STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395679	A. BLDG: 00 B. WING:	01/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT WASHINGTON STATE LICENSE NUMBER: **110102**	**1198 W WYLIE AVE** **WASHINGTON, PA 15301**

(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 a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance, and Abbreviated Survey, in response to five complaints, completed on January 17, 2025, it was determined that Kadima Rehabilitation and Nursing at Washington was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulation as they relate to the Health portion of the survey process.	F 0000		
F 0585 SS=E		F 0585		

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 0585 SS=E	Continued from page 1 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	F0585 1. The facility will provide the opportunity for residents and visitors to file an anonymous grievance. 2. The Regional Clinical Consultant or Designee will re-educate the Nursing Home Administrator and the Social Services Director on federal regulation 0585, detailing placing grievance boxes in an area where residents and visitors can file a grievance anonymously. 3. New grievances boxes were placed in designated areas of the facility that will give residents an area to file a griveance anoymously. 4. Social Services Director or designee will educate Residents on the whereabouts of the placement of the new grievance boxes. 4. The New Grievance procedure will be forwarded to the monthly Quality Assurance and Performace	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0585 SS=E	Continued from page 2 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	Improvement Committee for review. 5. SS Director/designee will audit/monitor (using audit grid) grievance box daily for 4 weeks and manager on duty will monitor/audit daily (using audit grid) daily on weekends for 4 weeks. 6. Discussion/questions/concerns will be discussed at resident council. 7. The results of the audits will be forwarded to the monthly quality asurance and performance improvement committee for review and frequency of audits.	

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F 0585 SS=E	Continued from page 3 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 4 Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to provide concern forms and grievance boxes to residents and visitors on the nursing units and failed to provide an opportunity for anonymous grievances (Resident group). Findings include: A review of the facility policy "Grievances" reviewed 1/31/24 and 1/9/25, indicated it is the policy of the facility to support each resident's right to voice grievances without discrimination, reprisal, or fear of discrimination. A grievance may include a formal, written grievance process or a resident's verbalized complaint to facility staff. During an interview on 1/14/25, at 10:30 a.m. the Resident Group stated, "you cannot file an anonymous grievance, the only box and forms are in front of the Nursing Home Administrator's (NHA) office."	F 0585		

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F 0585 SS=E	Continued from page 5 During an observation on 1/14/25, at 11:45 a.m. revealed the grievance box in the front lobby is in front of the NHA's office and within sight of the receptionist. During an observation on 1/14/25, at 1:45 p.m. revealed no grievance forms or boxes available for residents and visitors on the nursing units. During an interview on 1/15/25, at 10:00 a.m. the Nursing Home Administrator confirmed there was only one grievance box located in front of the NHA's office and the facility failed to provide the opportunity for residents and visitors to file an anonymous grievance. 28 Pa Code: 201.18(e)(4) Management. 28 Pa Code: 201.29(a)(b)(c) Resident rights.	F 0585		
F 0606 SS=D		F 0606		

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F 0606 SS=D	Continued from page 6 483.12(a)(3)(4) Not Employ/Engage Staff w/ Adverse Actions §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by:	F 0606	0606 1. The facility will ensure that residents are protected from potential abuse by performing criminal history background checks prior to hire for all personnel. The facility cannot retroactively correct the concerns identified with Employees E7 and E12. 2. The Nursing Home Administrator or Designee will re-educate the human Resources Director on federal regulation 0606, detailing completing criminal background checks prior to hire on all personnel. 3. Criminal History background check audits will be completed weekly for 4 weeks then monthly for three months to validate criminal background checks are completed prior to hire for all new employees. 4. Criminal background checks were completed for E7 amd E12. An audit will be completed on all current staff to ensure criminal background	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0606 SS=D	Continued from page 7	F 0606	checks were completed. 5. These audits will be forwarded to the monthly Quality Assurance Performance Improvement Committee for review and frequency of audits.	

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F 0606 SS=D	Continued from page 8 Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to ensure that residents were protected from potential for abuse by failing to perform criminal history background checks prior to hire for two of five personnel files reviewed (Employee E7 and E12). Findings Include: Review of facility policy "Abuse: Protection From Abuse" reviewed 1/31/24 and 1/9/25, revealed the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. The facility conducts background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals. Review of facility policy "Criminal Background Check" reviewed 1/31/24 and 1/9/25, indicated a request for a criminal background check must be	F 0606		

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F 0606 SS=D	Continued from page 9 submitted to the Pennsylvania State Police prior to the start of active employment. Applicants may not be hired or attend orientation until such time as the criminal background clearance is completed. Review of the personnel file for Dietary Aide Employee E7 failed to reveal evidence that a Pennsylvania State Police background check or an FBI background check (for new hires that have not resided in Pennsylvania for two years) was completed prior to her hire on December 16, 2024. Review of personnel file for Registered Nurse (RN) Employee E12 failed to reveal evidence that a Pennsylvania State Police background check or an FBI background check was completed prior to her hire on November 18, 2024. During an interview on January 17, 2025, at 10:45 a.m., Human Resources Employee E12 confirmed the facility failed to provide background checks prior to employee hire date. She stated she thought the facility had 30 days after the date of hire to	F 0606		

