

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
STATE LICENSE NUMBER: <b>012302</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	E 0000		
E 0004	483.73(a) Develop EP Plan, Review and Update Annually	E 0004		Completion Date: <b>08/19/2025</b>
SS=C	<p>Based on an Emergency Preparedness Survey completed on July 1, 2025, it was determined that Kadima Rehabilitation &amp; Nursing at Lititz was not in compliance with the requirements of 42 CFR 483.73.</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan</p>		<p>1. We can not retroactively correct.</p> <p>2. The Emergency Preparedness plan will be reviewed by the EPP committee.</p> <p>3. The Enviromental Services Director will be educated on the need for EPP review.</p> <p>4. The EPP plan review will be audited yearly in July.</p>	Status: <b>APPROVED</b> Date: <b>07/24/2025</b>

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: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>  STATE LICENSE NUMBER: <b>012302</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>
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E 0004  SS=C	Continued from page 1  must do all of the following:  * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.  * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.  * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.  This REQUIREMENT is not met as evidenced by:	E 0004		

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E 0004  SS=C	Continued from page 2  Based on document review and interview, it was determined the facility failed to provide documentation verifying the emergency preparedness plan was reviewed within the previous twelve months, which serves the entire component.  Findings include:  1. Review of documentation on July 1, 2025, at 2:00 PM, revealed the facility failed to provide documentation verifying the emergency preparedness plan had been reviewed by the EPP committee.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of documentation verifying the emergency preparedness plan had been reviewed within the previous twelve months.	E 0004		
E 0006  SS=F		E 0006		

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E 0006  SS=F	Continued from page 3  483.73(a)(1)-(2) Plan Based on All Hazards Risk Assessment  §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)  [[a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  (2) Include strategies for addressing emergency events identified by the risk assessment.  * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events	E 0006	1. We cannot retroactively correct.  2. The Hazard Risk Assessment will be updated.  3. Administration will be educated on the need for updating the Hazard risk Assessment.  4. The EPP committee will review the updated risk assessment.	Completion Date: <b>08/01/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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E 0006  SS=F	Continued from page 4  identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.  *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.  This REQUIREMENT is not met as evidenced by:	E 0006		

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E 0006  SS=F	Continued from page 5  Based on document review and interview, it was determined the facility failed to provide an updated all hazards risk assessment for the facility, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, at 2:00 PM, revealed the facility failed to provide an updated all hazards risk assessment for the facility.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility could not provide an updated all hazards risk assessment for the facility.	E 0006		



# Certified End Page

**KADIMA REHABILITATION & NURSING AT LITITZ**

**STATE LICENSE NUMBER: 012302**

**SURVEY EXIT DATE: 07/01/2025**

**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, 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

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K 0000	INITIAL COMMENT  Facility ID #012302 Component 01 Main Building  Based on a Medicare/Medicaid Recertification Survey completed on July 1, 2025, it was determined that Kadima Rehabilitation & Nursing at Lititz 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 III (200), unprotected ordinary structure, with a lower level, which is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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K 0100  SS=C	Continued from page 1  NFPA 101 General Requirements - Other  General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.  This REQUIREMENT is not met as evidenced by:	K 0100	<p>1. Life Safety floor plan drawings have been updated and are available for review. Carbon monoxide alarms throughout the facility will receive their annual testing per the manufacturer's instructions. Evacuation and alarm protocols are available for review.</p> <p>2. The facility has updated its floor plan drawings and made available its evacuation and alarm protocols. These items are posted in the Emergency Preparedness Manual.</p> <p>3. The Environmental Services Director was re-educated on the requirements of K0100. The carbon monoxide alarms will be tested annually in July. The Emergency Preparedness Manual will be reviewed quarterly and PRN for accuracy.</p> <p>4. The NHA or designee completed a one-time audit of the Emergency Preparedness Manual to ensure that floor plan drawings and evacuation/alarm protocols were</p>	Completion Date: <b>09/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/24/2025</b>

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K 0100  SS=C	Continued from page 2	K 0100	available. The NHA or designee will complete an annual audit of the Carbon Monoxide alarm testing in July x 2 years. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	

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K 0100  SS=C	Continued from page 3  28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE  (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met.  35 P.S. § 448.808. Issuance of license.  (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met:  (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered.  Based on document review, observation and	K 0100		

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K 0100  SS=C	Continued from page 4  interview, it was determined the following items did not meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component.  Findings include:  1. Review of documentation and interview on July 1, 2025, between 9:15 AM and 11:00 AM, revealed the facility failed to provide updated life safety drawings.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility could not provide accurate life safety floor plans.  2. Review of documentation, observation and interview, on July 1, 2025, at 11:05 AM, revealed the facility lacked documentation of annual testing	K 0100		

