



Certified End Page

KADIMA REHABILITATION & NURSING AT POTTSTOWN

STATE LICENSE NUMBER: 034202

SURVEY EXIT DATE: 12/09/2024

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
STATE LICENSE NUMBER: 034202				
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K 0000	INITIAL COMMENT ID #034202 Component 01 Main Building Based on a revisit to a Medicare/Medicaid Recertification Survey completed on October 8, 2024, it was determined that Kadima Rehabilitation & Nursing at Pottstown was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type III (200), unprotected ordinary structure, with a partial basement, which is fully sprinklered.	K 0000		
K 0100 SS=F		K 0100		

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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K 0100 SS=F	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	<ol style="list-style-type: none"> 1. The facility is unable to retroactively document testing, cleaning, and battery replacement program of the carbon monoxide alarms. 2. Facility-wide audit of carbon monoxide detectors conducted. Carbon monoxide detectors will be installed in places where fossil fuel appliances are in use. 3. Audits will be conducted monthly for twelve months and annually thereafter. Results of the audits will be presented to our QAPI committee for review and analysis of need for ongoing monitoring. <ol style="list-style-type: none"> 1. An evacuation and alarm protocol policy will be written and enacted. Education will be provided to staff regarding policy. 1. Exterior doors to the Main Mechanical Room have been secured and will remain secured at all times. 2. Audits will be conducted monthly for 12 months. 3. Results of the audits will be presented to our QAPI committee for review and analysis of need for 	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0100 SS=F	Continued from page 2	K 0100	ongoing monitoring.	

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

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K 0100 SS=F	Continued from page 4 determined the following item did not meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies, responsible for the health and welfare of residents within the component. Findings include: 1. Observation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility failed to document the testing, cleaning, and battery replacement program of the carbon monoxide alarms. Interview with the Director of Maintenance on October 8, 2024, at 12:20 PM, confirmed the carbon monoxide detection system was not being maintained. 2. Observation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility lacked an evacuation and alarm protocol policy for	K 0100		

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K 0100 SS=F	Continued from page 5 the carbon monoxide detection system. Interview with the Director of Maintenance on October 8, 2024, at 12:20 PM, confirmed the facility could not provide an alarm protocol and evacuation plan for carbon monoxide. 3. Observation on October 8, 2024, at 1:40 PM, revealed the exterior doors to the Main Mechanical Room (housing the domestic water main, main electrical panel, and the generator) was not secured from unauthorized access, leaving major utilities vulnerable. Interview with the Director of Maintenance at 1:40 PM, confirmed the room was not secure, leaving all the utilities vulnerable to unauthorized access. ***** Observation on December 9, 2024, at 12:00 PM, determined items 1 and 2 were not corrected. Interview with the Director of Maintenance on	K 0100		

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K 0100 SS=F	Continued from page 6 December 9, 2024, at 12:00 PM, confirmed items 1 and 2 were not corrected.	K 0100		
K 0225 SS=F	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	1. The facility is unable to retroactively ensure stair tower door gaps are within the allowed margin. 2. Facility-wide audit of all stair tower doors conducted. The basement and first floor stair tower doors will be adjusted to ensure gaps are less than one eighth of an inch. 3. Audits will be conducted monthly for 3 months then quarterly for 3 quarters. Results of the audits will be presented to our QAPI committee for review and analysis of need for ongoing monitoring..	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0225 SS=F	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain stairtower doors to be within the allowed gap margins, on two of two floors within the component. Findings include: 1. Observation on October 8, 2024, between 12:50 PM and 12:55 PM, revealed stairtower doors had gaps greater than one eighth of an inch, at the following locations: a. 12:50 PM, the basement stairtower; b. 12:55 PM, the 1st floor stairtower. Interview with the Director of Maintenance on October 8, 2024, at 12:55 PM, confirmed the stairtower doors exceeded the allowed gap margins. *** ** Observation on December 9, 2024, at 10:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on	K 0225		