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F 0606 SS=D	Continued from page 10 conduct the background checks. She stated they get a lot of staff do not report to work after being hired and did not want to waste the money on background checks if they were not going to show up for work. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.19(8) Personnel policies and procedures.	F 0606		
F 0623 SS=F		F 0623		

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F 0623 SS=F	Continued from page 11 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	0623 1. The facility will provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division. The facility cannot retroactively the concern identified during annual survey. 2. The facility will send the discharge/transfer list to the state Ombudsman monthly. 3. The Nursing Home Administrator or Designee will re-educate the Director of Social Services on federal tag 0623. 4. The Nursing Home Administrator or Designee will complete an audit monthly for three months to validate the transfer/discharge list is completed and sent to the state Ombudsman monthly. 5. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0623 SS=F	Continued from page 12 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	and frequency of audits.	

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F 0623 SS=F	Continued from page 13 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=F	Continued from page 14 Based on a review of facility policy, federal regulation, and staff interview, it was determined that the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division for 12 of 12 months (January 2024 through December 2024). Findings include: Review of the facility policy "Transfer and Discharge" 1/31/24, indicated no resident will be discharged without timely notification of the resident, responsible party, or authorized representative. Review of Title 42 Code of Federal Regulations §483.15(c)(3) Notice Before Transfer: indicates, before a facility transfers or discharges a resident, the facility must (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395679	A. BLDG: __00_____ B. WING: _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT WASHINGTON	**1198 W WYLIE AVE WASHINGTON, PA 15301**
STATE LICENSE NUMBER: **110102**	

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F 0623 SS=F	Continued from page 15 Care Ombudsman. Federal Regulations further define emergency transfers as, "When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer." During an interview on 1/15/25, at 1:00 p.m., the Nursing Home Administrator confirmed the facility failed to provide transfer notices to representatives of the Office of the Long-Term Care Ombudsman Division since 1/1/24. 28 Pa. Code 201.18(b)(3)(e)(2) Management.	F 0623		
F 0658 SS=F		F 0658		

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F 0658 SS=F	Continued from page 16 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	0658 1. The facility failed to have a Registered Dietitian on premises that participated in interdisciplinary meetings, monitor Food Service operations, or completed any in-person actions of the Registered Dietitian Job Description. 2. The Dietary Manager/Administrator/Designee will be educated by the NHA/Designee 3. Registered Dietician will be hired for on the premises and will participate in interdisciplinary meetings, monitor Food Service operations, and complete any in-person actions of the Registered Dietitian Job Description.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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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F 0658 SS=F	Continued from page 17 Based on review of facility policies, job descriptions, clinical records, and staff interviews, it was determined that the facility failed to adhere to acceptable standards of practice related to participation in interdisciplinary meetings, monitoring of Food Service operations, resident interviews, and participation in the Quality Assurance and Performance Improvement (QAPI), by the Registered Dietitian. Findings include: The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship. Review of the Registered Dietitian's Job	F 0658		

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F 0658 SS=F	Continued from page 18 Description, states that dietitian "encourages the resident/family to participate in the development and review of the residents' plan of care," "maintains an adequate liaison with families and residents as necessary," "meets with Dietary and Nursing staff as needed," "attends departmental meetings," "participates in QAPI," "inspect food storage rooms, utility/janitorial closets, etc. for upkeep and supply control." During an interview on 1/15/25, at approximately 10:30 a.m., Registered Dietitian (RD) Employee E6 stated that she worked eight hours per week remotely. RD Employee E6 stated she has not physically been in the facility for more than a year. RD Employee E6 remotely assesses, reviews, and documents the required elements for each resident, she reviews the notes and documentation in the computer with remote access. RD Employee E6 stated the Dietary Manager (DM) Employee E2 does the in-person communication with the resident, RD Employee E6 and DM Employee E2 email each other with any issues. RD Employee E6 also does	F 0658		

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F 0658 SS=F	Continued from page 19 email communication with nursing for any clinical dietary issues. RD Employee E6 stated that she is aware of the Registered Dietitian Job Description, and she does not do any of the in-person duties in the job description, she reported she is located out of state. RD Employee E6 stated that she accepted this position temporarily as the facility has been unable to fill the posted position for an onsite Registered Dietitian. RD Employee E6 stated multiple times "I been trying to help the facility until they can fill the position." RD Employee E6 stated she plans to resign this position as she cannot meet the in-person requirements. During an interview on 1/16/25, at approximately 10:08 a.m., DM Employee E2 confirmed that they had one Registered Dietitian, RD Employee E6, who worked eight hours per week and worked remotely. DM Employee E2 stated she does the in-person communication with the resident and she and RD Employee E6 email each other with any issues.	F 0658		

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F 0658 SS=F	Continued from page 20 During an interview on 1/17/25, at 11:10 a.m. Nursing Home Administrator confirmed the facility failed to have a Registered Dietitian on premises that participated in interdisciplinary meetings, monitor Food Service operations, or completed any in-person actions of the Registered Dietitian Job Description. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.12(d)(1) Nursing Services.	F 0658		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 21 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	0684 The facility will assess, document and notify the physician of increased and decreased Capillary Blood Glucose (CBG) levels for all residents. The facility cannot retroactively correct the concerns identified for residents R13, R26, R28, R29 and R46. The previous residents R13, R26, R28, R29 and R46 physicians were notified/will be notified of abnormal CBG results for any new orders. All diabetic residents orders will be reviewed to ensure accuracy/need for physician notification. The facility will complete a two week look back of diabetic residents to validate the physicain was notified of increased or decreased CBG, and resident was assessed for hypoglycemia and documented. The Director of Nursing or designee will re-educate licensed nurses on the facility policy and procedures for	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/10/2025**

