STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: __--_____ B. WING: _____	01/22/2025

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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 22, 2025, at Kadima Rehab and Nursing at Luzerne, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.

Certified End Page

KADIMA REHABILITATION & NURSING AT LUZERNE

STATE LICENSE NUMBER: 283802

SURVEY EXIT DATE: 01/22/2025

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

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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K 0000	INITIAL COMMENT Facility ID# 283802 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 22, 2025, it was determined that Kadima Rehabilitation and Nursing at Luzerne, was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one story, Type V (000), unprotected, wood frame building, with a basement, that is fully sprinklered.	K 0000		

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.

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K 0211 SS=C	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	1. The facility cannot retroactive more headroom in the basement 2. The facility will submit for an FSES exemption 3. The maintenance director was reeducated on headspace requirements and means of egress 4. Random audits will be done to make sure nothing is stored or placed to close to ceilings. 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: **02/04/2025**

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K 0211 SS=C	Continued from page 2 Based on observation and interview, it was determined the facility failed to provide acceptable exits on one of two levels within this component. Findings include: 1. Observation on January 22, 2025, at 11:45 a.m., revealed the basement-level exit access corridor system, used by staff only, had less than the required six feet eight inches of headroom, due to sprinkler piping and sprinkler heads. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the deficient headroom within the basement-level exit access corridor system.	K 0211		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 3 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	The soiled utility unsealed penetrations are being sealed. 2. A facility wide audit was conducted, and no other unsealed penetrations were found. 3. The maintenance director was re-educated to ensure all walls are free from penetration. 4. The NHA or designee will conduct a one-time audit to ensure soiled utility rooms are free from any wall penetration. The results will be submitted to the QAPI committee for review and analysis of the need of ongoing monitoring.	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain one hazardous area enclosure, affecting one of three smoke compartments. Findings include: 1. Observation on January 22, 2025, at 11:26 a.m., Soiled Utility, revealed 2 unsealed penetrations of the wall, around two pipes. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the hazardous area enclosure deficiency.	K 0321		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 5 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	1. Facility cannot retroactively go back on second hood cleaning 2. Beach lake sprinklers are contracted to do our hood cleaning. A calendar will be created to oversee hood cleaning from maintenance director 3. Maintenance director was reeducated on the importance of hood cleaning 4. Biannual audit will be done to make sure hood cleaning is performed. The results will be submitted to the QAPI committee for review and analysis of the need of ongoing monitoring	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

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K 0324 SS=E	Continued from page 6 Based on document review, observation, and interview, it was determined the facility failed to maintain cooking facilities, in one instance, affecting one of two floors. Findings include: 1. Observation on January 22, 2025, at 10:29 a.m., Facility lacked documentation for 2nd semi-annual hood duct cleaning for 2024. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the cooking facilities deficiencies.	K 0324		
K 0325 SS=E		K 0325		

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K 0325 SS=E	Continued from page 7 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 0325	1.The hand sanitizers were moved away from an electrical mounted light in rooms 9 and 12. 2. Whole house audit of ABHR dispensers done for the facility to ensure that they are not found over electrical outlets. 3. The maintenance director was reeducated on the importance of moving ABHR dispensers away from electrical outlets 4. Nha or designee will perform monthly audits to ensure no new dispensers are installed in accordance with NFPA 101standards	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

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K 0325 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to protect Alcohol Based Hand Rub Dispenser, in two locations, affecting one of two floors. Findings include: 1. Observation on January 22, 2025, between 11:38 a.m., and 11:42 a.m., revealed the following: a. At 11:38 a.m., Resident Room 12, ABHR dispenser were installed over a electrical wall mounted light. b. At 11:42 a.m., Resident Room 9, ABHR dispenser were installed over a electrical wall mounted light. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the dispensers were installed over electrical .	K 0325		

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K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	1. NHA and Maintenance Director could not retroactively complete the sample testing for the sprinklers 2. The whole house audit was done of the sprinkler system to identify which heads are from 1974 and 1975. 3. The maintenance director was reeducated on the importance of sprinkler testing/ Replacement of sprinkler heads every 50 years. Sprinkler heads are being replaced when they hit the 50-year mark 4. A one-time audit was completed of sprinkler heads due for replacement to make sure replacement was completed. The results will be submitted to the QAPI committee for review and analysis of the need of ongoing monitoring	Completion Date: 02/14/2025 Status: APPROVED Date: 02/04/2025

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K 0353 SS=E	Continued from page 10 Based on document review and interview, it was determined the facility failed to maintain the sprinkler system, affecting the entire facility. Findings include: 1. Observation on January 22, 2025, at 11:10 a.m., facility could not provide documentation, for sample testing data or replacement of sprinklers in service for 50 years, as stated on sprinkler report, sprinkler heads were found dated 1974 and 1975 throughout the facility. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the lack of documention for 50 year sample testing or replacement.	K 0353		

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STATE LICENSE NUMBER: **283802**	