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K 0225 SS=F	Continued from page 8 December 9, 2024, at 10:30 AM confirmed item 1 was not corrected.	K 0225		
K 0293 SS=C	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	1. The facility is unable to retroactively document visual inspection of exit signs. 2. Facility-wide audit of all exit signs completed. 3. Audits of exit signs will be conducted monthly. Results of the audits will be presented to our QAPI committee for review and analysis of need for ongoing monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0293 SS=C	Continued from page 9 Based on document review and interview, it was determined the facility failed to provide documentation of the monthly exit sign inspections, affecting the entire component. Findings include: 1. Review of documentation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility lacked documentation verifying exit signs were visually inspected for the past twelve months. Interview with the Director of Maintenance on October 8, 2024, at 12:20 PM, confirmed the facility could not provide documentation of exit sign inspections. *** ** Observation on December 9, 2024, between 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, between 10:30 AM and 11:30	K 0293		

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K 0293 SS=C	Continued from page 10 AM, confirmed item 1 was not corrected.	K 0293		
K 0321 SS=D		K 0321		

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K 0321 SS=D	Continued from page 12 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=D	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors to self-close and positively latch, on one of two floors within the component. Findings include: 1. Observation on October 8, 2024, at 12:25 PM, revealed the basement Central Supply door lacked latching hardware and failed to positively latch. Interview with the Director of Maintenance on October 8, 2024, at 12:25 PM, confirmed the facility failed to maintain latching hardware. 2. Observation on October 28, 2024, at 12:40 PM, revealed the basement Laundry door could not self-close, due to a wedge placed in the door. Interview with the Director of Maintenance on October 8, 2024, at 12:40 PM, confirmed the door could not self-close.	K 0321		

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K 0321 SS=D	Continued from page 14 3. Observation on October 28, 2024, at 12:43 PM, revealed the rated door, to the basement Laundry Chute Room, with closure, was impeded from closing, by a wedge. Interview with the Director of Maintenance on October 8, 2024, at 12:43 PM, confirmed the door was wedged open. *** ** Observation on December 9, 2024, at 11:40 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, at 11:40 AM, confirmed item 1 was not corrected.	K 0321		
K 0324 SS=C		K 0324		

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K 0324 SS=C	Continued from page 15 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	1. Vendor will be contacted to provide documentation of semi-annual inspection of the kitchen suppression system. 2. Audit will be conducted semi-annually to ensure inspections occur as required. 3. Results of audits will be reported to the governing body through QAPI.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0324 SS=C	Continued from page 16 Based on document review and interview, it was determined the facility failed to provide documentation of the semi-annual kitchen suppression system inspections, affecting the entire component. Findings include: 1. Review of documentation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility lacked documentation verifying the Kitchen suppression system had the semi-annually inspection performed in the past year. Interview with the Director of Maintenance on, October 8, 2024, at 12:20 PM, confirmed the the facility could not provide documentation of the semi-annual inspections. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected.	K 0324		

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K 0324 SS=C	Continued from page 17 Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0324		
K 0345 SS=C	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	1. Johnson Control was contacted to provide documentation of semi-annual visual fire alarm inspection. Per Johson Control documentation, the fire alarm inspection was last completed on 5/15/24 and will be completed again prior to 01/06/25 in order to maintain compliance. 2. NHA and Maintenance Director will conduct semi-annual audits to ensure inspections occur as required. Maintenance Director or designee will ensure that all fire alarm reports are received and file in life safety book. 3. Maintenance Director will report audit results to governing body through QAPI Committee for review and recommendation for continued monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0345 SS=C	Continued from page 18 Based on document review and interview, it was determined the facility failed to provide documentation of the semi-annual visual fire alarm system inspection, affecting the entire component. Findings include: 1. Review of documentation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility lacked documentation of the semi-annual visual fire alarm inspection. Interview with the Director of Maintenance on October 8, 2024,, at 12:20 PM, confirmed documentation verifying the semi-annual visual inspection had been conducted was not available. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM,	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0345 SS=C	Continued from page 19 confirmed item 1 was not corrected.	K 0345		
K 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0353 SS=F	Continued from page 20 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	1. Johnson Control will be contacted to come out before 01/06/25: a. Replace or recalibrate gauges as needed b. Internal valve inspection c. Internal pipe inspection d. Obstruction inspection 2. Maintenance Director and Maintenance Staff will be educated on inspection and documentation requirements. Deficiencies identified by Johnson Control will be repaired. 3. An audit of the life safety book will be conducted quarterly for 12 months and bi-annually thereafter. 4. A fire department sign will be installed at the site of the connection. 5. Maintenance Director or Designee	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0353 SS=F	Continued from page 21	K 0353	will conduct audits quarterly for 12 months, then biannually thereafter and filed in the LifeSafety. 6. Results of audits will be reported to the QAPI Committee for recommendations for review and analysis for ongoing monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0353 SS=F	Continued from page 22 Based on document review and interview, it was determined the facility failed to provide repairs to noted deficiencies, and required signage for the sprinkler system, affecting the entire component. Findings include: 1. Review of documentation and interview on October 8, 2024, between 11:00 AM and 12:20 PM, revealed deficiencies for the sprinkler system, as found by Johnson Control on February 29, 2024, had not been addressed: a. replacement or recalibration of the gauges; b. internal valve inspection; c. internal pipe inspection; d. obstruction inspection; e. a pin hole in a pipe, over the Kitchen, pipe needs replaced. Interview with the Director of Maintenance on, October 8, 2024, at 12:20 PM, confirmed the sprinkler system deficiencies had not been	K 0353		