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F 0684 SS=E	Continued from page 22	F 0684	Notifying the Physician with resident change in condition, detailing notification of increased or decreased CBG. The Director of Nursing or designee will complete an audit three times a week for four weeks then monthly for three months to validate physicians are notified of any increased or decreased blood sugars and residents are assessed for hypoglycemia. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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F 0684 SS=E	Continued from page 23 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels for five of seven residents reviewed (Residents R13, R26, R28, R29, and R46). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in	F 0684		

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F 0684 SS=E	Continued from page 24 your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.	F 0684		

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F 0684 SS=E	Continued from page 25 Review of facility policy "Nursing Care of the Diabetic Resident" reviewed 1/32/24 and 1/9/25, indicated the facility will recognize, assist, and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident and include vital signs, level of consciousness, assessment of the skin, emotional/mood changes, and pain/discomfort. Document results of any fingerstick blood glucose monitoring, interventions to stabilize blood glucose levels, and notification to physician. Review of facility policy "Notification of Condition Change: Physician" reviewed 1/31/24 and 1/9/25, indicated licensed professional nurses are responsible to provide timely and complete communication to physicians when there is a change in a resident ' s condition. Document assessment data, attempted or actual correspondence with physician, and physician ' s response in the medical record.	F 0684		

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F 0684 SS=E	Continued from page 26 Review of facility policy "Documentation" reviewed 1/31/24 and 1/9/25, indicated nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate. Review of facility "hypoglycemic Protocol" reviewed 1/31/24 and 1/9/25, indicated if resident ' s blood glucose is less than 70 administer rapidly absorbed simple carbohydrate such as 4 ounces (oz) of juice, 5 or 6 oz of regular soda, or tube of glucose gel. Repeat blood glucose in 10-15 minutes and repeat protocol if still less that 70. If resident is symptomatic, notify physician. Review of the clinical record indicated Resident R13 was re-admitted to the facility on 11/25/22, with diagnoses that included diabetes, depression, and high blood pressure. Review of Resident R13' s Minimum Data Set (MDS - a mandated assessment of a resident's	F 0684		

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F 0684 SS=E	Continued from page 27 abilities and care needs) dated 12/18/24, indicated the diagnoses remain current. Review of a physician ' s order dated 5/30/2024 to 8/14/2024, indicated to give Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) 13 units one time a day, and 16 units twice a day. A physician order dated 8/14/24 and 9/17/24, indicated to give Lispro 16 units before meals. On 5/30/24 to 11/21/24, a physician ' s order indicated to give Levemir (long-acting type of insulin that works slowly, over about 24 hours) 17 units one time a day. A physician order dated 11/21/24 to 11/29/24, indicated to give Levemir 20 units one time a day. A physician order dated 11/29/24, indicated to give Lantus (long-acting type of insulin that works slowly, over about 24 hours) 20 units one time a day. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows:	F 0684		

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F 0684 SS=E	Continued from page 28 On 7/10/24, at 4:56 p.m. the CBG was noted to be 549. On 7/11/24, at 1:02 p.m. the CBG was noted to be 432. On 7/11/24, at 7:31 p.m. the CBG was noted to be 459. On 7/13/24, at 12:57 p.m. the CBG was noted to be 485. On 7/14/24, at 9:26 p.m. the CBG was noted to be 428. On 7/27/24, at 6:19 a.m. the CBG was noted to be 405. On 10/22/24, at 5:36 p.m. the CBG was noted to be 402. Review of the care plan dated 3/22/22, indicated the following interventions: Accuchecks as ordered, diet as ordered, medications as ordered, monitor labs as ordered, report signs and symptoms of increased/decreased blood sugars. Review of Resident's eMAR and clinical progress	F 0684		

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F 0684 SS=E	Continued from page 29 notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of a clinical record indicated Resident R26 was admitted to the facility on 3/12/21, with diagnoses that included diabetes, high blood pressure, and muscle weakness. Review of the MDS dated 11/7/2024, indicated the diagnoses remain current. Review of physician ' s orders dated 12/17/24, indicated to give Basaglar (Lantus) 18 units one time a day. Review of Resident 26's eMAR revealed that the resident's CBG's were as follows: On 12/13/24, at 3:39 p.m. the CBG was 405.	F 0684		

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F 0684 SS=E	Continued from page 30 A review of Resident R26's care plan dated 12/21/21 and 11/15/22, indicated the following interventions: Accuchecks as ordered. Medications as ordered. Report signs and symptoms of increased/decreased blood sugars. Review of Resident R26's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. Review of the clinical record indicated Resident R28 was admitted to the facility on 7/12/24, with diagnoses that included diabetes, overactive bladder, and muscle weakness. Review of the MDS dated 11/27/24, indicated the diagnoses remain current. Review of the physician orders indicated on	F 0684		

