STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395758	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT HARMONY STATE LICENSE NUMBER: **051302**	**191 EVERGREEN MILL ROAD HARMONY, PA 16037**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to three complaints, completed on December 12, 2024 it was determined that Kadima Rehabilitation and Nursing at Harmony was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0677 SS=D		F 0677		

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 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Resident R1 has been provided a bed bath per resident request and continues to be offered showers as per shower schedule. The facility will ensure that nursing staff follow shower schedules as per plan of care. The Director of Nursing or designee will educate all nursing staff on proper shower schedules and appropriate documentation of care. The Director of Nursing or designee will perform 10 shower audits weekly for 4 weeks then monthly for 3 months to ensure residents are receiving appropriate hygienic care per their plan of care. 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: **01/13/2025** Status: **APPROVED** Date: **01/03/2025**

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 0677 SS=D	Continued from page 2 Based on review of facility policy, shower schedule documents, resident clinical records, resident and staff interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for one of seven sampled residents (Resident R1). Findings include: The facility "Flow of care" policy dated 2/1/24, indicated that care will be provided to residents, as needed 24-hour a day to attain and maintain the highest level of functioning. The flow of care is to be implemented on a continuous basis to promote quality of life with the resident. The provision of targeted care needs shall be documented on Care Tracker (electronic record), Point of Care (electronic record), or ADL (Activity of Daily Living) Flow Records. The 7 a.m. -3 p.m. shift may provide the following: oral hygiene, toileting, breakfast, and showers/baths. The 3 p.m.- 11 p.m. shift may provide the following: Evening meal, repositioning, hydration, and bath/showers.	F 0677		

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F 0677 SS=D	Continued from page 3 Review of facility shower schedule documentation indicated that Resident R1 showers are scheduled for Tuesdays and Fridays during the 3 p.m. to 11 p.m. shift. Review of Resident R1's admission record indicated he was admitted 12/11/23. Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/22/24, indicated he had diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), hyperlipidemia (elevated lipid levels within the blood), and hypertension (a condition impacting blood circulation through the heart related to poor pressure). The diagnoses were found current upon review. Review of Resident R1's care plan indicated that he was risk for functional decline in ADL's and to	F 0677		

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F 0677 SS=D	Continued from page 4 monitor skin integrity during baths/showers as Review of Resident R1's shower documentation indicated there was no shower provided the week of 12/1/24 to 12/7/24. Review of Resident R1's clinical nurse progress notes did not indicate he was provided a shower or refused a shower the week of 12/1/24. During an interview on 12/12/24, at 11:04 a.m. Resident R1 stated: "They are a little short on staff in the evenings. I get an aide to help me in the shower. I did miss one shower." During an interview on 12/12/24, at 12:40 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance with showers for Resident R1 as required.	F 0677		

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F 0677 SS=D	Continued from page 5 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(6) Management. 28 Pa. Code: 201.20 Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.	F 0677		

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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	The facility cannot correct that nurse aide staffing ratios were not met on 11/22/24, 11/23/24, 11/25/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/5/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, 12/10/24. The facility will ensure that nurse aide staffing ratios are met every shift. 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 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	Completion Date: **01/13/2025** Status: **APPROVED** Date: **01/02/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 2	P 5520	to assist. 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 nurse staffing documents, resident interview and staff interview, it was determined that the facility failed to provide the State required minimum of one Nurse Aide (NA) per ten residents on the daylight shifts for 11 out of 21 days (11/22/24, 11/23/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/4/24, 12/7/24, 12/8/24, and 12/9/24), one Nurse Aide (NA) per 11 residents on the evening shifts for 15 out of 21 shifts (11/22/24, 11/23/24, 11/25/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/2/24, 12/3/24, 12/5/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24 and 12/10/24) and failed to provide the State required minimum of one NA per 15 residents for the overnight shift on four out of 21 shifts (11/29/24, 12/3/24, 12/4/24, and 12/10/24). Findings include: A review of 3-week nurse staffing schedules (11/21/24-12/11/24) did not include the State required minimum of Nurse Aides (NA) on the daylight shifts for the following dates: (11/22/24,	P 5520		

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P 5520	Continued from page 4 11/23/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/4/24, 12/7/24, 12/8/24, and 12/9/24). A review of 3-week nurse staffing schedules (11/21/24-12/11/24) did not include the State required minimum of Nurse Aides (NA) on the evening shifts for the following dates: (11/22/24, 11/23/24, 11/25/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/2/24, 12/3/24, 12/5/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24 and 12/10/24). A review of 3-week nurse staffing schedules (11/21/24-12/11/24) did not include the State required minimum of Nurse Aides (NA) on the overnight shifts for the following dates: (11/29/24, 12/3/24, 12/4/24, and 12/10/24). During an interview on 12/12/24, at 11:04 a.m. Resident R1 stated: "They are a little short on staff in the evenings." During an interview on 12/12/24, at 11:23 a.m. Resident R2 stated: "They are short sometimes on	P 5520		

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P 5520	Continued from page 5 staff here." During an interview on 12/12/24, at 12:19 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide the State required minimum of one Nurse Aide (NA) per ten residents on the daylight shifts for 11 out of 21 days (11/22/24, 11/23/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/4/24, 12/7/24, 12/8/24, and 12/9/24), one Nurse Aide (NA) per 11 residents on the evening shifts for 15 out of 21 shifts (11/22/24, 11/23/24, 11/25/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/2/24, 12/3/24, 12/5/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24 and 12/10/24) and failed to provide the State required minimum of one NA per 15 residents for the overnight shift on four out of 21 shifts (11/29/24, 12/3/24, 12/4/24, and 12/10/24) as required.	P 5520		