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K 0353 SS=F	Continued from page 23 addressed. 2. Observation and interview on October 8, 2024, at 1:40 PM, revealed the facility lacked a fire department connection sign. Interview with the Director of Maintenance on October 8, 2024, at 1:40 PM, confirmed the the fire department connection sign was not present. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined items 1 and 2 were not corrected. Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed items 1 and 2 were not corrected.	K 0353		
K 0363 SS=D		K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0363 SS=D	Continued from page 24 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	1. The facility is unable to retroactively ensure corridor door gaps are within the allowed margin. 2. Maintenance Director completed facility-wide audit of all corridor doors. Doors will be adjusted as needed to ensure gaps conform to regulation. Fire/Smoke door seal will be installed on doors where adjustments won't close the gap to regulation. 3. Door to Room 124, and activity room will be corrected to positively latch. Fire/smoke door seal will be installed to close the gap on the door to room 113. 4. All staff will be educated on the need to report doors that do not positively latch. Maintenance staff will be educated on door gap regulatory requirements. Maintenance Director or Designee will complete audits monthly for 12 months. Results of the audits will be presented to the QAPI Committee for review and analysis of need for	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0363 SS=D	Continued from page 25 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363	ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0363 SS=D	Continued from page 26 Based on observation and interview, it was determined the facility failed to maintain corridor doors to be smoke tight, and to positively latch, on one of two floors within the component. Findings include: 1. Observation on October 8, 2024, at 12:53 PM, revealed the door to resident room 113 had a gap between the door and the frame, greater than 1/2 inch. Interview with the Director of Maintenance on October 8, 2024, at 12:53 PM, confirmed the corridor door was not smoke tight. 2. Observation on October 8, 2024, between 1:00 PM and 1:50 PM, revealed corridor doors failed to positively latch, at the following locations: a. 1:00 PM, Resident Room 124; b. 1:50 PM, Activity Room double doors had the latch removed.	K 0363		

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K 0363 SS=D	Continued from page 27 Interview with the Director of Maintenance on October 8, 2024, at 1:50 PM, confirmed the corridor doors failed to positively latch. *** ** Observation on December 9, 2024, between 11:15 AM, and 11:30 AM, determined items 1 and 2 were not corrected. Interview with the Director of Maintenance on December 9, 2024, between 11:45 AM and 12:00 PM, confirmed items 1 and 2 were not corrected.	K 0363		
K 0712 SS=C		K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0712 SS=C	Continued from page 28 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	1. The facility is unable to retroactively ensure fire drills are completed in compliance with regulations. 2. Fire drills will be completed monthly in varying locations and varying shifts as per regulation. Quarterly audits will be completed to confirm drills are being conducted on the shifts for which they are scheduled. 3. Maintenance Director or Designee will conduct documentation audits to ensure compliance with regulation. Audit results will be presented to the QAPI Committee for review and analysis of need for ongoing monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0712 SS=C	Continued from page 29 Based on document review and interview, it was determined the facility failed to conduct and perform fire drills as required, for the entire component. Findings include: 1. Review of documentation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility did not perform fire drills, during the following: a. 2nd quarter, 1st and 2nd shifts; b. 3rd quarter, 3rd shift; c. 4th quarter, 2nd shift. Interview with the Director of Maintenance on October 8, 2024, at 12:20 PM, confirmed the fire drills were not performed. *** ** Observation on December 9, 2024, at 10:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on	K 0712		