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K 0100  SS=C	Continued from page 5  and inspection of installed Carbon Monoxide Alarms per manufacturer's instructions, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. A Nighthawk battery-operated carbon monoxide detector was located at the main desk, but no documentation was provided.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of documentation confirming annual inspections were not done per manufacturer's instructions.  3. Review of documentation on July 1, 2025, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation, verifying evacuation and alarm protocols, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act.  Interview at the time of the exit conference with the	K 0100		

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K 0100  SS=C	Continued from page 6  Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of documentation of evacuation and alarm protocols.	K 0100		
K 0225  SS=E	NFPA 101 Stairways and Smokeproof Enclosures  Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2  This REQUIREMENT is not met as evidenced by:	K 0225	1. The first floor stair tower door's hardware was adjusted to ensure positive latch.  2. A facility wide audit was completed to ensure positive latch of required doors.  3. The Environmental Services Director was re-educated on the requirements of K0225. Monthly door latch audits will occur.  4. The NHA or designee will complete a random audit of facility doors weekly x 4 weeks then monthly x 2 months to ensure positive latch. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/24/2025</b>

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K 0225  SS=E	Continued from page 7  Based on observation and interview, it was determined the facility failed to maintain the stairtower door to positively latch, affecting one of two floors within the component.  Findings include:  1. Observation on July 1, 2025, at 11:50 AM, revealed the first floor stairtower door, by South Nurses' Station, failed to latch in frame, due to improper mounted magnet hardware.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the door failed to positively latch.	K 0225		
K 0291  SS=C		K 0291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
STATE LICENSE NUMBER: <b>012302</b>				
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K 0291  SS=C	Continued from page 8  NFPA 101 Emergency Lighting  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1  This REQUIREMENT is not met as evidenced by:	K 0291	1. The facility is unable to retroactively perform this testing.  2. Monthly and annual battery-powered emergency lighting tests were completed in July.  3. The Environmental Services Director was re-educated on the requirements of K0291. Monthly battery-powered emergency lighting tests are scheduled. Annual testing will occur in July of each year.  4. The NHA or designee will complete an audit of the battery-powered emergency lighting testing monthly x 6 months. Annual testing will be confirmed in July. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0291  SS=C	Continued from page 9  Based on document review and interview, it was determined the facility failed to provide documentation verifying the monthly and annual battery-powered emergency lighting tests had been performed, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, it was revealed the facility failed to document monthly and annual testing of battery powered emergency lighting sources.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility could not provide documentation for installed back-up emergency lighting testing.	K 0291		
K 0293  SS=C		K 0293		

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K 0293  SS=C	Continued from page 10  NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)  This REQUIREMENT is not met as evidenced by:	K 0293	1. The facility is unable to retroactively perform this testing.  2. A monthly exit sign inspection was completed in July.  3. The Environmental Services Director was re-educated on the requirements of K0293. Monthly exit sign inspections are scheduled.  4. The NHA or designee will complete an audit of exit sign inspection documentation monthly x 6 months. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0293  SS=C	Continued from page 11  Based on document review and interview, it was determined the facility failed to provide documentation of monthly exit signs inspections, affecting the entire the component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, revealed the facility lacked documentation verifying exit signs were visually inspected for the last 12 months.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the faciity could not provide documentation of exit sign inspections.	K 0293		
K 0321  SS=E		K 0321		



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K 0321  SS=E	Continued from page 13  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, it was determined the facility failed to maintain the rating of hazardous area enclosures, affecting one of five smoke compartments within the component.  Findings include:  1. Observation on July 1, 2025, at 11:53 AM, revealed the South Nurses' Station and Food Storage Room door failed to automatically close and latch within the door frame, due to a faulty door closure.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the door failed to automatically close and latch within the frame.	K 0321		
K 0341  SS=E		K 0341		

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NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>  STATE LICENSE NUMBER: <b>012302</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
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K 0341  SS=E	Continued from page 14  NFPA 101 Fire Alarm System - Installation  Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8  This REQUIREMENT is not met as evidenced by:	K 0341	<ol style="list-style-type: none"> <li>1. The facility cannot retroactively correct.</li> <li>2. All new plans related to the fire alarm system will undergo both a formal plan review and an occupancy survey prior to implementation.</li> <li>3. The Environmental Services Director has been re-educated on the requirements of regulation K0341.</li> <li>4. The Nursing Home Administrator (NHA) or their designee will review all proposed changes to the fire alarm system to ensure full compliance with applicable codes and regulations.</li> </ol>	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0341  SS=E	Continued from page 15  Based on observation and interview, it was determined the facility failed to have a plan review and occupancy survey for changes to the fire alarm system, which serves the entire component.  Findings include:  1. Observation and interview on July 1, 2025, at 11:10 AM, revealed the facility installed carbon monoxide detectors on the existing fire alarm system without prior plan approval. No documentation was provided.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility failed to obtain plan approval from the Department of Health.  2. Based on observation and interview on July 1, 2025, at 11:12 AM, revealed the facility entered the system into service without an occupancy	K 0341		

