STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395538	A. BLDG: 00 B. WING:	01/07/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT CHESWICK STATE LICENSE NUMBER: **740302**	**3876 SAXONBURG BLVD CHESWICK, PA 15024**

(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 an Abbreviated Survey in response to five complaints, completed on January 7, 2025, it was determined that Kadima Rehabilitation &Nursing at Cheswick was not in 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 0567 SS=F		F 0567		

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 0567 SS=F	Continued from page 1 483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and	F 0567	1.The facility cannot correct that we did not maintain a sufficient amount of petty cash for 3 days (January 1, 2 & 3, 2025) to provide residents the amount they wanted to withdraw from their personal funds. 2.The facility will increase the dollar amt of petty cash to have on hand to ensure residents are not denied requested cash withdrawals from their RFMS accounts. 3.The NHA will educate the new BOM on the RFMS process to include maintaining a sufficient amount of cash to meet resident's requests for withdrawals from their accounts. 4.The Social Service Director/Designee will Interview 5 residents with RFMS accounts weekly x 4 weeks, then 5 residents a month x 2, to determine if they received requested withdrawals from personal funds. The results of these audits will be reported to the Quality Assurance Performance	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/24/2025**

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F 0567 SS=F	Continued from page 2 that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:	F 0567	Improvement Committee for review, recommendations, and frequency of audits. 5.Date of compliance 2-10-25	

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F 0567 SS=F	Continued from page 3 Based on a review of facility policies and resident and staff interviews it was determined that the facility failed to maintain amounts of petty cash on hand that may be required by the residents for three days 1/1/25, 1/2/25, and 1/3/25, as required. (1/1/25, 1/2/25, and 1/3/25) Findings Include: A review of facility "Resident Funds Distribution" policy date 7/1/24, revealed that the facility maintains petty cash funds that contain sufficient amounts to meet the resident's needs. During an interview on 1/7/25, at 10:00 am Resident R1 confirmed that residents have been having concerns regarding obtaining their personal funds from the facility when requested. It was stated that the facility was denying withdrawals based on the availability of funds. During an interview on 1/7/25, at 1:00 pm the Nursing Home Administrator confirmed that she	F 0567		

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F 0567 SS=F	Continued from page 4 was aware that the facility failed to maintain a sufficient amount of petty cash for three days 1/1/25, 1/2/25, and 1/3/25, resulting in the residents being denied withdrawal of cash from their personal funds as requested. PA Code: 201.18 Management (f)(h)	F 0567		
F 0570 SS=F		F 0570		

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F 0570 SS=F	Continued from page 5 483.10(f)(10)(vi) Surety Bond-Security of Personal Funds §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by:	F 0570	1.The facilities Resident Trust Surety Bond was increased to $252,200.00 on 1/7/25 to protect the residents financial funds deposited in the facility Resident Trust Accounts 2.The facility will ensure the value of the facilities Surety Bond protects the balance of resident's financial funds that are deposited in the facility Resident Trust Fund. 3.The NHA will educate the new BOM on the requirement to protect the total amount of resident's financial funds that are deposited in the facilities Resident Trust Fund by ensuring the resident Surety Bond value meets or exceeds the value of funds identified in the Facility Trial Balance. 4.The NHA/designee will complete a Facility Trial Balance monthly x 3 and compare the amt to the value of the resident Surety Bond to ensure the resident funds are protected. If the Surety Bond is found to be not enough to protect the residents	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/24/2025**

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F 0570 SS=F	Continued from page 6	F 0570	funds, the Surety Bond will be increased immediately. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits. 5.Date of compliance 2-10-25	

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F 0570 SS=F	Continued from page 7 Based on a review of facility policies, documents and staff interviews it was determined that the facility failed to secure a surety bond on behalf of the residents of the facility that assured the security of all personal funds of residents deposited with the facility for three months 11/24, 12/24, and 1/25 as required. (11/24, 12/24, and 1/25) Finding include: A review of facility "Surety Bond" policy dated 7/1/24, indicated that a surety bond is purchased on behalf of the residents by the facility to protect the financial security of resident's funds deposited in a resident trust account. The facility evaluates the value of the bond annually to make certain that sufficient coverage is maintained. A review of the facility's Resident Trust Surety Bond effective 11/1/24, revealed that the bond's value at $193,915.84, A review of the Facillity Trial Balance (a document	F 0570		

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F 0570 SS=F	Continued from page 8 providing evidence of each resident's current balance held by the facility) date 1/7/25, indicated the value of funds held by the facility at $252,107.96 During an interview on 1/7/25, at 1:00 pm the Nursing Home Administrator confirmed that the amount of the facility's surety bond failed to protect all resident financial funds deposited in the facility Reisdent Trust Fund as required. PA Code: 201.18(e)(1) Management	F 0570		
F 0826 SS=E		F 0826		

