameters, and develop and implement individualized nutritional interventions to maintain nutritional parameters and deter weight loss for three residents (Residents 18, 12, and 29) out of 15 residents sampled. Findings include: The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship. Review of the Facility Assessment dated November 29, 2024, failed to indicate the necessity of a qualified dietitian or clinically qualified nutrition professional to meet the nutritional needs of the	F 0692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0692 SS=E	Continued from page 16 residents. During interview with the foodservice director (FSD) on January 14, 2025, at approximately 9:30 AM confirmed she was the full-time Certified Dietary Manager but does not meet the minimum qualifications to be the qualified dietitian or clinically qualified nutrition professional. The FSD stated the facility does employ a part-time registered dietitian who works remotely. The FSD stated that she interacts with the registered dietitian via e-mail and telephone to provide/receive updates on residents. The FSD stated she does visit residents to obtain food preferences which are added to each resident's meal ticket and documented in the clinical record. The FSD also noted that she attends plan of care meetings for residents. A review of the facility's Nutrition Assessment Policy last reviewed September 16, 2024, indicated a nutrition assessment shall be completed for each resident admitted to the facility. The dietitian or the dining services manager under the guidance of the	F 0692		

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F 0692 SS=E	Continued from page 17 dietitian is responsible for developing a nutrition assessment for each resident admitted to the facility. A nutrition assessment will be conducted, and such information will include at least the following information: Weight Height Hematological data (information related to blood) Nutritional intake Eating habits Food preferences and dislikes Dietary restrictions Diagnoses Other information deemed necessary and appropriate. Nutrition assessments shall be initiated within 72 hours of admission to the facility and completed prior to developing the resident's MDS 3.0 assessment and care plan. Nutrition assessments will be reviewed quarterly and revised as necessary. A review of the facility Resident Weights policy last	F 0692		

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F 0692 SS=E	Continued from page 18 reviewed September 16, 2024, indicated weights must be obtained routinely to monitor the parameters of nutrition over time and identify residents at risk for significant weight change. Upon admission/readmission, the resident will be weighed each day for the first 2 days. The first weight will be within 24 hours of admission or readmission. After admission weights are obtained, the individual will be weighed weekly for 4 weeks. After the first 4 weeks, the interdisciplinary team will determine the need for continuation of weekly weights or a change to monthly weights. All monthly weights will be completed by the seventh of the month. Re-weights will be obtained within 72 hours of a monthly weight if a weight change is greater than 3%. If the weight change is validated, the licensed nurse will notify the physician and dietitian. The licensed nurse will notify the interdisciplinary team for further assessment if the weight change is significant (a weight loss or gain of 5% in a month, 7.5% in 90 days, or 10% in 6 months), the family will be notified. All weights will be transcribed (including weekly weights and any reweigh) in the resident's electronic medical record.	F 0692		

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F 0692 SS=E	Continued from page 19 A review of the facility Enteral Tube (flexible tube placed in stomach in which medications and liquid nutritional supplements are given to provide calories, nourishment, and fluids) Medication Administration Policy last reviewed September 16, 2024, indicated the facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and consultant pharmacist. Enteral formulas, equipment, route of administration, and flow rate are based on an assessment of the resident's condition and need. Clinical record review revealed that Resident 18 was admitted to the facility on February 10, 2023, with diagnoses to include Huntington's disease (inherited condition that affects cells in your brain and causes physical and emotional changes that get	F 0692		

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F 0692 SS=E	Continued from page 20 worse over time) and oropharyngeal dysphagia (difficulty swallowing). A review of Resident 18's quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated December 20, 2024, revealed the resident had a BIMS score of 3 (Brief Interview for Mental Status-a tool that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severely cognitively impaired), weighed 122 pounds, 62 inches tall, had no significant weight loss or weight gain, and was on a mechanically altered diet (change in texture of solids or liquids to assist swallowing). A review of the resident's Weight Record revealed the following: July 11, 2024- 129.7 pounds. August 5, 2024- 126.9 pounds. September 1, 2024- 124.4 pounds. October 4, 2024- 122.2 pounds.	F 0692		

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STATE LICENSE NUMBER: **283802**	

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F 0692 SS=E	Continued from page 21 November 2024- no weight obtained. December 2024- no weight obtained. Further review of the clinical record revealed no documented evidence of a reason for not obtaining a monthly weight for the months of November 2024 and December 2024. A quarterly nutrition note written by the registered dietitian dated December 18, 2024, noted the resident's current weight is 122.2 pounds, height 62 inches, BMI (body mass index, measure that relates body weight to height to determine healthy weight) 22.3 below ideal body weight, receives regular puree (foods are blenderized to pudding consistency) with nectar-thick liquids, average intakes 75-100%. Divided plate at meals and Kennedy cup (spill-proof drinking cup) for hot beverages. Resident eats meals in the dining room. Offered health shakes (nutritional beverage) twice daily, fortified cereal three times per day, 30 ml liquid protein (liquid nutritional supplement) twice daily, skin intact, no edema noted. Continue diet	F 0692		