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K 0355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	1. The maintenance director could not retroactively do monthly fire extinguisher inspections 2. A facility wide audit of fire extinguishers was completed and updated 3. 3. The Maintenance Director was re-educated on the maintenance of portable fire extinguishers 4. NHA or designee will do a whole house monthly audit x 3 months of fire extinguisher testing	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/04/2025**

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K 0355 SS=E	Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain monthly portable fire extinguishers inspections, in four locations, affecting two of two floors. Findings include: 1. Observation on January 22, 2025, between 11:22 a.m., and 11:54 a.m., revealed the following: a. At 11:22 a.m., Kitchen, revealed that the "K" extinguisher lacked monthly inspection since 5/2024. b. At 11:49 a.m., Basement Level, Laundry portable fire extinguisher, lacked monthly inspection since 10/2024. c. At 11:50 a.m., Basement Level, Maintenance Shop portable fire extinguisher, lacked monthly inspection since 8/2024. d. At 11:54 a.m., Basement Level, Boiler Room portable fire extinguisher, lacked monthly inspection since 8/2024. Exit interview with the Facility Administrator and the	K 0355		

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K 0355 SS=E	Continued from page 13 Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the lacked of monthly inspections.	K 0355		
K 0363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height	K 0363	1.The room 9 door was adjusted to fully latch. 2. A facility wide audit was conducted and no other doors in need of adjustment were identified. 3. The maintenance director was re-educated on ensuring all doors fully latch. 4. The NHA or designee will conduct a one-time audit to ensure room 9 positively latches. 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: **02/04/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: __01_____ B. WING: _____	01/22/2025

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
K 0363 SS=D	Continued from page 14 are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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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K 0363 SS=D	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain one corridor opening, affecting one of three smoke compartments. Findings include: 1. Observation on January 22, 2025, at 11:42 a.m., revealed Resident Room 9, door was getting stuck on flooring when tested, requiring excessive force to close door. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the corridor opening deficiency.	K 0363		
K 0712 SS=D		K 0712		

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:
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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
K 0712 SS=D	Continued from page 16 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	1. NHA and Maintenance Director could not retroactively complete the missed annual fire drills. 2. NHA and the Director of Maintenance were re-educated on the importance of completing scheduled annual fire drills. 3. NHA and the Maintenance Director created a new schedule for fire drills to ensure they happen monthly on each shift (12 per year). 4. NHA will perform monthly audits to ensure one fire drill was performed that month.	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:
	395484	A. BLDG: __01_____ B. WING: _____	01/22/2025

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

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K 0712 SS=D	Continued from page 17 Based on documentation review and interview, it was determined the facility failed to conduct two of twelve fire drills, affecting two of two floors. Findings include: 1. Observation on January 22, 2025, at 9:40 a.m., revealed the facility lacked documentation for 3rd shift, 3rd and 4th quarter fire drills in 2024. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the missing fire drill documentation.	K 0712		
K 0918 SS=E		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: 01 B. WING:	01/22/2025

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
K 0918 SS=E	Continued from page 18 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1. There was no negative effect or loss of generator power. 2. Genserve will be performing 4-hour load bank testing annually and was out to facility on 1/31 for service. part was ordered awaiting instillation date based off part available. 3. Maintenance director reeducated on importance of generator service and upkeep 4. The maintenance director will conduct random audits that generator is fully functional	Completion Date: **02/14/2025** Status: **APPROVED** Date: **02/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395484	A. BLDG: __01_____ B. WING: _____	01/22/2025

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

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K 0918 SS=E	Continued from page 19 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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

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K 0918 SS=E	Continued from page 20 Based on document review and interview, it was determined the facility failed to maintain the emergency generator which serves the entire center. Findings include: 1. Observation on January 22, 2025, at 10:45 a.m., revealed the 4-hour load bank documents dated 5/31/2024, stated the generator shut off when 180 degree temperature was reached due to a low coolant sensor fail. Generator 4-hour load bank was completed using 2/0 pigtails, as stated on documents low coolant sensor would be replaced, facility could not provide documents that this sensor has been replaced. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the lack of documentation.	K 0918		

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

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K 0919 SS=E	NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0919	1.The light switch cover was replaced. 2. There are no missing light covers found in the facility. 3. The Maintenance Director was re-educated on maintaining electrical wiring and equipment. 4. The NHA conducted a onetime audit to ensure the soiled utility was free from exposed wiring. 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: **02/04/2025**

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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K 0919 SS=E	Continued from page 22 Based on observation and interview, it was determined the facility failed to maintain the electrical systems in one location, affecting one of three smoke compartments. Findings include: 1. Observation on January 22, 2025, at 11:25 a.m., Soiled Utility, revealed a missing light switch cover plate, exposing the wiring, within the room. Exit interview with the Facility Administrator and the Facilities Manager on January 22, 2025, at 12:30 p.m., confirmed the exposed wiring.	K 0919		

Certified End Page

KADIMA REHABILITATION & NURSING AT LUZERNE

STATE LICENSE NUMBER: 283802

SURVEY EXIT DATE: 01/22/2025

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