STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395590	A. BLDG: 00 B. WING:	04/29/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LITITZ STATE LICENSE NUMBER: 012302	125 SOUTH BROAD STREET LITITZ, PA 17543

(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 Findings of an Abbreviated Complaint Survey completed on April 30, 2025, at Kadima Rehabilitation & Nursing at Lititz, identified deficient practice, related to the reported complaint allegations, under the 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 as they relate to the Health portion of the survey process.	F 0000		
F 0568 SS=E		F 0568		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT LITITZ STATE LICENSE NUMBER: **012302**	**125 SOUTH BROAD STREET** **LITITZ, PA 17543**

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F 0568 SS=E	Continued from page 1 483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 0568	1. Facility will send retro quarterly statements to residents affected. 2. Resident records that should receive quarterly statements will be audited by NHA or designee to ensure that an updated and accurate list is available of all residents that receive quarterly statements. 3 Re-education will be completed by NHA or BOM regarding distribution of quarterly statements. Statements will be sent to POA via certified mail or if the resident is cognitive and does own finances a quarterly statement receipt will be signed by the resident to document that residents received necessary paperwork. 4.. Audits will be conducted monthly x4 by NHA or designee and "will be submitted to QAPI for review and analysis of need for ongoing monitoring.	Completion Date: **06/09/2025** Status: **APPROVED** Date: **06/04/2025**

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	395590	A. BLDG: __00_____ B. WING: _____	04/29/2025

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KADIMA REHABILITATION & NURSING AT LITITZ STATE LICENSE NUMBER: **012302**	**125 SOUTH BROAD STREET LITITZ, PA 17543**

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F 0568 SS=E	Continued from page 2 Based upon interview, it was determined the facility failed to ensure residents were provided quarterly statements in regard to their personal funds for three of three residents interviewed (Resident 1, Resident 2 and Resident 3). Findings include: During an interview with residents on April 29, 2025 at 11:00 a.m. it was revealed that residents do not receive quarterly statements regarding personal finances. No documented evidence was provided on April 29, 2025 to support quarterly statements sent to residents by facility staff. Interview with the Nursing Home Administrator via telephone on April 30, 2025 at 2:00 p.m. revealed that the facility and/or corporate offices have not sent quarterly statements to any residents during 2024 or 2025.	F 0568		

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F 0568 SS=E	Continued from page 3 28 Pa. Code 201.18(b)2) Management	F 0568		

Certified End Page

KADIMA REHABILITATION & NURSING AT LITITZ

STATE LICENSE NUMBER: 012302

SURVEY EXIT DATE: 04/29/2025

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