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F 0692 SS=E	Continued from page 22 and supplements as ordered, monitor weights, and intakes for significant changes. Offer assistance as needed and honor preferences. Follow with interdisciplinary care plan team. A nurses note dated December 30, 2024, indicated the resident was positive for COVID-19, had a poor appetite skin turgor (elasticity or firmness of the skin) was fair. A nurses note dated December 30, 2024, at 6:51 PM noted a physician order to start Normal Saline IV (intravenous- fluids given through a tube inserted into a vein)1000 ml at 80 cc/hour over 12 hours to prevent dehydration. A nurses note dated December 31, 2024, at 9:52 AM noted the resident was having difficulty catching her breath, SPO2 (measure of amount of oxygen in the blood) 84% and the resident was coughing with poor effort to cough. Suctioned for large amount of thick white mucous, after suctioning SPO2 92% on oxygen 2 liters/min via nasal cannula. 911 called.	F 0692		

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F 0692 SS=E	Continued from page 23 Ambulance arrived and resident was transferred with IV in left hand to emergency room. CRNP (certified registered nurse practitioner) and resident representative was made aware. A nurses note dated December 31, 2024, at 9:05 PM indicated the resident returned from the hospital after IV fluids were given at the hospital. The Resident's representative was made aware of return. A nurse's note dated January 2, 2025, at 3:54 PM indicated the resident remained lethargic. Resident representative called with update with resident representative asking for IV fluids. Attempted to start IV per orders (physician) and resident representative request. IV insertion attempt unsuccessful. Resident representative was agreeable to sending resident to the emergency department for IV fluids and hospice placement. A nurses note dated January 10, 2025, noted the resident was readmitted to the facility with diagnosis of COVID-19 related pneumonia. New feeding	F 0692		

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F 0692 SS=E	Continued from page 24 tube in place. Resident was strict NPO (nothing by mouth). Jevity 1.5 at 25 ml/hr continuous as per hospital nutritionist, resident is too high risk for bolus feedings. Free water flushes every 6 hours at 60 ml. A physician order dated January 11, 2025, noted an order for Jevity 1.5 10 ml/hr for 22 hours. Assess for tolerance by monitoring residual, nausea/vomiting. Advance by 10 ml/hr every 24 hours until goal of 45 ml/hr is reached. A nursing change in condition note dated January 12, 2025, at 7:43 AM indicated the resident with no urine output for 2 shifts (sixteen hours). Dry mucous membranes, skin turgor dry. CRNP and resident representative aware. New order to send to emergency room for evaluation and treatment. A nurses note date January 12, 2025, at 2:03 PM indicated the resident returned from the hospital with a physician order to flush feeding tube with water, 120 ml, every 4 hours.	F 0692		

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F 0692 SS=E	Continued from page 25 A physician order dated January 16, 2025, noted an order for Jevity 1.5 at 45 ml/hr for 22 hours daily via g-tube (a tube surgically inserted through the abdomen into the stomach). The resident was readmitted on January 10, 2025, with a feeding tube in place due to high aspiration risk, yet no weight was obtained until January 15, 2025, revealing further weight loss to 114 lbs. (7% over 3 months) since the last recorded weight on October 4, 2024. Despite the significant weight loss, there was no evidence that the registered dietitian evaluated the resident's nutritional requirements or updated the care plan following the implementation of enteral feeding. The nursing home administrator confirmed on January 16, 2025, at 10:00 AM that the facility lacked an on-site dietitian and relied on a part-time remote dietitian, without face-to-face interaction	F 0692		

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F 0692 SS=E	Continued from page 26 with the residents, resulting in limited oversight of residents' nutritional needs. The NHA confirmed that weights were to be timely obtained and nutritional assessments were to be timely completed to ensure nutritional parameters are maintained to the extent possible for each resident. Clinical record review revealed that Resident 12 was admitted to the facility on May 30, 2021, with diagnosis which included cerebral infarction (stroke-occurs when blood flow to the brain is blocked). Further review of the clinical record revealed a registered dietitian note dated September 14, 2024, which noted the resident receives a puree diet with pudding-thickened liquids. Monitor weights and food and fluid intakes for significant changes. Honor preferences and offer assistance as needed. Follow with care team. A review of the resident's weights noted the following: October 4, 2024- 114.6 pounds.	F 0692		

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	395484	A. BLDG: 00 B. WING:	01/16/2025

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F 0692 SS=E	Continued from page 27 November 3, 2024- 112.8 pounds December 3, 2024- 113.6 pounds January 1, 2025- 106.8- pounds Resident 12 experienced a 6.8 lb. weight loss (5.9%) between December 3, 2024, and January 1, 2025. A reweight was not obtained within the required 72-hour timeframe per facility policy. Following surveyor inquiry, a reweight obtained on January 15, 2025, (14 days late) showed 112.6 lbs. The Director of Nursing confirmed on January 15, 2025, that the reweight was not timely obtained. A review of the clinical record revealed Resident 29 was admitted to the facility on October 19, 2023, with diagnoses to include atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls which causes obstruction of blood flow), hypertension (high blood pressure) and dementia with mild psychotic disturbance (chronic disorder of the mental	F 0692		

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STATE LICENSE NUMBER: **283802**	

