STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395506	A. BLDG: 00 B. WING:	07/29/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT PALMYRA STATE LICENSE NUMBER: **161102**	**341 N RAILROAD STREET PALMYRA, PA 17078**

(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 July 29, 2025, at Kadima Rehabilitation &; Nursing at Palmyra, 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 PALMYRA

STATE LICENSE NUMBER: 161102

SURVEY EXIT DATE: 07/29/2025

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 #161102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on July 29, 2025, it was determined that Kadima Rehabilitation &; Nursing at Palmyra 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 (111), protected wood frame structure, with a basement, which is fully sprinklered.	K 0000		
K 0211 SS=B	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	K 0211	The facility is requesting that DSI conduct an FSES survey for the head room of the basement.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/08/2025**

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395506	A. BLDG: 01 B. WING:	07/29/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0211 SS=B	Continued from page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain corridors to be unobstructed, affecting one of two smoke compartments within the component. Findings include: 1. Observation on July 29, 2025, at 10:00 AM, revealed the headroom of the basement corridor was approximately 6 feet 2 inches. Interview with the Administrator on July 29, 2025, at 10:00 AM, confirmed the headroom in the basement corridor was less than 6 feet, 8 inches above the finished floor.	K 0211		
K 0241 SS=B	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	K 0241	The facility is requesting DSI to conduct an FSES survey for the second exit in the basement.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/08/2025**

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K 0241 SS=B	Continued from page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide not less than two exits remote from one another, for each floor, affecting one of two smoke compartments within the component. Findings include: 1. Observation on July 29, 2025, at 11:50 AM, revealed a single exit from the basement. Interview with the Administrator on July 29, 2025, at 11:50 AM, confirmed the basement did not have at least two exits remote from each other.	K 0241		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 3 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	1) The facility cannot retroactively conduct the fire alarm system inspections for 2024 2) The facility placed the fire alarm system inspections on a calendar schedule with a contracted vendor. The annual inspection will take place on 8/21/2025. 3) The facility re educated the maintenance director on ensuring vendor completion of scheduled inspections 4) The NHA or designate will complete a sprinkler fire alarm system inspections audit quarterly ×1 year then semi-annually x1 year. The results will be submitted to the QAPI committee for review and analysis of the need of ongoing monitoring.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/13/2025**

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K 0345 SS=F	Continued from page 4 Based on observation and interview, it was determined the facility failed to provide documentation verifying a functional inspection of the fire alarm system occurred within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on July 29, 2025, at 10:29 AM, revealed the facility failed to provide documentation verifying a functional inspection of the fire alarm system occurred within the previous twelve months. Interview with the Administrator on July 29, 2025, at 10:29 AM, confirmed the lack of documentation verifying a functional inspection of the fire alarm system occurred within the previous twelve months.	K 0345		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 5 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) A quarterly sprinkler system inspection was completed on 12/13/2024 and 4/25/2025. The obstructed sprinkler head in the walk-in freezer was cleared, and the wire supported by the sprinkler system in the basement Activities Room was removed. 2) The NHA reached out to SA Comunale to confirm next quarterly sprinkler inspection was scheduled. The Maintenance Director will complete facility rounds to ensure sprinkler heads are free of obstruction, and that sprinkler pipes are free of obstruction. 3) The maintenance director was reeducated on quarterly sprinkler inspection requirements, on ensuring that sprinkler heads are free of obstruction, and that sprinkler pipes are not obstructed. 4) The NHA or designee will complete weekly rounds ×4 weeks then monthly ×2 months to ensure sprinkler heads and pipes are free of	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/13/2025**

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K 0353 SS=F	Continued from page 6	K 0353	obstruction. A quarterly audit for the sprinkler reports and schedule for service will be completed x1 year. The results will be submitted to the QAPI committee for review and analysis of the need of ongoing monitoring.	

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K 0353 SS=F	Continued from page 7 Based on document review, observation, and interview, it was determined the facility failed to provide documentation of quarterly sprinkler inspections, to maintain sprinkler heads as unobstructed, and to maintain the automatic sprinkler system as free from extraneous weight, affecting the entire component. Findings include: 1. Review of documentation on July 29, 2025, at 10:27 AM, revealed the facility failed to provide documentation verifying quarterly sprinkler system inspections had occurred within the previous twelve months. Interview with the Administrator on July 29, 2025, at 10:27 AM, confirmed the lack of documentation verifying quarterly sprinkler inspections had occurred within the previous twelve months. 2. Observation on July 29, 2025, at 11:00 AM, revealed the sprinkler head protecting the walk-in freezer was obstructed by boxes. Interview with the Administrator on July 29, 2025, at 11:00 AM, confirmed the obstructed sprinkler head.	K 0353		

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K 0353 SS=F	Continued from page 8 3. Observation on July 29, 2025, at 11:02 AM, revealed a white wire within the basement Activities Room was supported by the sprinkler system. Interview with the Administrator on July 29, 2025, at 11:02 AM, confirmed the wire was supported by the sprinkler system.	K 0353		
K 0355 SS=E		K 0355		