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	395679	A. BLDG: 00 B. WING:	01/17/2025

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KADIMA REHABILITATION & NURSING AT WASHINGTON STATE LICENSE NUMBER: **110102**	**1198 W WYLIE AVE WASHINGTON, PA 15301**

(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 0684 SS=E	Continued from page 31 7/12/24, Resident R28 was ordered Glucose Gel 40% (used to treat low blood glucose) give 1 application as needed for hypoglycemia of less or equal to 70 and able to swallow. Re-check blood sugar in 10-15 minutes. A physician order dated 8/6/24, indicated Accuchecks without coverage with meals. Physician orders dated 9/12/24, indicated Determir (Levemir) 26 units one time a day, and Determir 8 units one time a day. Review of Resident 28's eMAR revealed that the resident's CBG's were as follows: On 9/15/24, at 3:51 p.m. the CBG was noted to be 60. A review of Resident R28's care plan dated 12/21/21 and 11/15/22, indicated the following interventions: Accuchecks as ordered. Medications as ordered. Report signs and symptoms of increased/decreased blood sugars. Review of Resident R28's eMAR and clinical	F 0684		

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F 0684 SS=E	Continued from page 32 progress notes indicated the resident was not assessed for hypoglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. Review of the clinical record indicated Resident R29 was admitted to the facility on 10/20/22, with diagnoses that included diabetes, high blood pressure, and constipation. Review of the MDS dated 11/7/24, indicate the diagnoses remain current. Review of the physician order dated 9/24/24, indicated Accucheck without coverage one time a day. A physician order dated 11/21/24, indicated to give Lantus 17 units at bedtime. Review of Resident 29's eMAR revealed that the resident's CBG's were as follows: On 12/19/24, at 6:02 a.m. the CBG was noted to	F 0684		

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F 0684 SS=E	Continued from page 33 be 440. A review of Resident R29's care plan dated 10/25/22 and 5/16/24, indicated the following interventions: Accuchecks as ordered. Medications as ordered. Report signs and symptoms of increased/decreased blood sugars. Review of Resident R29's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. Review of the clinical record indicated Resident R46 was admitted to the facility on 1/24/23, with diagnoses that included diabetes, high blood pressure, and dementia (group of symptoms affecting memory, thinking and social abilities). Review of the MDS dated 11/5/24, indicated the diagnoses remain current.	F 0684		

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F 0684 SS=E	Continued from page 34 Review of a physician order dated 7/10/24, indicated Accuchecks without coverage. Call MD if less than 70 or greater than 400, one time a day for monitoring. An order dated 7/9/24 through 10/15/24, indicated Humalog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) 5 units two times a day. A physician order dated 10/15/24, indicated give Humalog 5 units with meals. A physician order dated 5/7/24 to 7/16/24, indicated give Lantus 20 units one time a day. A physician order dated 7/16/24, indicated Lantus 25 units one time a day. Review of Resident 46's eMAR revealed that the resident's CBG's were as follows: On 7/10/24, at 4:58 p.m. the CBG was noted to be 420. On 7/29/24, at 5:38 p.m. the CBG was noted to be 438. On 8/9/24, at 4:16 p.m. the CBG was noted to be	F 0684		

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F 0684 SS=E	Continued from page 35 402. On 8/23/24, at 4:36 p.m. the CBG was noted to be 481. On 9/13/24, at 5:23 p.m. the CBG was noted to be 422. A review of Resident R46's care plan dated between 1/31/23 and 10/15/24, indicated the following interventions: Accuchecks as ordered. Medications as ordered. Report signs and symptoms of increased/decreased blood sugars. Review of Resident R46's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, blood sugar was not rechecked, and the physician was not notified of abnormal results. During an interview on 1/15/25, at 1:15 p.m. Licensed Practical Nurse (LPN) Employee E10 stated for blood glucose results under 70, they would give juice and/or snacks, and check the vital signs. If blood glucose was greater than 400, they	F 0684		

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F 0684 SS=E	Continued from page 36 would call the doctor, and document in the eMAR. During an interview on 1/15/25, at 1:20 p.m. Registered Nurse (RN) Employee E11 stated if the blood glucose was under 70, they would give a snack or juice. If the blood glucose was greater than 400, they would give the ordered insulin, call the doctor, and recheck the blood glucose in 15-30 minutes. They would document in the progress notes. During an interview on 1/17/25, at 1:25 p.m. LPN Employee E8 stated if the blood glucose was less than 70, they would check the physician orders, give juice or snacks. If blood glucose was over 400, they would check the physician orders, and call the doctor. They would document in progress notes. During an interview on 1/17/25, at 9:00 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition, failed to document an assessment or interventions used related to blood glucose, and failed to follow	F 0684		

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F 0684 SS=E	Continued from page 37 physicians orders for Residents R13, R26, R28, R29, and R46. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident rights 28 Pa. Code 211.10 (c)(d) Resident care policies	F 0684		
F 0689 SS=E		F 0689		