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F 0692 SS=E	Continued from page 28 processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning experiencing hallucinations and delusions). A quarterly Minimum Data Set Assessment (MDS-standardized assessment process conducted at periodic intervals to plan resident care) dated November 3, 2024, revealed the resident was moderately cognitively impaired with a BIMS score of 8 (Brief Interview for Mental Status-a tool to assess the resident's attention, orientation, and the ability to register and recall new information, a score of 8-12 equates to moderate cognitive impairment). Review of Resident 29's plan of care initiated on October 19, 2023, revealed a focus area that the resident may be nutritionally at risk related to therapeutic diet, dementia, diabetes, hypertension and GERD with interventions to consult with the dietician, honor food preferences, monitor for changes in the amount of food consumed, monitor for signs and symptoms of diet intolerance and	F 0692		

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F 0692 SS=E	Continued from page 29 dehydration, provide diet as ordered: consistent carbohydrate/heart healthy diet, regular texture, think liquids, record and monitor intakes, and record and monitor weights as ordered. Resident 29's weight record revealed: June 3, 2024, 140.2 lbs. July 8, 2024, 132.2 lbs. (5.71% weight loss in one month) August 5, 2024, 129.2 lbs. September 10, 2024, 127.4 lbs. Resident 29 experienced significant weight loss from 140.2 lbs. (June 2024) to 132.2 lbs. (July 2024, a 5.71% loss). No reweight was conducted within the 72-hour timeframe as required, and there was no evidence that the physician, dietitian, or interdisciplinary team was notified of the significant weight change. Further review of the clinical record revealed no	F 0692		

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STATE LICENSE NUMBER: **283802**	

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F 0692 SS=E	Continued from page 30 evidence that the physician or the dietitian was notified of the resident's significant weight loss of 8 lbs., or 5.71% on July 8, 2024. There was no evidence that the licensed nurse notified the Interdisciplinary Team for further assessment for the significant weight loss on July 8, 2024, as per facility policy. There was no documented evidence that the facility identified Resident 29's continued weight loss during the month of August 2024. Review of a dietary note dated September 11, 2024, indicated the resident's current weight was 127.4 lbs., -1.8 lbs. x 30 days, -13lbs. /-10.2 lbs. x 180 days. Height is 63", BMI 21.9 which is below her ideal body weight of 140-169 lbs. Weight monitoring continued to show ongoing weight loss, but no updated nutritional assessments or individualized interventions were documented between the resident's admission in October 2023	F 0692		

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F 0692 SS=E	Continued from page 31 and September 2024 Interview with the Director of Nursing (DON) on January 16, 2025, at approximately 12:15 PM confirmed the facility failed to obtain and record Resident 29's reweights and failed to timely notify the physician and dietician of the residents significant weight loss that occurred on June 8, 2024, to provide the necessary information to accurately assess the resident's nutritional status and needs and evaluate the adequacy of the resident's nutritional intake and plan nutritional support as necessary. Refer F801, F838 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services.	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 32 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident 13 and 24's oxygen concentrator filters are clean and in place. 2. An oxygen concentrator audit was completed to ensure filters are clean and in place. 3. Licensed Nursing staff were re-educated on the Maintenance of Oxygen Delivery policy. The Infection Control Nurse will complete weekly audits of oxygen concentrators to ensure compliance. 4. The Infection Control Nurse or designee will conduct an audit of oxygen concentrators weekly x 4 weeks then monthly x 2 months to ensure appropriate maintenance. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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	395484	A. BLDG: 00 B. WING:	01/16/2025

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F 0695 SS=D	Continued from page 33 Based on review of clinical records, select facility policy, observation, and staff interview, it was determined the facility failed to maintain oxygen equipment in a functional and sanitary manner for two residents out of 15 sampled (Residents 13 and 24). Findings include: Review of the facility policy titled "Oxygen Concentrator" last reviewed by the facility on September 16, 2024, revealed that precautions will be taken to maintain the integrity of the oxygen concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) unit and to promote safety during oxygen administration. Be sure the cabinet air filter is in place. The air filter is to be removed from the door in the back of the unit by nursing. Wash the filter in warm water and towel dry. Do not operate the unit without the air filter or while the air filter is still damp.	F 0695		

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F 0695 SS=D	Continued from page 34 Review of Resident 13's clinical record revealed the resident was admitted to the facility on April 12, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), and hypertension (high blood pressure). The resident had a current physician's order dated October 29, 2024, for oxygen therapy administration via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) at 4.0 liters per minute for shortness of breath due to COPD. An observation conducted on January 14, 2024 at 10:55 AM revealed that Resident 13 was awake and lying in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 4.0 liters per minute. The resident's oxygen concentrator filter was missing from the unit. Review of Resident 24's clinical record revealed the resident was admitted to the facility on May 18,	F 0695		

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F 0695 SS=D	Continued from page 35 2023, with diagnoses to include moderate persistent asthma (airwys become inflamed, narrow and swell, and produce extra mucus, making if difficult to breathe) and dependence on supplemental oxygen. The resident had a current physician's order dated November 4, 2024, for oxygen therapy administration via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) at 2.0 liters per minute PRN (as needed) for shortness of breath. May increase up to 5 liters per minute for SPO2 below 90%, every 8 hours as need for shortness of breath. An observation conducted on January 14, 2025 at 11:33 AM revealed that Resident 24 was lying in his bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 2.0 liters per minute. The resident's oxygen concentrator filter was visibly covered in dust. Interview with Employee 1 (licensed practical nurse) on January 14, 2025, at 11:40 AM confirmed that	F 0695		