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P 5530		P 5530		

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P 5530	Continued from page 7 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	The facility cannot correct that LPN staffing ratios were not met on 11/21/24, 11/22/24, 11/23/24, 11/24/24, 11/25/24, 11/26/24, 11/28/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/8/24, 12/9/24, 12/10/24. The facility will ensure that LPN staffing ratios are met every shift. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation P5530 and ensuring LPN staffing ratios are met each shift. Daily shift staffing ratios will be reviewed at daily staffing meeting. The Nursing Supervisors will review shift staffing ratios on the weekends. If the facility projects to not meet staffing ratios on a given shift, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist. The Nursing Home	Completion Date: **01/13/2025** Status: **APPROVED** Date: **01/02/2025**

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P 5530	Continued from page 8	P 5530	Administrator/designee will audit staffing daily for four weeks and monthly for three months to ensure LPN 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	

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 Based on review of nursing time schedule documents, resident interview and staff interview, it was determined that the facility to provide a minimum of one licensed practical nurse (LPN) per 25 residents during daylight shifts for two out of 21 days (11/24/24 and 12/7/24) and failed to provide a minimum of one Licensed Practical Nurse (LPN) per 40 residents during the overnight shift for 14 out of 21 shifts (11/21/24, 11/22/24, 11/23/24, 11/25/24, 11/26/24, 11/28/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/8/24, 12/9/24 and 12/10/24). Findings include: A review of 3-week nurse staffing schedules (11/21/24-12/11/24) did not include one Licensed Practical Nurse (LPN) per 25 residents during the day shift on the following dates: (11/24/24 and 12/7/24). A review of 3-week nurse staffing schedules (11/21/24-12/11/24) did not include one Licensed	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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KADIMA REHABILITATION & NURSING AT HARMONY STATE LICENSE NUMBER: 051302	191 EVERGREEN MILL ROAD HARMONY, PA 16037

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P 5530	Continued from page 10 Practical Nurse (LPN) per 40 residents during the overnight shift on the following dates: (11/21/24, 11/22/24, 11/23/24, 11/25/24, 11/26/24, 11/28/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/8/24, 12/9/24 and 12/10/24). During an interview on 12/12/24, at 11:04 a.m. Resident R1 stated: "They are a little short on staff in the evenings." During an interview on 12/12/24, at 11:23 a.m. Resident R2 stated: "They are short sometimes on staff here." During an interview on 12/12/24, at 12:19 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide the State required minimum of one licensed practical nurse (LPN) per 25 residents during daylight shifts for two out of 21 days (11/24/24 and 12/7/24) and failed to provide a minimum of one Licensed Practical Nurse (LPN) per 40 residents during the overnight shift for 14 out of 21 shifts (11/21/24, 11/22/24, 11/23/24,	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395758	A. BLDG: 00 B. WING:	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KADIMA REHABILITATION & NURSING AT HARMONY STATE LICENSE NUMBER: **051302**	**191 EVERGREEN MILL ROAD HARMONY, PA 16037**

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P 5530	Continued from page 11 11/25/24, 11/26/24, 11/28/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/8/24, 12/9/24 and 12/10/24) as required.	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 12 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	The facility cannot correct that the PPD was below a 3.20 staffing level on 11/22/24, 11/23/24, 11/24/24, 11/25/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, 12/10/24. The facility will ensure that PPD is met for every day. The Regional Clinical Consultant will re-educate the Nursing Home Administrator, Director of Nursing, and HR Director/Scheduler on regulation PPDS and making sure that PPDS are met. Daily schedules will be reviewed to monitor the projected PPD and the IDT will adjust if needed to ensure PPDS are met. The Nursing Supervisors will review staffing sheets on the weekends. If the facility projects to not meet PPD on a given day, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist. The Nursing Home Administrator or	Completion Date: **01/13/2025** Status: **APPROVED** Date: **01/02/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395758	A. BLDG: __00_____ B. WING: _____	12/12/2024

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P 5640	Continued from page 13	P 5640	designee will audit staffing daily for four weeks and monthly for three months to ensure PPDS 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.	

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 14 Based on a review of nursing time schedules and staff interview it was determined that the facility failed to provide a minimum of 3.20 PPD (per patient daily) hours of direct care for each resident for 15 out of 21 days reviewed (11/22/24 , 11/23/24 , 11/24/24, 11/25/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, and 12/10/24). Findings include: Review of staffing documents and nurse schedules for 3 weeks (11/21/24-12/11/24) indicated that State required PPD (per patient daily) minimum hours of 3.20 was not met on the following days: 11/22/24= 3.07 PPD 11/23/24= 3.13 PPD 11/24/24= 3.15 PPD 11/25/24= 3.19 PPD 11/28/24= 3.10 PPD 11/29/24= 3.01 PPD 11/30/24= 2.91 PPD 12/1/24= 2.86 PPD	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 15 12/2/24= 2.97 PPD 12/3/24= 2.90 PPD 12/6/24= 3.13 PPD 12/7/24= 2.83 PPD 12/8/24= 2.88 PPD 12/9/24= 3.14 PPD 12/10/24= 3.16 PPD During an interview on 12/12/24, at 12:19 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide a minimum of 3.20 PPD (per patient daily) hours of direct care on 11/22/24, 11/23/24, 11/24/24, 11/25/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, 12/3/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, and 12/10/24 as required.	P 5640		

Certified End Page

KADIMA REHABILITATION & NURSING AT HARMONY

STATE LICENSE NUMBER: 051302

SURVEY EXIT DATE: 12/12/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY