| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395524 | A. BLDG: 00<br>B. WING: | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **KADIMA REHABILITATION & NURSING AT NEW CASTLE**<br>STATE LICENSE NUMBER: **100502** | **715 HARBOR STREET**<br>**NEW CASTLE, PA 16101** |

| (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<br><br>Based on an Abbreviated Complaint Survey completed on December 3, 2024, it was determined that Kadima Rehabilitation & Nursing at New Castle, was not in compliance with the following Requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations. | F 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395524 | A. BLDG: __00_____ B. WING: _____ | 12/03/2024 |

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| **KADIMA REHABILITATION & NURSING AT NEW CASTLE** STATE LICENSE NUMBER: **100502** | **715 HARBOR STREET NEW CASTLE, PA 16101** |

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|---|---|---|---|---|
| P 5520 | | P 5520 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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|---|---|---|---|---|
| P 5520 | Continued from page 1<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5520 | 1.The facility is unable to correct the nurse aide staffing ratios that were not met during the overnight shifts on 10/21/24, 10/25/24, 11/18/24 and 11/19/24 due to unplanned absences. However, we will educate all nurse aides on the importance of staffing levels and their responsibilities to prevent absences.<br><br>2.The facility will work to ensure that nurse aide ratios are met every shift.<br><br>3.The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing and HR Director/Scheduler on regulation P5520 to ensure nurse aide ratios are met every shift. Daily shift staffing ratios will be reviewed at daily staffing meetings. The Nursing Supervisors will review shift staffing rations on the weekends. If the facility project to not meet staffing ratios on a given shift, the scheduler/designee will be responsible for calling off duty personnel or for calling extra support staff to assist. | Completion Date: **02/24/2025**<br>Status: **APPROVED**<br>Date: **01/09/2025** |

| 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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|---|---|---|---|---|
| P 5520 | Continued from page 2 | P 5520 | 4.The Nursing Home Administrator will audit staffing daily for four weeks and then monthly for two months to ensure nurse aide ratios are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations and frequency of audits.<br><br>5.The facility will conduct an Employee Retention survey from 12/27/2024 through 1/6/2025 to evaluate staffing concerns and reasons for call-offs. This will be done to prevent further call-off concerns meeting daily staffing ratios.<br><br>6.ADON/designee will ensure staffing levels meet direct care requirements and report to DON or Nursing Home Administrator every day with needs or call-offs. | |
| | | | | |

| 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 5520 | Continued from page 3<br><br>Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one NA per 15 residents on the overnight shift, for four of 21 days reviewed for staffing ratio (10/21/24, 10/25/24, 11/18/24 and 11/19/24).<br><br>Findings include:<br><br>Review of facility census on the overnight shift revealed that the facility failed to meet the minimum required NA ratio.<br><br>Review of 21 days of nursing staffing documentation for the time periods from 9/22/24 through 9/28/24, 10/20/24 through 10/26/24, and 11/17/24 through 11/23/24, revealed the following NA shortages for the overnight shift:<br><br>10/21/24, facility census of 58 residents, 3.63 NA worked and 3.87 were required.<br><br>10/25/24, facility census of 58 residents, 3.00 NA | P 5520 | | |

| 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 5520 | Continued from page 4<br><br>worked and 3.87 were required.<br><br>11/18/24, facility census of 59 residents, 3.53 NA worked and 3.93 were required.<br><br>11/19/24, facility census of 59 residents, 3.60 NA worked and 3.93 were required.<br><br>During an interview on 12/02/24, at 3:45 p.m. the Assistant Director of Nursing confirmed that the facility failed to meet the minimum NA ratio requirements on the above shift and dates. | P 5520 | | |
| P 5530 | | P 5530 | | |

| 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 5530 | Continued from page 5<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5530 | Plan of Correction:<br>1. The facility cannot correct that LPN staffing ratios that were not met during the overnight shift on one of 21 days (10/25/24). However we will educate staff on the importance of staffing levels and their responsibilities to prevent absences.<br>2. The facility will ensure that LPN staffing ratios are met every shift.<br>3. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5530 and ensuring LPN staffing ratios are met each shift. Daily shift staffing ratios will be reviewed at daily staffing meeting. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects to not meet staffing ratios on a given shift, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist.<br>4. The Nursing Home Administrator/designee will audit staffing daily for four weeks and | Completion Date: **02/24/2025**<br>Status: **APPROVED**<br>Date: **01/02/2025** |

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|---|---|---|---|---|
| P 5530 | Continued from page 6 | P 5530 | monthly for two months to ensure LPN staffing ratios are being met. Outcomes will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.<br>5. Employee Retention survey will be taken from 12/27/24 through 01/06/2025 to evaluate staffing concerns and reasons for call-offs. To prevent further call off concerns in order to achieve needed staff ratios daily.<br>6. ADON and DON will ensure staffing levels meet direct care requirements and report to Director every day with needs or call-offs. | |
| | | | | |

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|---|---|---|---|---|
| P 5530 | Continued from page 7<br><br>Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 40 residents on the overnight shift, for one of 21 days reviewed for staffing ratio (10/25/24).<br><br>Findings include:<br><br>Review of facility census on the overnight shift revealed that the facility failed to meet the minimum required LPN ratio.<br><br>Review of 21 days of nursing staffing documentation for the time periods from 9/22/24 through 9/28/24, 10/20/24 through 10/26/24, and 11/17/24 through 11/23/24, revealed the following LPN shortage for the overnight shift:<br><br>10/25/24, facility census of 58 residents, 1.32 LPN worked and 1.45 were required. | P 5530 | | |

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|---|---|---|---|---|
| P 5530 | Continued from page 8<br><br>During an interview on 12/02/24, at 3:45 p.m. the Assistant Director of Nursing confirmed that the facility failed to meet the minimum LPN ratio requirements on the above shift and date. | P 5530 | | |

# Certified End Page

**KADIMA REHABILITATION & NURSING AT NEW CASTLE**

**STATE LICENSE NUMBER: 100502**

**SURVEY EXIT DATE: 12/03/2024**

**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