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F 0695 SS=D	Continued from page 36 Resident 24's the oxygen concentrator filter was covered in dust. Employee 1 confirmed that the oxygen concentrator filter was missing for Resident 13. Interview with Nursing Home Administrator on January 16, 2025, at 12:20 PM confirmed the condition of the oxygen concentrators were not consistent with facility policy for maintenance of oxygen delivery equipment. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(c) Resident Care Policies	F 0695		
F 0801 SS=F		F 0801		

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F 0801 SS=F	Continued from page 37 483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered	F 0801	1. A RD was hired to provide 10 hours/week of onsite dietary support and evaluation. 2. The facility will maintain an onsite RD. 3. The recruiter was re-educated on ensuring that an onsite RD was available to the facility for at least 10 hours/week. The NHA will report open positions to the recruitment department. 4. The NHA or designee will conduct an audit of RD onsite hours weekly x 4 weeks then monthly x 2 months to ensure onsite support is provided. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0801 SS=F	Continued from page 38 dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State	F 0801		

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F 0801 SS=F	Continued from page 39 requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=F	Continued from page 40 Based on staff interview, a review of personnel files and employee credentials, it was determined the facility failed to provide sufficient staff with the necessary skill set and competencies to ensure appropriate nutritional oversight for residents in the facility and failed to ensure the full-time director of food and nutrition services, who was not a qualified dietitian or other clinically qualified nutrition professional, received frequently scheduled consultations from a qualified dietitian or other clinically qualified nutritional professional. Findings include: Federal regulations require the facility to employ sufficient staff with the appropriate competencies and skill sets to meet the nutritional needs of residents, considering resident assessments, individual plans of care, and the facility assessment. In the absence of a full-time qualified dietitian, the Director of Food and Nutrition Services must meet minimum qualifications and receive frequent consultations from a qualified dietitian or other	F 0801		

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F 0801 SS=F	Continued from page 41 clinically qualified nutrition professional The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship. Review of the Facility Assessment dated November 29, 2024, failed to indicate the necessity of a qualified dietitian or clinically qualified nutrition professional to meet the nutritional needs of the residents. During interview on January 14, 2025, at approximately 9:30 AM the full-time foodservice director (FSD) confirmed she was a Certified Dietary Manager but does not meet the minimum qualifications to be the qualified dietitian or clinically	F 0801		

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F 0801 SS=F	Continued from page 42 qualified nutrition professional. The FSD stated that the facility does employ a part-time registered dietitian (RD) who works remotely. The FSD stated that she interacts with the RD via e-mail and telephone to provide/receive updates on residents. The FSD stated that she does visit residents to obtain food preferences which are added to each resident's meal ticket and documented in the clinical record. The FSD also noted that she attends plan of care meetings for residents. A review of the Certifying Board for Dietary managers (the credentialing agency for the Association of Nutrition and Food Service professionals) scope of practice for certified dietary managers, these individuals were able to conduct routine nutritional screening including food/fluid intake information, calculate nutrient intake, implement diet plans and orders, utilize standard nutrition nutrition care procedures, document nutritional care screening data in the medical record and complete forms, review meal intakes, complete meal rounds, document food intake, participate in	F 0801		

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F 0801 SS=F	Continued from page 43 care conferences and review the effectiveness of nutritional care. Basic diet information could be provided using evidence based education materials. Their scope of practice did not include the clinical assessment and evaluation of residents for medically related nutritional therapy or to make recommendations regarding medications or supplementation. The facility's FSD had limited scope of practice and lacked necessary credentials/qualifications to provide the operational and nutritional oversight of a RD or clinically qualified nutrition professional. A review of a facility provided job description for the RD indicated that the primary purpose of the job description is to implement, coordinate, and evaluate the medical nutrition therapy for the residents, provide resident, and family education, provide nutritional assessment and consultation to assist planning, organizing, and directing the food and nutritional services of the facility. Functions of the	F 0801		

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F 0801 SS=F	Continued from page 44 RD included to perform administrative duties such as completing necessary forms, reports, evaluations, studies, etc., to assure control of the Food Service Department, inspect food storage rooms, utility/janitorial closets, etc., for upkeep and supply control, participate in facility surveys (inspections) made by authorized government agencies, assist in developing methods for determining quality and quantity of food served, and participate in Quality Assurance programs, and any facility committee or program, which seeks to improve the performance or accuracy of resident care. However, the RD's part time remote status limited her ability to fulfill these responsibilities effectively. Interview with the nursing home administrator (NHA) on January 16, 2025, at 9:00 AM failed to provide documentation confirming the RD's role included on site consultation or oversight, or that the FSD received frequently scheduled consultations from the RD. Interview with the part-time RD on January 16,	F 0801		

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F 0801 SS=F	Continued from page 45 2025, at 1:30 PM revealed that she works remotely and has worked with the facility on-and-off since December 18, 2020. The RD confirmed that she completes all job tasks including nutritional assessments remotely with input from the interdisciplinary team including nursing and the FSD. The RD confirmed that she accesses residents' clinical records remotely. The RD stated that she does not contact residents on the phone before completing nutritional assessments and had not been in the facility to observe the residents' ability to eat, interview residents and provide nutritional consultation or observe the residents for signs and symptoms of nutritional and hydration inadequacies/deficiencies and provide oversight of the operations of the food and nutritional services department. Refer F692, F838 28 Pa Code 201.18(e)(1)(6) Management.	F 0801		