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K 0355 SS=E	Continued from page 9 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 facility is unable to retroactively conduct monthly fire extinguisher inspections. The basement fire extinguisher was added to the master list of fire extinguishers and inspected. 2) The maintenance director conducted a monthly audit to ensure all fire extinguishers were inspected and are on the master list. 3) The maintenance director was re-educated on ensuring that monthly fire extinguisher inspections are completed. 4) The NHA or designee will conduct an audit quarterly × 1 year to ensure that monthly fire extinguisher inspections are completed and on the master list. Results will be submitted to QAPI for review and analysis to determine need of ongoing monitoring.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/13/2025**

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K 0355 SS=E	Continued from page 10 Based on document review and interview, it was determined the facility failed to provide documentation verifying portable fire extinguishers had been inspected on a monthly basis, during the previous twelve months, affecting one of two smoke compartments within the component. Findings include: 1. Review of documentation on July 29, 2025, at 11:23 AM, revealed the facility failed to provide documentation verifying basement portable fire extinguishers had been inspected since 1/3/2025. Interview with the Administrator on July 29, 2025, at 11:23 AM, confirmed the lack of documentation verifying the basement portable fire extinguishers had been inspected since 1/3/2025.	K 0355		
K 0371 SS=B	NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any	K 0371	The facility is requesting that DSI conduct an FSES survey.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/08/2025**

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K 0371 SS=B	Continued from page 11 point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide at least two smoke compartments on each resident sleeping floor containing 30 or more resident beds, affecting one of two floors within the component. Findings include: 1. Observation on July 29, 2025, at 11:30 AM, revealed the facility lacked a smoke barrier on the resident sleeping floor. Interview with the Administrator on July 29, 2025, at 11:30 AM, confirmed the lack of a smoke barrier wall.	K 0371		
K 0712 SS=F		K 0712		

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K 0712 SS=F	Continued from page 12 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) The facility could not retroactively perform the missing fire drills for 2024. 2) A fire drill was conducted for the month of August to ensure the facility is back into compliance. 3) The maintenance director was re educated on quarterly fire drill schedule per shift. 4) The NHA or designee will conduct an audit of the fire drills quarterly x 1 year to ensure fire drills are being completed. The results will be submitted to the QAPI committee for review and analysis of the need for ongoing monitoring.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/13/2025**

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K 0712 SS=F	Continued from page 13 Based on document review and interview, it was determined the facility failed to provide documentation verifying staff were subjected to quarterly fire drills within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on July 29, 2025, at 10:22 AM, revealed the facility failed to provide documentation verifying fire drills were performed prior to 6/2/2025. Interview with the Administrator on July 29, 2025, at 10:22 AM, confirmed the lack of documentation verifying fire drills were performed prior to 6/2/2025.	K 0712		
K 0918 SS=F		K 0918		

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KADIMA REHABILITATION & NURSING AT PALMYRA STATE LICENSE NUMBER: **161102**	**341 N RAILROAD STREET PALMYRA, PA 17078**

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K 0918 SS=F	Continued from page 14 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) The facility cannot retroactively complete an annual monthly and weekly generator check. 2) The weekly generator check was completed, the monthly generator check was completed, and the annual generator was completed by Penn Power on 8/8/2025. Records were placed in the life safety binder. 3) The maintenance director was re-educated on monthly, weekly, and annual generator inspections 4)The NHA or designee will conduct a quarterly audit x 1 year monthly then ×3 year to ensure generator inspections are completed. The results will be submitted to QAPI committee for review and analysis of need for continued monitoring.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/13/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395506	A. BLDG: __01_____ B. WING: _____	07/29/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0918 SS=F	Continued from page 15 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to provide documentation verifying weekly inspections, and monthly and annual testing of the emergency generator within the previous twelve months, affecting the entire component. Findings include: 1. Review of documentation on July 29, 2025, at 10:31 AM, revealed the facility failed to provide documentation verifying weekly inspections, monthly testing, and annual testing of the emergency generator occurred within the previous twelve months. Interview with the Administrator on July 29, 2025, at 10:31 AM, confirmed the lack of documentation verifying weekly inspections, monthly testing, and annual testing of the emergency generator occurred within the previous twelve months.	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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K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	1) The surge suppressor in the maintenance office was removed. 2) A facility wide audit was completed to ensure there were no other surge suppressors in the facility. 3) The maintenance director was reeducated on monitoring usage of search suppressors. 4) The NHA or designee will conduct an audit of facility surge suppressors weekly ×4 weeks then monthly ×2 months. The results will be submitted to the copy committee for review and analysis of the need for ongoing monitoring.	Completion Date: **08/14/2025** Status: **APPROVED** Date: **08/08/2025**

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 0920 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors, affecting one of two smoke compartments within the component. Findings include: 1. Observation on July 29, 2025, at 11:20 AM, revealed a surge suppressor, supplying electrical power to another surge suppressor, within the basement Maintenance Office. Interview with the Administrator on July 29, 2025, at 11:20 AM, confirmed the daisy-chained surge suppressors.	K 0920		

Certified End Page

KADIMA REHABILITATION & NURSING AT PALMYRA

STATE LICENSE NUMBER: 161102

SURVEY EXIT DATE: 07/29/2025

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