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F 0689 SS=E	Continued from page 38 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	0689 The facility will ensure residents are assessed for safe smoking . A smoking assessment will be completed for residents R4, R10 and R54 to ensure it is current and resident is safe to smoke. A house audit will be completed to validate residents who smoke have a current smoking assessment completed. The Director of Nursing or Designee will re-educate licensed nurses, including new hires and agency, on the facility policy and procedures for Smoking, detailing completing safe smoking assessments for residents who wish to smoke. The Director of Nursing or Designee will complete an audit weekly for four weeks then monthly for three months to validate resident who smoke have a current and accurate smoking assessment.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0689 SS=E	Continued from page 39	F 0689	The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	

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F 0689 SS=E	Continued from page 40 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess a resident for safe smoking for three of five residents reviewed (Residents R4, R10, and R54). Findings include: Review of the facility policy "Smoking Policy" dated 1/31/24, indicated that smokers will be reviewed on admission, at least quarterly, and as necessary depending on individual circumstances and changes in the resident's condition. Review of Resident R4's clinical record indicated an admission date of 9/19/09. Review of resident R4's MDS (Minimum Data Set- a periodic assessment of resident care needs) dated 11/8/24, indicated the diagnoses of atrial fibrillation (arrhythmia of the heart), seizures, and cognitive communication deficit.	F 0689		

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F 0689 SS=E	Continued from page 41 Review of resident R4's care plan dated 2/6/24 indicated the resident goes outside to smoke, is at risk for side effects and injury form smoking due to limited range of motion, and a smoking safety screen will be reviewed per protocol. During an interview on 1/16/25, at 10:50 a.m. the Director of Nursing (DON) confirmed the last smoking assessment completed for resident R4 was 12/22/23, no further assessments were completed as required. Review of Resident R10's clinical record indicated an admission date of 12/15/21. Review of resident R10's MDS dated 11/26/24, indicated the diagnoses of diabetes, asthma, and heart failure. Review of resident R10's care plan dated 12/11/24 indicated smoking is a priority for the resident. The resident goes outside to smoke, is at risk for side effects and injury form smoking, and a smoking	F 0689		

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F 0689 SS=E	Continued from page 42 safety screen will be reviewed per protocol. During an interview on 1/16/25, at 10:50 a.m. the DON confirmed the last smoking assessment completed for resident R10 was 7/2/24, no further assessments were completed as required. Review of Resident R54's clinical record indicated an admission date of 8/20/24. Review of resident R54's MDS dated 11/11/24, indicated the diagnoses diabetes and high blood pressure. Review of resident R54's care plan dated 8/23/24 indicated the resident enjoys smoking. The resident goes outside to smoke, is at risk for side effects and injury form smoking, and a smoking safety screen will be reviewed per protocol. During an interview on 1/16/25, at 10:50 a.m. the DON confirmed the last smoking assessment completed for resident R54 was 8/20/24, no further	F 0689		

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F 0689 SS=E	Continued from page 43 assessments were completed as required, and the facility failed to assess residents for safe smoking for Residents R4, R10, and R54. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0689		
F 0760 SS=D		F 0760		

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F 0760 SS=D	Continued from page 44 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	0760 The facility will ensure residents are free of significant medication errors. The facility cannot retroactively correct the concern identified for resident R3. The Director of Nursing or designee will re-educate licensed nurses on the facility policy and procedures for medication administration, detailing priming the insulin pen prior to administering medications. The Director of Nursing or designee, will complete 5 nurse medication administration competencies weekly for four weeks then monthly for three months to ensure insulin pens are primed prior to medication administration and residents are free from significant medication errors. The results of these audits will be forwarded to the monthly Quality Assurance and Performance Improvement Committee for review and frequency of audits.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0760 SS=D	Continued from page 45 Based on review of facility policy, observations, manufacturers recommendations, clinical records, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of two residents observed (Resident R3). Findings include: A review of the facility policy "Medication Administration" dated 1/31/24, indicated medications are administered, as prescribed, in accordance with good nursing principles and practices to ensure the safe, accurate and timely administration of medications. A review of the manufacturer's guideline for glargine insulin (Lantus-long acting type of insulin that works slowly, over about 24 hours) Solostar prefilled pen, November 2000, specified to perform a "safety test" before each injection. Select a dose of two units, hold the pen with the needle pointing upwards, gently tap the reservoir to remove air bubbles, press	F 0760		

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F 0760 SS=D	Continued from page 46 the injection button all the way in and check if insulin comes out of the needle tip. A review of a clinical record indicated Resident R3 was admitted to the facility on 6/19/24, with diagnoses that included diabetes and high blood pressure. A review of a physician order dated 10/24/24, indicated to inject insulin Lantus Solostar 100 u/ml (units per milliliter) Subcutaneous (under the skin) inject 12 units in the morning. During an observation on 1/16/25, at 8:00 a.m. of Resident R3's medication administration Licensed Practical Nurse (LPN) Employee E13 set the Lantus insulin pen to 12 units, failed to prime the insulin pen, and administered the medication. During an interview on 1/16/25, at 8:30 a.m. LPN Employee E13 confirmed she failed to prime the insulin pen prior to administering the medication.	F 0760		