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F 0801 SS=F	Continued from page 46	F 0801		
F 0838 SS=F	483.71(a)(1)(3)(b)(1)(c)(1)-(5) Facility Assessment §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that	F 0838	1. The Facility Assessment was updated to reflect the current resident population and needs. 2. The Facility Assessment will be reviewed at least quarterly and PRN. 3. The facility's IDT were re-educated on completion of the Facility Assessment to accurately reflect the current resident population and needs. The NHA will ensure regular updates. 4. The NHA will conduct an audit of the Facility Assessment monthly x 6 months to ensure accuracy. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0838 SS=F	Continued from page 47 population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as	F 0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: **283802**	**463 N HUNTER HIGHWAY DRUMS, PA 18222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0838 SS=F	Continued from page 48 systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based	F 0838		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0838 SS=F	Continued from page 49 on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by:	F 0838		

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F 0838 SS=F	Continued from page 50 Based on a review of professional literature, the facility's assessment, facility documentation, a review of the medical and nutritional needs of the resident census, and staff interview it was determined the facility failed to conduct and document a facility-wide assessment, using evidence-based methods, which identified and accurately reflected the specific resources necessary and available to care for its specific resident population. Findings include: Review of the Centers for Medicare and Medicaid Services Memorandum, Revised Guidance for Long-Term Care Facility Assessment Requirements (QSO-24-13-NH) dated June 18, 2024, revealed the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions), and any other pertinent information about the resident population as a whole that may affect the services the facility	F 0838		

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	395484	A. BLDG: __00_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: 283802	463 N HUNTER HIGHWAY DRUMS, PA 18222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0838 SS=F	Continued from page 51 must provide. Further review revealed the assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess to deliver the necessary care required by the residents being served. Review of the Facility Assessment, last reviewed by the facility on November 29, 2024, indicated the number of resident beds in the facility is 37 and the average daily census of the facility is 36 residents. There was no further information specific to the facility, the facility's population, and facility resources necessary to care for its residents competently during both day-to-day operations and emergencies. The Facility Assessment failed to accurately reflect the current staff employed in the facility to ensure a sufficient and competent number of qualified staff are available to meet each resident's needs. Review of the facility's Resident Matrix (list of all residents in the facility), dated January 14, 2025,	F 0838		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: 283802	463 N HUNTER HIGHWAY DRUMS, PA 18222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0838 SS=F	Continued from page 52 revealed a total census of 35 residents. Of the 35 residents, the Matrix identified one resident (Resident 18) receiving enteral feeding (method of feeding that delivers food and fluid via a tube inserted into the stomach or small intestine) who would require services of a qualified dietitian. During an interview on January 14, 2025, at approximately 9:30 AM the full-time foodservice director (FSD) confirmed she was a Certified Dietary Manager but does not meet the minimum qualifications to be the qualified dietitian or clinically qualified nutrition professional. The FSD stated that the facility does employ a part-time registered dietitian who works remotely. The FSD stated that she interacts with the registered dietitian via e-mail and telephone to provide/receive updates on residents. The FSD stated that she does visit residents to obtain food preferences which are added to each resident's meal ticket and documented in the clinical record. The FSD also noted that she attends plan of care meetings for residents.	F 0838		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: **283802**	**463 N HUNTER HIGHWAY** **DRUMS, PA 18222**

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F 0838 SS=F	Continued from page 53 An interview with the NHA on November 20, 2024, at 9:30 AM confirmed the current part-time registered dietitian who also works for sister facilities works remotely and completes nutritional assessments and nutritional progress notes offsite, without face-to-face interaction with the residents. The facility failed to conduct and document a comprehensive facility-wide assessment, which is required to identify the specific resources necessary to meet the unique needs of its resident population. This deficient practice has the potential to negatively affect the quality of care and quality of life for all residents. During an interview on January 16, 2025, at 9:00 AM the Nursing Home Administrator confirmed that the Facility Assessment did not contain all the required information. Refer F692, F801	F 0838		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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STATE LICENSE NUMBER: **283802**	

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F 0838 SS=F	Continued from page 54 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(3) Management	F 0838		
F 0883 SS=D		F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 55 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	1. Resident 29 was administered a PNA vaccination. 2. A facility wide audit was completed to ensure residents that want the PNA vaccination were offered it and received it. 3. The Infection Control Nurse was re-educated on ensuring PNA vaccinations are administered to residents wanting them. The DON will complete random vaccination administration audits to ensure that they are administered per resident preference. 4. The DON or designee will conduct an audit of new admissions weekly x 4 weeks then monthly x 2 months to ensure those that want the PNA vaccination receive it timely. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 56 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

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F 0883 SS=D	Continued from page 57 Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to offer and/or provide the pneumococcal immunization, unless the immunization was medically contraindicated or the resident has already been immunized, to one resident out of five residents reviewed (Residents 29). Findings include: A review of facility policy titled "Influenza and Pneumococcal Pneumonia Vaccination and Immunization Program" last reviewed September 16, 2024, revealed that each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated. Nursing staff will provide education information to the resident/authorized representative prior to the administration of each vaccine. Once education has been completed, a signed consent form is to be obtained prior to administration of the vaccine. A review of the clinical record revealed that	F 0883		