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K 0712 SS=C	Continued from page 30 December 9, 2024, at 10:30 AM, confirmed item 1 was not corrected.	K 0712		
K 0761 SS=C	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	1. The facility is unable to retroactively document inspection of rated/labeled doors. 2. Maintenance staff will be educated on the annual fire door inspection procedures. Rated doors will be inspected annually per regulations. 3. NHA and Maintenance Director will conduct annual audits to ensure inspections and corresponding documentation is completed per annual regulatory requirement. Audit results will be documented in the Life Safety Book. 4. Audit results and corresponding documentation will be presented to QAPI committee for review and analysis of need for ongoing monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0761 SS=C	Continued from page 31 Based on document review, observation and interview, it was determined the facility failed to conduct the all rated/labeled doors inspection, per NFPA 80, for the entire component. Findings include: 1. Review of documentation and observation on October 8, 2024, between 11:00 AM and 2:00 PM, revealed rated doors in all areas were not inspected, in the last 12 months. Interview with the Director of Maintenance on October 8, 2024, at 2:00 PM, confirmed the rated doors were not inspected. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0761 SS=C K 0914 SS=E	Continued from page 32 NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0761 K 0914	1. Facility is unable to retroactively conduct annual electrical receptacle inspection in resident care areas. 2. A facility-wide audit of electrical receptacles will be completed. Maintenance Staff will be educated on the requirement to perform annual receptacle inspections. 3. Maintenance Director will complete annual electrical receptacle inspections by 01/27/2025. 4. NHA or designee will audit Life Safety Book semi-annually to confirm completion of annual inspections and that the documentation has been completed. The results of monitoring will be submitted to the QAPI committee for review and analysis of need for ongoing monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0914 SS=E	Continued from page 33 Based on document review and interview, it was determined the facility failed to conduct the annual electrical receptacle inspection in resident care areas, in one of two smoke zones within the component. Findings include: 1. Review of documentation on October 8, 2024, between 11:00 AM and 12:20 PM, revealed the facility lacked documentation verifying electrical receptacles were tested within the last 12 months. Interview with the Director of Maintenance on October 8, 2024, at 12:20 PM, confirmed the receptacles in patient care areas were not tested in the last 12 months. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on	K 0914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202	STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465
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K 0914 SS=E	Continued from page 34 December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0914		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202	STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465
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K 0918 SS=F	Continued from page 35 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1. Facility is unable to retroactively conduct inspections and tests of the emergency generator. 2. GenServ-DynaTech will be contacted to complete the following required inspections before 01/06/25. Tests of the emergency generator will be completed with corresponding documentation kept on file: a. Weekly visual inspection b. Weekly recording of the battery voltage c. Monthly load test and operation of the transfer switch d. Annual fuel quality test e. 3-year, 4-hour load bank 3. Maintenance Director will complete audits. Maintenance Director and Maintenance staff will be educated on and complete the required weekly, monthly, annual, and tri-annual inspection, as	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
STATE LICENSE NUMBER: 034202				
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K 0918 SS=F	Continued from page 36 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	required by regulation. 4. NHA or Designee will complete monthly audits of the Life Safety Book to ensure that inspections and tests are being completed weekly, monthly, annually, and tri-annually per regulation. Audits will be done quarterly once substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0918 SS=F	Continued from page 37 Based on document review, observation, and interview, it was determined the facility failed to conduct inspection and tests of the emergency generator, which serves the entire component. Findings include: 1. Review of documentation and observation on October 8, 2024, between 11:00 AM and 2:00 PM, revealed the facility failed to perform and/or document the required inspections and tests, including the following: a. the weekly visual inspection; b. the weekly recording of the battery voltage; c. the monthly load test and operation of the transfer switch; d. the annual fuel quality test; e. the required 3-year, 4-hour load bank. Interview with the Director of Maintenance on October 8, 2024, at 2:00 PM, confirmed the facility failed to provide verification that generator	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
NAME OF PROVIDER OR SUPPLIER: KADIMA REHABILITATION & NURSING AT POTTSTOWN STATE LICENSE NUMBER: 034202		STREET ADDRESS, CITY, STATE, ZIP CODE: 3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19465		
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K 0918 SS=F	Continued from page 38 inspections and tests had been performed. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0918		
K 0920 SS=D		K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0920 SS=D	Continued from page 39 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	1. A facility-wide audit of electrical panels has been completed. Any electrical panel found to be unlocked was locked. 2. Education will be provided to staff that electrical panels should remain locked at all times. 3. NHA or designee will audit electrical panels weekly for 4 weeks then monthly for 2 months, and monthly thereafter to ensure they are locked. 4. Results of the audits will be presented to the QAPI committee for review and analysis of need for ongoing monitoring.	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0920 SS=D	Continued from page 40 Based on observation and interview, it was determined the facility failed to verify electrical panels were secured, throughout the component. Findings include: 1. Observation, during the survey on October 8, 2024, at 12:58 PM, revealed 3 wall-mounted recessed electrical panels, off the corridor, behind the 1st floor Nurses' Station, were unlocked and accessible to any unauthorized persons. Interview with the Director of Maintenance on October 8, 2024, at 12:58 PM, confirmed the electrical panels were unlocked. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected. Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0920 SS=D	Continued from page 41	K 0920		
K 0921 SS=F		K 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0921 SS=F	Continued from page 42 NFPA 101 Electrical Equipment - Testing and Maintenance Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by:	K 0921	1. The facility is unable to retroactively conduct a 30-second monthly test or 90-minute annual test of the battery backup emergency lighting in the generator room before the survey. 2. The facility had a new Maintenance Director that started on 12/09/24. Maintenance or Designee will conduct a 30-second monthly test and a 90-minute annual test of the battery backup emergency lighting. The 90 minute test will be completed by 01/27/2025. Battery will be replaced as necessary. 3. Education will be provided to Maintenance staff regarding testing of the battery backup emergency lighting. Documentation of testing will be maintained in the Life Safety Book per regulation. 4. Maintenance Director or Designee will complete audits of routine testing monthly until substantial	Completion Date: 01/06/2025 Status: APPROVED Date: 01/02/2025

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K 0921 SS=F	Continued from page 43	K 0921	compliance has been achieved and quarterly thereafter. 5. Results of the audits will be presented to the QAPI committee for review and analysis for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024	
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K 0921 SS=F	Continued from page 44 Based on observation and interview, it was determined the facility failed to perform functional tests of battery-powered emergency lighting source at the generator, for one of one generator, which serves the entire component. Findings include: 1. Observation on October 8, 2024, between 11:00 AM and 1:30 PM, revealed the facility failed to perform the battery back-up emergency lighting test at the generator for 30 seconds monthly, and 90-minutes annually, and the light was not mounted and laying on an electrical duct. Interview with the Director of Maintenance on October 8, 2024, at 1:30 PM, confirmed the tests were not performed, and the fixture was not mounted. *** ** Observation on December 9, 2024, at 10:30 AM and 11:30 AM, determined item 1 was not corrected.	K 0921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395827	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/09/2024
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K 0921 SS=F	Continued from page 45 Interview with the Director of Maintenance on December 9, 2024, at 10:30 AM and 11:30 AM, confirmed item 1 was not corrected.	K 0921			



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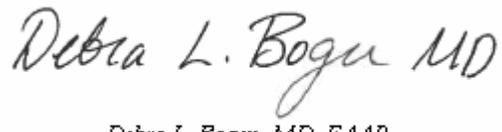
KADIMA REHABILITATION & NURSING AT POTTSTOWN

STATE LICENSE NUMBER: 034202

SURVEY EXIT DATE: 12/09/2024

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, 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