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K 0341  SS=E	Continued from page 16  inspection. A record of completion was not provided for the changes.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the fire alarm system was altered without approval from the Pennsylvania Department of Health.	K 0341		
K 0345  SS=F		K 0345		

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K 0345  SS=F	Continued from page 17  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 has received documentation of the semi-annual and annual tests of the fire alarm system.  2 The facility will ensure that all verifying documentation is received and on premises of any inspections that are completed.  3 The Environmental Services Director has been re-educated on the requirements of regulation K0345.  4 The NHA or designee will complete an annual audit of the tests of the fire alarm system in July x 2 years. The results will be submitted to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0345  SS=F	Continued from page 18  Based on document review and interview, it was determined the facility failed to provide documentation verifying semi-annual and annual inspections/testing were performed, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:00 AM, revealed the facility failed to provide documentation verifying that a semi-annual inspection and annual test of the fire alarm system had occurred within the previous twelve months.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility lacked documentation of the semi-annual inspection and the annual testing of the fire alarm system.	K 0345		

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K 0346  SS=C	NFPA 101 Fire Alarm System - Out of Service  Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6  This REQUIREMENT is not met as evidenced by:	K 0346	1 The facility has a Fire Watch Policy that is available for review.  2 The fire watch Policy will be placed in the Safety and Disaster Policy & Procedure Manual.  4 The Environmental Services Director will be educated on the Fire Watch Policy.  4 The Safety and Disaster Policy & Procedure Manual will be reviewed yearly every July.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0346  SS=C	Continued from page 20  Based on document review and interview, it was determined the facility failed to provide a full and accurate fire watch policy for the impairment or when fire alarm system is out of service for more than four hours, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, revealed the facility lacked a fire watch policy for the fire alarm system, when the system is out of service for more than four hours.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of a fire watch policy.	K 0346		
K 0353  SS=F		K 0353		

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K 0353  SS=F	Continued from page 21  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 The facility is unable to retroactively perform this testing.  2 Testing will be completed for the wet/dry valve System. Three-year leak tests will be performed. The facility will ensure that all verifying documentation is received and on premises of any inspections that are completed.  3 The Environmental Services Director was re-educated on the requirements of K0353.  4 The NHA or designee will complete an annual audit of the tests of the wet/dry Valve system in August x 2 years. The results will be submitted to the QAPI Committee for review and analysis of the need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0353  SS=F	Continued from page 22  Based on document review and interview, it was determined the facility failed to provide quarterly, semi-annual, annual, 3-year, and 5-year sprinkler maintenance documentation, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:50 AM and 9:57 AM, revealed the facility lacked documentation of the facility's installed sprinkler systems, for the following:  a. 9:50 AM, wet/dry system, semi-annual Valve Supervisory Switches and Pressure Switch Waterflow Alarm; b. 9:53 AM, 1st and 3rd quarterly wet/dry Inspections; c. 9:54 AM, annual wet/dry Main Drain/Control Valve Test; d. 9:56 AM, annual dry system partial trip test; e. 9:57 AM, 3-year dry system full trip test.	K 0353		