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F 0883 SS=D	Continued from page 58 Resident 29 was admitted to the facility on October 19, 2023, with diagnoses to include atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls which causes obstruction of blood flow), dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and diabetes (body has trouble controlling blood sugar and using it for energy). Review of Resident 29's Informed Consent for Pneumococcal Vaccine signed by Resident 29's resident representative on July 18, 2024, indicated permission for the facility to administer the pneumococcal vaccine. Further review of the clinical record revealed no documented evidence the facility administered the pneumococcal vaccine as requested per the signed consent.	F 0883		

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F 0883 SS=D	Continued from page 59 Interview with the Director of Nursing on January 16, 2025, at 12:08 PM confirmed the facility failed to provide pneumococcal immunizations to Residents 29. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.5 (f)(i) Medical records 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa code 211.12 (c)(d)(1)(5) Nursing Services	F 0883		
F 0912 SS=B		F 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: __00_____ B. WING: _____	01/16/2025

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F 0912 SS=B	Continued from page 60 483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by:	F 0912	This situation poses no threat to the safety or well-being of the residents in these rooms; therefore, the facility has requested a waiver continuation of 42CFR 428.70 (d) (1) (ii) by previously submitted letter. Please note that the facility meets the variation in square footage requirements adopted by the Commonwealth of Pennsylvania at 28 PA Code section 205.20 € and 205.30 (g). 2. The facility is selective in room placement and considers residents' needs and safety when assigning rooms. This facility remains committed to assuring the special needs of the residents in these rooms are met to ensure that their health and safety are not adversely affected. 3. If a resident or family member requests a room change, the facility makes every effort to place the resident in a different room. 4. NHA or designee will discuss room change requests at the Interdisciplinary Team meeting. NHA or designee will audit resident	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0912 SS=B	Continued from page 61	F 0912	Council meeting minutes to ensure concerns regarding room placement are addressed monthly x 6 months. The results of the audit will be reviewed by the QAPI Committee for review and analysis of need for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0912 SS=B	Continued from page 62 Based on observations and space measurements provided by the facility, it was determined the facility failed to provide the regulatory required minimum square footage in nine of 21 resident rooms. Findings include: Observations made on Janaury 14, 2025, at 9:30 AM, revealed square footage was not adequate in the following resident rooms: Room 22 is a single-bedded resident room, which requires a minimum of 100 square feet. The square footage of this room measured 85 square feet. Resident rooms 15, 16, 17, 18, 19, 20, 21, and 23 are two- bedded resident rooms with square footage measurements of only 143 square feet. These multi-bed rooms failed to provide the minimum square footage requirement of 80 square feet per bed, or a total of 160 square feet in a semi-private room.	F 0912		

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F 0912 SS=B	Continued from page 63 CFR 483.90(d)(1)(ii) Bedrooms 28 Pa. Code: 205.20 (d)(f) Resident bedrooms	F 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1210	Management. (2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death, including the return of any personal property remaining at the facility within 30 days after discharge or death. This REGULATION is not met as evidenced by:	P 1210	1. Resident 187 has discharged from the facility. 2. A facility wide audit of Inventory Sheets was conducted to ensure accuracy and appropriate signatures. 3. Licensed Nurses were re-educated on completing a Resident Inventory Sheet with signature on admission and discharge. The Administrative Assistant will complete random chart checks to ensure completion. 4. The NHA or designee will complete a resident inventory sheet audit weekly x 4 weeks and monthly x 2 months of resident admissions and discharges to ensure accuracy and appropriate signatures. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: **283802**	**463 N HUNTER HIGHWAY DRUMS, PA 18222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 1210	Continued from page 1 Based on the review of clinical records and staff interview it was determined that the facility failed to maintain a complete and accurate record of a residents' personal possessions upon admission and discharge for one residents out of three sampled (Resident 187) Findings included: A review of the clinical record of Resident 187 revealed the resident was admitted to the facility on October 23, 2024, and discharged on November 24, 2024. The inventory list upon admission for Resident 187 revealed that sixteen (16) personal items were noted on the inventory form. Resident 187's inventory list on admission and discharge did not have a resident or responsible party signature present, and or a staff member's signature. Interview with the Director of Nursing on January 16, 2025, at 12:05 PM confirmed the inventory	P 1210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: 00 B. WING:	01/16/2025

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P 1210	Continued from page 2 sheet did not have the resident/representative or staff member's signature upon admission and when discharged.	P 1210		
P 4880	Medical records. (f) In addition to the items required under 42 CFR 483.70(i)(5) (relating to administration), a resident ' s medical record shall include at a minimum: (i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death. This REGULATION is not met as evidenced by:	P 4880	1. Residents 34, 35 and 187 had physician discharge summaries completed. 2. A 30 day look back was completed and physician discharge summaries were completed. 3. The DON was re-educated on ensuring physician discharge summaries are completed on discharge. The Administrative Assistant will complete discharge chart audits to ensure completion. 4. The NHA or designee will conduct an audit of discharged resident charts weekly x 4 weeks then monthly x 2 months to ensure completion of the physician discharge summary. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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P 4880	Continued from page 3 Based on a review of closed clinical records and staff interview, it was determined the facility failed to ensure that a discharge summary, with the physician's final diagnosis and prognosis or cause of death, was completed for three out of three discharged residents reviewed (Residents 35, 187, and 34). Findings include: A review of Resident 35's closed clinical record revealed that the resident was admitted to the facility on April 14, 2022. The resident expired at the facility on October 25, 2024. A review of the resident's closed clinical record on January 16, 2025, revealed the resident's record did not contain a physician's discharge summary with the resident's final diagnosis and cause of death. A review of Resident 187's closed clinical record revealed that the resident was admitted to the facility on October 23, 2024, and was discharged from the	P 4880		