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F 0760 SS=D	Continued from page 47 During an interview on 1/16/25, at 1:15 p.m. the Director of Nursing confirmed the facility failed to administer the correct dose of insulin by failing to prime the insulin pen needle for Resident R3. 28 Pa. Code 211.12 (c)(1)(3) Nursing services. 28 Pa. Code 201.29 (j) Resident rights. 28 Pa Code: 201.18 (b)(1)(3) Management. 28 Pa Code: 211.10 (d) Resident care policies.	F 0760		
F 0880 SS=F		F 0880		

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F 0880 SS=F	Continued from page 48 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	-The facility will implement an effective Water Management Program and Infection Control Program that, at a minimum will have a system of preventing, identifying, reporting, investigating and controlling infections and communicable diseases. -A Water Management Program will be developed based on the framework outlined in ASHRAE standards. -The Maintenance Director/Designee will be educated on the development of the Water Management Program and its implementation by the Administrator/Designee. -Water samples will be taken inhouse and sent to certificed lab for testing -Audits will be completed by the Administrator /Designee on compliance with the Water Management system. These audits will be completed weekly times 8 weeks.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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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F 0880 SS=F	Continued from page 49 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	-The Infection Control Program will be revised so that documentation is present for preventing, identifying, reporting, investigating and controlling infections and communicable diseases. -The Infection Preventionist will be educated on the revised process by the Director of Nursing/Designee. -These audits will be forwarded to the monthly Quality Assurance Performance Improvement Committee for review and frequency of audits	

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F 0880 SS=F	Continued from page 50	F 0880		

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F 0880 SS=F	Continued from page 51 Based on policy review, documentation and review of Centers for Disease Control (CDC) guidelines for Legionella (bacteria that causes disease found in contaminated water) control, and staff interviews it was determined that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility for twelve of twelve months (December 2023 through December 2024). Finding include: Review of the facility policy "Legionella Policy" dated 1/9/25, previously dated 1/31/24, indicated Specific actions should be taken for prevention of Legionella and for investigation should a case occur. Core Elements of the Water Management Plan are: 1. Establish Water Management Plan team. 2. Describe Center's water system using text and flow diagram. 3. Risk assessment with control methods and	F 0880		

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F 0880 SS=F	Continued from page 52 corrective actions. 4. Monitoring control measures. 5. Corrective actions. 6. Verification and validation. 7. Documentation and communication. Review of Department of Health and Human services, Centers for Medicare and Medicaid services (CMS) memo, "Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)" dated 7/6/18, revealed, "Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread Legionella and other opportunistic pathogens in water. This policy memorandum applies to Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations. Facilities must have water management plans and documentation that, at minimum, ensure each facility:	F 0880		

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F 0880 SS=F	Continued from page 53 -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Nontuberculous Mycobacteria, Burkholderia, Stenotrophomonas, and fungi) could grow and spread in the facility water system. -Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air Conditioning Engineers) industry standard and the CDC toolkit. -Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. -Maintains compliance with other applicable Federal, State, and local requirements. Review of the ASHRAE guidance "Managing the Risk of Legionellosis Associated with Building Water Systems" dated December 2020, indicated the most commonly used supplemental disinfection methods are treatment with chlorine,	F 0880		

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F 0880 SS=F	Continued from page 54 chlorine-dioxide, copper-silver ions, and monochloramine." The guidance further indicated the recommended levels of residual chlorine are 0.50-3.00 ppm (part per million). Review of the Water Management Program Control Measures did not contain a log for Point of Use Disinfectant (the level of chlorine concentration in the water) indicated to measure and record hot water and cold-water chlorine concentration as point of use, and to note that chlorine concentration below 0.5 ppm and above 4.0 ppm as outside the control limits. Review of the Water Management Program Preventive Maintenance did not contain logs for flushing of all hot water and storage tanks monthly, minimum water temperature testing in all tanks. During an interview on 1/17/25 at approximately 11:00 a.m. the Maintenance Director, Employee E1 confirmed the facility had no documentation of water or temperature testing as per the Legionella Policy.	F 0880		

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F 0880 SS=F	Continued from page 55 During an interview on 1/17/25, at approximately 11:30 a.m. the Nursing Home Administrator confirmed that they termed the Maintenance Director the week of 12/23/24 and that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.	F 0880		

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P 5520		P 5520		

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

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P 5520	Continued from page 1 Nursing services. (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. This REGULATION is not met as evidenced by:	P 5520	5520 1. The facility cannot correct that a minimum of one nurse aide (NA) per 10 residents during the day shift for 12 of 21 days (12/29 and 12/31/2024, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/10, 1/11, 1/12, 1/14, and 1/16/25), one NA per 11 residents during the evening shift for 14 of 21 days (12/31/2024, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/16, and 1/18 25) and one NA per 15 residents during the night shift for 19 of 21 days (12/29 and 12/30, 12/31/24, 1/1, 1/2/25, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/17, and 1/18/25). 2. The facility will ensure that nurse aide staffing ratios are met every shift. 3. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5520 and ensuring nurse aide staffing ratios are met each	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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P 5520	Continued from page 2	P 5520	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. 4. The Nursing Home Administrator/designee will audit staffing daily for four weeks and monthly for three months to ensure nurse aide staffing ratios are being met. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.	