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F 0826 SS=E	Continued from page 9 483.65(b) Rehab Services Physician Order/Qualified Pers §483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by:	F 0826	1.The facility cannot correct that E2 had no SLP supervision from 11-10-24 to 12/12/24. 2.The facility will ensure the SLP on a provisional license will receive supervision from a licensed SLP. 3.The Regional Clinical Consultant will re-educate the Nursing Home Administrator on Federal regulation 0826, detailing ensuring if a Speech language Pathologist (SLP) is currently working on a provisional license, is provided supervision from a Licensed SLP. 4.The NHA/designee will audit weekly x 4 weeks then monthly x 2 to ensure that a SLP on a provisional license who provides care is supervised by a licensed SLP. 5.Date of compliance 2-10-25	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/24/2025**

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F 0826 SS=E	Continued from page 10 Based on review of clinical records and staff interview, it was determined that the facility failed to ensure that a Speech Therapist who provided care to residents was licensed as a Speech Therapist for three of 12 months (November, and December 2024, and January 2025) Findings include: Review of Title 49 Chapter 45 indicated that Speech Therapists on a provisional license shall practice only under supervision of a supervisor who holds the same type of license as the provisional licensee, who is physically present in the area or unit where the provisional licensee is practicing. During an interview on 1/7/25, at 11:09 a.m. Speech Language Pathologist (SLP) Employee E2 confirmed that she has a provisional speech therapist license, as she is required to complete nine months of a fellowship before she will be issued a regular license. SLP Employee E2 stated that she had been supervised by a licensed SLP on a daily basis,	F 0826		

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F 0826 SS=E	Continued from page 11 however this stopped on 11/10/24 when the licensed SLP terminated her employment at the facility. Since 11/10/24, SLP Employee E2 has been working without daily supervision. No licensed SLP was available until 12/12/24 when SLP E3 was hired, who comes into the facility "once every two to three weeks" to supervise SLP Employee E2. During an interview on 1/7/25, at 11:57 a.m. Supervisor for the State Licensing Board confirmed that a SLP with a provisional license requires supervision from a licensed SLP, who must be physically present in the building. During an interview on 1/7/25, at 2:08 p.m. Nursing Home Administrator confirmed that the facility failed to provide speech therapy services by a licensed SLP or provide supervision to a SLP with a provisional license since 11/10/24. 28 Pa. Code: 201.18(b)(3) Management	F 0826		

Pennsylvania Department of Health

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P 5530		P 5530		

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

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P 5530	Continued from page 1 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 will ensure state-required LPN ratios are met during the overnight shift. The facility cannot correct that LPN staffing ratios were not met on the overnight shift on 12/10/24 & 12/15/24. 2.The facility will ensure that the LPN staffing ratio of 1:40 are met during the overnight shift. 3.The Nursing Home Administrator will re-educate the Director of Nursing, HR Director/Scheduler and RN Supervisors on regulation P5530 and ensuring LPN staffing ratios are met during the overnight shift. Staffing ratios will be reviewed at our daily staffing meeting to ensure ratios are scheduled to be met. The RN Nursing Supervisors will continue to review shift staffing ratios on evenings and weekends. If the facilities projections to meet LPN ratios on the overnight shift fall below required ratios due to call offs , No Call No Shows etc, the RN Supervisors will be responsible to	Completion Date: **02/10/2025** Status: **APPROVED** Date: **01/24/2025**

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P 5530	Continued from page 2	P 5530	ask currently working staff to pick up a shift, call off duty personnel and/or call extra support staff via staffing agencies to assist as necessary. 4.The Nursing Home Administrator/designee will audit staffing sheets daily for three months to ensure LPN staffing ratios are being met during the overnight shift. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits. 5.Date of compliance 2-10-25	

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P 5530	Continued from page 3 Based on review of nursing time schedules and staff interview it was determined that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 40 residents during the night shift on two of 21 days (12/10/24, and 12/15/24). Findings include: Review of facility census data, nursing time schedules from 12/8/24 through 12/28/24, revealed the following LPN staffing shortages. Day shift: Date Census FTE required FTE present 12/10/24 91 2.28 2.19 12/15/24 91 2.28 2.06	P 5530		

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P 5530	Continued from page 4 During an interview on 1/7/25, at 10:44 a.m. Assistant Director of Nursing confirmed that the facility failed to provide a minimum of one LPN per 40 residents during the night shift, with no additional excess higher-level staff to compensate this deficiency.	P 5530		

Certified End Page

KADIMA REHABILITATION & NURSING AT CHESWICK

STATE LICENSE NUMBER: 740302

SURVEY EXIT DATE: 01/07/2025

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