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P 4880	Continued from page 4 facility on November 24, 2024. A review of the resident's closed clinical record on January 16, 2025, revealed the resident's record did not contain a physician's discharge summary with the resident's final diagnosis and prognosis. A review of Resident 34's closed clinical record revealed that the resident was admitted to the facility on November 14, 2024, and was discharged from the facility on November 17, 2024. A review of the resident's closed clinical record on January 16, 2025, revealed the resident's record did not contain a physician's discharge summary with the resident's final diagnosis and prognosis. An interview with the Director of Nursing on January 16, 2025, at 12:05 PM confirmed the facility could not provide documentation that a physician discharge summary was completed for Residents 35, 187, and 34.	P 4880		

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P 5520	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	1.The Facility is unable to retroactively provide a minimum CNA ratio for cited days. 2. A facility wide audit was completed to ensure ratios were met. Recruitment initiatives were increased, and wages remain competitive for the area 3. The DON and recruitment were reeducated on ensuring that the nursing care ratios are provided, and that the facility is actively recruiting CNAs. The DON will review census and schedule daily to ensure adequate staffing. 4. The DON or designee will conduct and audit of the nursing care ratios to ensure it is provided weekly x4 weeks then monthly x 2 months. The results will be submitted to the QAPI committee for review and analysis of need on an ongoing basis	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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P 5520	Continued from page 6 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 23 shifts out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census per the regulation that was effective July 1, 2024. December 22, 2024- 2.13 nurse aides on the night shift, versus the required 2.40 for a census of 36. December 23, 2024- 3 nurse aides on the evening shift, versus the required 3.18 for a census of 35. December 24, 2024- 2.13 nurse aides on the night shift, versus the required 2.20 for a census of 33. December 25, 2024- 2.53 nurse aides on the evening shift, versus the required 2.91 for a census	P 5520		

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P 5520	Continued from page 7 of 32. December 26, 2024- 2.73 nurse aides on the evening shift, versus the required 2.91 for a census of 32. December 27, 2024- 3 nurse aides on the day shift, versus the required 3.20 for a census of 32. December 28, 2024- 3 nurse aides on the day shift, versus the required 3.30 for a census of 33. December 28, 2024- 2 nurse aides on the night shift, versus the required 2.20 for a census of 33. December 29, 2024- 3 nurse aides on the day shift, versus the required 3.30 for a census of 33. December 30, 2024- 2.67 nurse aides on the evening shift, versus the required 3.00 for a census of 33. December 30, 2024- 1.87 nurse aides on the night shift, versus the required 2.20 for a census of 33. December 31, 2024- 2 nurse aides on the evening shift, versus the required 3 for a census of 33. January 1, 2025- 1.6 nurse aides on the night shift, versus the required 2.20 for a census of 33. January 3, 2025- 3 nurse aides on the day shift, versus the required 3.30 for a census of 33.	P 5520		

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P 5520	Continued from page 8 January 3, 2025- 1.6 nurse aides on the night shift, versus the required 2.20 for a census of 33. January 9, 2025- 2 nurse aides on the night shift, versus the required 2.20 for a census of 33. January 10, 2025- 2.13 nurse aides on the night shift, versus the required 2.33 for a census of 35. January 11, 2025- 3.07 nurse aides on the evening shift, versus the required 3.18 for a census of 35. January 11, 2025- 1.53 nurse aides on the night shift, versus the required 2.33 for a census of 35. January 12, 2025- 1.87 nurse aides on the evening shift, versus the required 3.18 for a census of 35. January 12, 2025- 1.67 nurse aides on the night shift, versus the required 2.33 for a census of 35. January 13, 2025- 3 nurse aides on the evening shift, versus the required 3.18 for a census of 35. January 13, 2025- 2 nurse aides on the night shift, versus the required 2.33 for a census of 35. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 9 An interview with the director of nursing on January 16, 2025, at approximately 10:00 AM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 10 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	1.The facility is unable to retroactively provide a minimum LPN ratio for cited dates. 2. A wide audit of the facility was completed to ensure ratios were met. Recruitment initiatives were increased, LPN sign on bonuses, and wages are competitive with surrounding areas. 3. The DON and Recruitment were re-educated on ensuring that nursing care ratios are provided, and that the facility is actively recruiting LPNs. The DON will review census and schedule daily to ensure adequate staffing of LPN's 4. The DON or designee will conduct an audit of the nursing care ratios to ensure it is provided weekly x4 weeks then monthly x 2 months. The results will be submitted to the QAPI Committee for review and analysis of need of ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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P 5530	Continued from page 11 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for 24 shifts out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift, 1:30 on the evening shift, and 1:40 on the night shift based on the facility's census. December 24, 2024 - 1 LPN on the day shift, versus the required 1.36 for a census of 34. December 24, 2024 - 1 LPN on the evening shift, versus the required 1.10 for a census of 33. December 24, 2024 - 2.13 LPN on the night shift, versus the required 2.20 for a census of 33. December 25, 2024 - 1 LPN on the day shift, versus the required 1.32 for a census of 33.	P 5530		