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P 5520	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 nurse aide (NA) per 10 residents during the day shift for 12 of 21 days (12/29 and 12/31/2024, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/10, 1/11, 1/12, 1/14, and 1/16/25), one NA per 11 residents during the evening shift for 14 of 21 days (12/31/2024, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/16, and 1/18 25) and one NA per 15 residents during the night shift for 19 of 21 days (12/29 and 12/30, 12/31/24, 1/1, 1/2/25, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/17, and 1/18/25). Findings include: Review of the facility census data, nursing time schedules, and deployment sheets from 12/29/24 through 1/18/25, revealed the following nurse aide staffing shortages: On 12/31/24, 1/12, 1/14, and 1/16/25 the census	P 5520		

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P 5520	Continued from page 4 was 62, which required 6.20 NAs during the day shift. Review of the nursing time schedules revealed 6.00, 5.87, 6.00, and 6.00 NAs provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/29/24, 1/10, and 1/11/25 the census was 63, which required 6.30 NAs during the day shift. Review of the nursing time schedules revealed 6.00, 6.00, and 5.80 NAs provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/3, 1/6, 1/7/25 the census was 64, which required 6.40 NAs during the day shift. Review of the nursing time schedules revealed 6.00, 3.57, and 5.00 NAs provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/4/25 and 1/5/25 the census was 65, which required 6.50 NAs during the day shift. Review of the nursing time schedules revealed 5.00 and 5.53	P 5520		

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P 5520	Continued from page 5 NAs provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/11, 1/12, 1/13, 1/16, and 1/18/25 the census was 62, which required 5.64 NAs during the evening shift. Review of the nursing time schedules revealed 5.00, 3.00, 5.00, 5.00, and 5.00 NAs provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/31/24, 1/3, 1/7, 1/8, 1/9, and 1/10/25 the census was 63, which required 5.73 NAs during the evening shift. Review of the nursing time schedules revealed 4.00, 5.00, 5.00, 5.00, 3.00, and 5.00 NAs provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/6/25 the census was 64, which required 5.82 NAs during the evening shift. Review of the nursing time schedules revealed 3.80 NAs provided care on	P 5520		

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P 5520	Continued from page 6 the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/4/25 and 1/5/25 the census was 65, which required 5.91 NAs during the evening shift. Review of the nursing time schedules revealed 5.00 and 3.80 NAs provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 11/11, 1/12, 1/13, 1/14, 1/17, and 1/18/25, the census was 62, which required 4.13 NAs during the night shift. Review of the nursing time schedules revealed 3.00, 4.00, 3.00, 4.00, and 4.00 NAs provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/29, 12/30, and 12/31/24, 1/3, 1/7, 1/8, 1/9, and 1/10/25 the census was 63, which required 4.20 NAs during the night shift. Review of the nursing time schedules revealed 4.00, 4.00, 4.00, 4.00, 3.00, 4.00, 4.00, and 2.00 NAs provided	P 5520		

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P 5520	Continued from page 7 care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/1/25, 1/2/25, 1/5/25, and 1/6/25 the census was 64, which required 4.27 NAs during the night shift. Review of the nursing time schedules revealed 4.00, 4.00, 3.00, and 1.93 NAs provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/4/25 the census was 65, which required 4.33 NAs during the night shift. Review of the nursing time schedules revealed 3.00 NAs provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. During an interview on 1/14/25, at 10:50 a.m. the Director of Nursing (DON) confirmed that the facility failed to provide a minimum of one nurse aide per 10 residents during the day shift for 12 of 21 days, one NA per 11 residents during the evening shift for 14 of 21 days, and one NA per 15	P 5520		

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KADIMA REHABILITATION & NURSING AT WASHINGTON STATE LICENSE NUMBER: **110102**	**1198 W WYLIE AVE WASHINGTON, PA 15301**

(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
P 5520	Continued from page 8 residents during the night shift for 19 of 21 days reviewed.	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 9 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	5530 1. The facility cannot correct that the facility administrative staff failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for 13 of 21 days (12/29/24, 1/3, 1/4/25, 1/5, 1/7, 1/8, 1/9, 1/12, 1/13, 1/14, 1/15, 1/16, and 1/18/25), one LPN per 30 residents on the evening shift for 7 of 21 days (12/30/24, 1/5, 1/6, 1/12, 1/14, 1/16, and 1/18/25) and one LPN per 40 residents on the night shift for 13 of 21 days (12/29, 12/30, and 12/31/24, 1/1, 1/2/25, 1/5, 1/6, 1/9, 1/10, 1/11, 1/14, 1/16, and 1/18/25). 2. The facility will ensure that LPN staffing ratios are met every shift. 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.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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 5530	Continued from page 10	P 5530	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. 4. The Nursing Home Administrator/designee will audit staffing daily for four weeks and monthly for three 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.	

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 11 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 25 residents during the day shift for 13 of 21 days (12/29/24, 1/3, 1/4/25, 1/5, 1/7, 1/8, 1/9, 1/12, 1/13, 1/14, 1/15, 1/16, and 1/18/25), one LPN per 30 residents on the evening shift for 7 of 21 days (12/30/24, 1/5, 1/6, 1/12, 1/14, 1/16, and 1/18/25) and one LPN per 40 residents on the night shift for 13 of 21 days (12/29, 12/30, and 12/31/24, 1/1, 1/2/25, 1/5, 1/6, 1/9, 1/10, 1/11, 1/14, 1/16, and 1/18/25). Findings include: Review of the facility census data, nursing time schedules, and deployment sheets from 12/29/24 through 1/18/25, revealed the following nurse LPN staffing shortages: On 1/13, 1/14, 1/15, 1/16, and 1/18/25 the census was 62, which required 2.48 LPN's during the day	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 12 shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/29/24, 1/8, and 1/9/25 the census was 63, which required 2.52 LPN's during the day shift. Review of the nursing time schedules revealed 2.00 and 2.13 LPN's provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/3 and 1/7/25 the census was 64, which required 2.56 LPN's during the day shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the day shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/4/25 and 1/5/25 the census was 65, which required 2.60 LPN's during the day shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the day shift. No additional	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 13 excess higher-level staff were available to compensate this deficiency. On 1/12, 1/14, 1/16, and 1/18/25 the census was 62, which required 2.07 LPN's during the evening shift. Review of the nursing time schedules revealed 1.56, 2.00, 2.00, and 2.00 LPN's provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/30/24 the census was 63, which required 2.10 LPN's during the evening shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/5/25 the census was 65, which required 2.17 LPN's during the evening shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 14 On 1/6/25 the census was 64, which required 2.13 LPN's during the evening shift. Review of the nursing time schedules revealed 2.00 LPN's provided care on the evening shift. No additional excess higher-level staff were available to compensate this deficiency. On 1/11, 1/14, 1/16, and 1/18/25 the census was 62, which required 1.55 LPN's during the night shift. Review of the nursing time schedules revealed 1.25, 0.00, 1.00, and 1.00 LPN's provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. On 12/29/24, 12/30/24, 12/31/24, 1/9, and 1/10/25 the census was 63, which required 1.58 LPN's during the night shift. Review of the nursing time schedules revealed 1.00, 0.88, 0.75, 1.00, and 1.00 LPN's provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 15 On 1/1, 1/2/25, 1/5, and 1/6/25 the census was 64, which required 1.60 LPN's during the night shift. Review of the nursing time schedules revealed 0.25, 1.25, 1.00, and 1.00 LPN's provided care on the night shift. No additional excess higher-level staff were available to compensate this deficiency. During an interview on 1/14/25, at 10:50 a.m. the Director of Nursing (DON) confirmed that the facility failed to provide a minimum of one LPN per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents during the night shift.	P 5530		
P 5640		P 5640		

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 5640	Continued from page 16 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	5640 1. The facility cannot correct that the minimum number of general nursing hours to each resident in a 24-hour period were not met on 17 of 21 days (12/29, 12/30, and 12/31/24, 1/1, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/14, 1/16, and 1/18/25). 2. The facility will ensure that general nursing hours are met every shift. 3. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5640 and ensuring general nursing hours to each resident are met each shift. Daily shift staffing hours will be reviewed at daily staffing meeting. The Nursing Supervisors will review shift staffing on the weekends. If the facility projects to not meet general nursing hours to each resident on a given shift, the scheduler/designee will be responsible to call off duty	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/07/2025**

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P 5640	Continued from page 17	P 5640	personnel or call extra support staff to assist. 4. The Nursing Home Administrator/designee will audit staffing daily for four weeks and monthly for three months to ensure general nursing hours for each resident are being met. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for review, recommendations, and frequency of audits.	

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P 5640	Continued from page 18 Based on review of nursing time schedules and staff interviews it was determined that the facility administrative staff failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 17 of 21 days (12/29, 12/30, and 12/31/24, 1/1, 1/3, 1/4/25, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/14, 1/16, and 1/18/25). Findings include: Review of the nursing schedules and census information for 12/29/24 through 1/18/25, revealed that the facility failed to maintain 3.20 hours of general nursing care to each resident in a 24-hour period on the following dates: -12/29/24, Census 63. PPD 3.14. -12/30/24, Census 63. PPD 3.15. -12/31/24, Census 63. PPD 2.90. -1/1/25, Census 65. PPD 3.10. -1/3/25, Census 63. PPD 3.02. -1/4/25, Census 65. PPD 2.73. -1/5/25, Census 65. PPD 2.41.	P 5640		

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P 5640	Continued from page 19 -1/6/25, Census 64. PPD 2.21. -1/7/25, Census 64. PPD 2.77. -1/8/25, Census 63. PPD 3.13. -1/9/25, Census 63. PPD 2.93. -1/10/25, Census 63. PPD 2.89. -1/11/15, Census 63. PPD 3.00. -1/12/25, Census 62. PPD 2.39. -1/14/25, Census 62. PPD 2.72. -1/16/25, Census 62. PPD 2.97. -1/18/25, Census 62. PPD 2.97. During an interview on 1/14/25, at 10:50 a.m. the Director of Nursing (DON) confirmed the above findings and that the facility failed to provide the minimum number of general nursing hours to each resident in a 24-hour period on 17 of 21 days.	P 5640		

Certified End Page

KADIMA REHABILITATION & NURSING AT WASHINGTON

STATE LICENSE NUMBER: 110102

SURVEY EXIT DATE: 01/17/2025

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