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:	02/11/2025

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 a revisit survey completed on February 11, 2025, it was determined that Kadima Rehabilitation and Nursing at Harmony failed to correct the deficiencies cited during the survey of January 23, 2025, under the requirements of the 28 Pa, Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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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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 2/3/25, 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, and 2/9/25. 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 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: **02/24/2025** Status: **APPROVED** Date: **02/19/2025**

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	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.	

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 3 Based on a review of staffing documents provided by the facility and staff interview it was determined that the facility failed to provide one nurse assistant (NA) per 10 residents on the daylight shift on six of seven days (2/4/25 through 2/9/25), one NA per 11 residents on the second shift on four of seven days (2/3/25, 2/4/25, 2/7/25 and 2/8/25) and one NA per 15 residents on the night shift on three of seven days (2/3/25, 2/5/25 and 2/9/25) as required. Findings include: A review of facility staffing documents provided by the facility from 2/3/25 through 2/9/25, revealed the facility failed to provide NA on the following shifts as required: Daylight shift: Date Census Actual hours Hours required	P 5520		

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		P 5520		

Continued from page 4

2/4/25	108	75.77	81.00
2/5/25	105	66.53	78.75
2/6/25	104	54.72	78.00
2/7/25	102	65.62	76.50
2/8/25	102	68.59	76.50
2/9/25	103	74.60	77.25

Evening shift:

Date required	Census	Actual hours	Hours
2/3/25	107	52.73	72.95
2/4/25	108	63.07	73.64
2/7/25	102	69.05	69.55

Night shift:

Date required	Census	Actual hours	Hours
2/3/25	107	36.09	53.50
2/5/25	105	52.29	52.50

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P 5520	Continued from page 5 2/9/25 103 37.90 51.50 During an interview on 2/11/25 at 10:30 a.m., the Assistant Director of Nursing confirmed that the facility failed to provide NA's in the facility on the above shifts as required.	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 6 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 2/3/25, 2/4/25, 2/6/25, 2/8/25, 2/9/25. 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 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 Administrator/designee will audit staffing daily for four weeks and monthly for three months to ensure	Completion Date: **02/24/2025** Status: **APPROVED** Date: **02/19/2025**

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 7	P 5530	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 8 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 on the day shift for one of seven days (2/8/25) and one LPN per 40 residents on the night shift on five of seven days (2/3/25, 2/4/25, 2/6/25, 2/8/25 and 2/9/25). Findings include: Review of facility census data, nursing time schedules from 2/3/25 through 2/9/25, revealed the following LPN staffing shortage: Day shift: 2/8/25 census 102 31.14 actual hours 32.64 hours required. Night shift:	P 5530		

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P 5530	Continued from page 9 2/3/25 census 107 15.60 actual hours 21.40 hours required. 2/4/25 census 108 8.00 actual hours 21.60 hours required. 2/6/25 census 104 18.65 actual hours 20.80 hours required. 2/8/25 census 102 15.85 actual hours 20.40 hours required. 2/9/25 census 103 16.00 actual hours 20.60 hours required. During an interview on 2/11/25, at 10:30 a.m. the Assistant Director of Nursing confirmed the facility failed to provide the minimum of LPN's on the above day 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 10 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 2/3/25, 2/4/25, 2/5/25, 2/8/25, 2/9/25. 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 P5640 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 any given day, the scheduler/designee will be responsible to call off duty personnel or call extra support staff to assist. The nursing Home Administrator/designee will audit staffing daily for four weeks and	Completion Date: **02/24/2025** Status: **APPROVED** Date: **02/19/2025**

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P 5640	Continued from page 11	P 5640	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.	

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P 5640	Continued from page 12 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 on five of seven days reviewed (2/3/25, 2/4/25, 2/5/25, 2/8/25 and 2/9/25). Findings include: Review of staffing documents and nursing staff schedules from 2/3/25 through 2/9/25, indicated that the State required PPD minimum hours of 3.20 was not met on the following days: 2/3/25= 2.73 PPD. 2/4/25= 2.95 PPD. 2/5/25= 3.07 PPD. 2/8/25= 2.85 PPD. 2/9/25= 2.82 PPD. During an interview on 2/11/25, at 10:30 a.m. the Assistant Director of Nursing confirmed that the	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 13 facility failed to provide a minimum of 3.20 PPD hours of direct care on the above dates as required.	P 5640		

Certified End Page

KADIMA REHABILITATION & NURSING AT HARMONY

STATE LICENSE NUMBER: 051302

SURVEY EXIT DATE: 02/11/2025

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