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P 5530	Continued from page 12 December 25, 2024 - 1 LPN on the evening shift, versus the required 1.07 for a census of 32. December 25, 2024 - 0.50 LPN on the night shift, versus the required 1 for a census of 32. December 27, 2024 - 1 LPN on the evening shift, versus the required 1.07 for a census of 32. December 27, 2024 - 0.50 LPN on the night shift, versus the required 1 for a census of 32. December 28, 2024 - 1 LPN on the day shift, versus the required 1.32 for a census of 33. December 28, 2024 - 1 LPN on the evening shift, versus the required 1.10 for a census of 33. December 29, 2024 - 1 LPN on the day shift, versus the required 1.32 for a census of 33. December 30, 2024 - 1 LPN on the evening shift, versus the required 1.10 for a census of 33. December 31, 2024 - 1 LPN on the evening shift, versus the required 1.10 for a census of 33. January 1, 2025- 1 LPN on the day shift, versus the required 1.32 for a census of 33. January 1, 2025- 1 LPN on the evening shift, versus the required 1.10 for a census of 33. January 1, 2025- 0.25 LPN on the night shift,	P 5530		

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P 5530	Continued from page 13 versus the required 1 for a census of 33. January 2, 2025- 1 LPN on the day shift, versus the required 1.32 for a census of 33. January 3, 2025- 0.50 LPN on the night shift, versus the required 1 for a census of 33. January 9, 2025- 1 LPN on the day shift, versus the required 1.32 for a census of 33. January 9, 2025- 0 LPN on the night shift, versus the required 1 for a census of 33. January 10, 2025- 0 LPN on the night shift, versus the required 1 for a census of 35. January 11, 2025- 0.75 LPN on the day shift, versus the required 1.40 for a census of 35. January 12, 2025- 1 LPN on the day shift, versus the required 1.44 for a census of 36. January 13, 2025- 0 LPN on the night shift, versus the required 1 for a census of 35. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency. An interview with the director of nursing on January	P 5530		

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P 5530	Continued from page 14 16, 2025, at approximately 10:00 AM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5540	Nursing services. (5) Effective July 1, 2023, a minimum of 1 RN per 250 residents during all shifts. This REGULATION is not met as evidenced by:	P 5540	1.The facility is unable to retroactively provide minimum registered nurse ratio for cited dates. 2.A facility wide audit was completed to ensure ratios were met. Recruitment increased, RN sign on bonuses, and wages are competitive with surrounding areas. 3.The DON was re-educated on ensuring that the nursing care ratios are provided, and that the facility is actively recruiting RNs. The DON will review census and schedule daily to ensure adequate staffing of RN's each day. 4.The DON or designee will conduct an audit of the registered nurse ratios to ensure it is provided weekly x4 weeks then monthly x 2 months. The results will be submitted to the QAPI Committee for review and analysis of need of ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

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P 5540	Continued from page 15 Based on a review of nurse staffing and staff interview, it was determined that the facility failed to ensure the minimum Registered nurse staff to resident ratio was provided on each shift for 3 shifts out of 63 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum Registered nurse (RN) staff of 1:250 on the night shift based on the facility's census. December 26, 2024 - 0 RNs on the night shift, versus the required 1 for a census of 32. December 31, 2024 - 0 RNs on the night shift, versus the required 1 for a census of 33. January 2, 2025- 0 RNs on the night shift, versus the required 1 for a census of 33. On the above dates mentioned no additional excess higher-level staff were available to compensate this	P 5540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5540	Continued from page 16 deficiency. An interview with the director of nursing on January 16, 2025, at approximately 10:00 AM, confirmed the facility had not met the required RN to resident ratios on the above dates.	P 5540		
P 5640		P 5640		

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KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: **283802**	**463 N HUNTER HIGHWAY DRUMS, PA 18222**

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P 5640	Continued from page 17 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	1.The facility is unable to retroactively correct PPD for dates cited. 2. A facility wide audit was completed to ensure the minimum PPD of 3.2 hours are met daily for each resident 3. The DON/ Designee were reeducated on the total number of hours of general nursing care provided in each 24-hour period be a minimum of 3.2 hours. The DON will review the census daily to ensure 3.2 hours of nursing care are being provided within a 24-hour period. If staffing levels are not being met, DON will instruct the scheduler to adjust the schedule by filling any gaps with per diem staff. The facility continues all effort to recruit and hire licensed staff. 4. The DON/ Designee will conduct an audit of daily staffing sheets weekly x 4 weeks and then monthly x 2 months to ensure facility meets the minimum daily 3.2 nursing hours for each resident. The results will be submitted to the QAPI committee for	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: 00 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LUZERNE STATE LICENSE NUMBER: 283802	463 N HUNTER HIGHWAY DRUMS, PA 18222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 5640	Continued from page 18 Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident: January 12, 2025- 3.01 direct care nursing hours per resident. The facility's general nursing hours were below minimum required levels on the dates noted above. An interview with the director of nursing on January 16, 2025, at approximately 10:00 AM confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640	review and analysis of need of ongoing monitoring	

Certified End Page

KADIMA REHABILITATION & NURSING AT LUZERNE

STATE LICENSE NUMBER: 283802

SURVEY EXIT DATE: 01/16/2025

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
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