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K 0353  SS=F	Continued from page 23  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility lacked documentation of the facility's installed sprinkler systems.  2. Review of documentation and interview on July 1, 2025, at 10:00 AM, revealed the previous sprinkler company, Johnson Controls, listed a 3-year air leak failure on the February 7, 2024 inspection, but no documentation was provided, confirming the 3-year leak test was performed.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility lacked documentation, verifying the dry sprinkler system deficiency was repaired.	K 0353		
K 0354  SS=C		K 0354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
STATE LICENSE NUMBER: <b>012302</b>				
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K 0354  SS=C	Continued from page 24  NFPA 101 Sprinkler System - Out of Service  Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)  This REQUIREMENT is not met as evidenced by:	K 0354	1 The facility has a Fire Watch Policy that is available for review.  2 The fire watch Policy will be placed in the Safety and Disaster Policy & Procedure Manual.  3 The Environmental Services Director will be educated on the Fire Watch Policy.  4 The Safety and Disaster Policy & Procedure Manual will be reviewed yearly every July.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
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K 0354  SS=C	Continued from page 25  Based on document review and interview, it was determined the facility failed to provide a full and accurate fire watch policy for the impairment or when the sprinkler system is out of service for more than ten hours, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, revealed the facility lacked a fire watch policy for sprinkler system impairment or if the system is out of service exceeding ten hours.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of a fire watch policy.	K 0354		
K 0700  SS=C		K 0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
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K 0700  SS=C	Continued from page 26  NFPA 101 Operating Features - Other  Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features 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 in Form CMS-2567.  This REQUIREMENT is not met as evidenced by:	K 0700	1 The facility has a Snow Removal Policy that is available for review.  2 The Snow Removal Policy will be placed in the Safety and Disaster Policy & Procedure Manual.  3 The Environmental Services Director will be educated on the Snow Removal Policy.  4 The Safety and Disaster Policy & Procedure Manual will be reviewed yearly every July.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
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K 0700  SS=C	Continued from page 27  Based on document and interview, it was determined the facility failed to provide a policy to keep the egress to the public way free and clear in the event of snow or ice, affecting the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, revealed the facility lacked a snow removal policy.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of a snow removal policy.	K 0700		
K 0741  SS=E		K 0741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KADIMA REHABILITATION &amp; NURSING AT LITITZ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>125 SOUTH BROAD STREET LITITZ, PA 17543</b>		
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K 0741  SS=E	Continued from page 28  NFPA 101 Smoking Regulations  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4  This REQUIREMENT is not met as evidenced by:	K 0741	1 The facility has a Smoking Policy that is available for review. Kadima at Lititz is a no smoking campus. All ashtrays have been removed from around the facility  2 The Smoking Policy will be placed in the Safety and Disaster Policy & Procedure Manual.  3 All staff will be educated on the smoking policy.  4 The Safety and Disaster Policy & Procedure Manual will be reviewed yearly every July.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0741  SS=E	Continued from page 29  Based on document review, observation and interview, it was determined the facility failed to provide an updated smoking policy, ashtrays of noncombustible material, and metal containers with a self-closing device, which serves the entire component. Findings include: 1. Review of documentation on July 1, 2025, between 9:15 AM and 11:15 AM, revealed the facility lacked an updated smoking policy for staff.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of an updated smoking policy.  2. Observation on July 1, 2025, between 12:10 PM and 12:12 PM, revealed discarded cigarette butts, at the following locations: a. 12:10 PM, back area by dumpster, cigarette butts on ground; b. 12:12 PM, rear parking area, Smoking Area,	K 0741		

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K 0741  SS=E	Continued from page 30  cigarettes butts on ground.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed discarded cigarette butts on the ground.  3. Observation on July 1, 2025, between 12:14 PM and 12:16 PM, revealed the Designated Smoking Area lacked the following items: a. 12:14 PM, noncombustible ashtray; b. 12:16 PM, self-closing metal container.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the lack of a required ashtray and metal, self-closing container.	K 0741		
K 0918  SS=F		K 0918		

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K 0918  SS=F	Continued from page 31  NFPA 101 Electrical Systems - Essential Electric System  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 is unable to retroactively perform this testing.  2 Testing will be completed for the annual, 90-minute load bank and the 3-year, 4-hour load bank.  3 The Environmental Services Director was re-educated on the requirements of K0918.  4 The NHA or designee will complete an annual audit of the annual testing yearly in August. The results will be submitted to the QAPI Committee for review and analysis of the need for ongoing monitoring.	Completion Date: <b>08/19/2025</b> Status: <b>APPROVED</b> Date: <b>07/28/2025</b>

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K 0918  SS=F	Continued from page 32  (NFPA 70)  This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395590</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/01/2025</b>
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K 0918  SS=F	Continued from page 33  Based on document review and interview, it was determined the facility failed to provide annual an three year testing results for the emergency generator, which serves the entire component.  Findings include:  1. Review of documentation on July 1, 2025, between 10:03 AM and 10:06 AM, revealed the facility lacked documentation for the following required tests:  a. 10:03 AM, annual, 90-minute load bank; b. 10:06 AM, 3-year, 4-hour load bank.  Interview at the time of the exit conference with the Director of Nursing and Director of Maintenance on July 1, 2025, at 2:00 PM, confirmed the facility failed to supply test results for the emergency generator.	K 0918		
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# Certified End Page

**KADIMA REHABILITATION & NURSING AT LITITZ**

**STATE LICENSE NUMBER: 012302**

**SURVEY EXIT DATE: 07/01/2025**

**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, 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