STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395019	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Meadow Springs	845 Germantown Pike Plymouth Meeting, PA 19462

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview with resident and staff, review of facility provided documentation and review of policy, it was determined that facility failed to ensure that one of six residents reviewed was free of physical abuse during respiratory care. (Resident R1)Findings include: Review of facility policy ?Abuse,' revised April 2026, defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of Resident R1's clinical record revealed medical diagnosis of tracheostomy (tube inserted through the neck to assist breathing) status, acute and chronic respiratory failure with hypoxia (a condition of low oxygen levels), gastrostomy (a surgical place tube that delivers nutrition) status, restlessness and agitation, anxiety disorder, major depressive disorder, Review of Minimum Data Set (MDS)/Resident Assessment and Care Screening, completed February 24, 2026, revealed Resident R1's Brief Interview for Mental Status (BIMS) score of 14, which indicated that the resident was cognitively intact. Review of facility documentation reported to the State Survey Agency, revealed that on May 8, 2026, at approximately 12:30 p.m., an interview was conducted with Resident R1 regarding concerns related to respiratory care provided on May 6, 2026 and May 7, 2026.Resident R1 stated that at approximately 9:00 p.m. on May 5, 2026, a respiratory therapist entered (her/his) room to perform tracheostomy care and change (her/his) inner cannula. The resident stated that while the therapist was changing the gauze, the care was causing (her/his) pain. [Resident R1] reported that (she/he) asked the therapist to stop; however, according to (her/his) statement, he continued the care and was pushing (her/his) head upward during the procedure. The resident stated that (she/he) allowed him to finish the treatment and afterward began crying. (She/He) reported that (she/he) did not notify staff at that time because (she/he) did not believe the therapist would return to her room. Continued review of the reported incident revealed [Resident R1] further stated that at approximately 5:00 a.m. on May 7, 2026, the same respiratory therapist returned to provide tracheostomy care. The resident reported that (she/he) told the therapist not to touch (her/him) and raised (her/his) hands in an attempt to stop him from providing care. According to the resident, the therapist continued attempting to provide care despite (her/his) objections. [Resident R1] stated that (she/he) grabbed a reacher/grabber device and attempted to hit the therapist with it in an effort to make him stop. (She/He) reported that the therapist then took the grabber device and placed it on the floor between the bedside table and the bed. The resident further alleged that the therapist held both of (her/his) hands down, preventing (her/his) from moving. Based on the investigation conducted, statements and interviews the allegation of physical abuse was substantiated. The Respiratory Therapist (Employee E1) continued providing care to the resident after Resident R1 verbally and physically refused treatment. Review of the facility's investigation report revealed that a Licensed nurse, Employee E2, entered the room during the incident; according to the Resident R1, the Respiratory Therapist (Employee E1) asked the Licensed nurse (Employee E2) You are going to let her get away with that? Further review of investigation report revealed that Resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was not scared, but it just hurt, further stating that the respiratory therapist was really rough and he did not introduce himself upon entering the room or explaining the care he was performing. Review of Licensed nurse, Employee E2 statement, completed on May 11, 2026, at 3:04 pm, revealed that on May 6, 2026, during a night shift, she responded to yelling coming from room [ROOM NUMBER] around 4:50 a.m. The nurse observed a resident swinging a hand-grabber at a respiratory therapist, who stated he was attempting to provide trach care but the resident refused treatment. After the therapist left, the resident reported that the therapist had been too rough while turning (her/his) neck and said (she/he) wanted to report him. The nurse apologized, assessed the resident for injuries or pain, found no bruising, and the resident denied being in pain. Interview with Resident R1 on Wednesday, May 27, 2026, at 10:50 am, revealed that (she/he) has resided at the facility for past two years; has not been receiving respiratory care from Employee E1 prior to incident on May 6, 2026, and stated that Respiratory Therapist, Employee E1 tilted (her/his) neck and head upward excessively during care. Per statement from Respiratory therapist, Employee E1, completed on May 8, 2026, at 3:49 pm, while checking residents needing suction or trach care, Employee E1 entered a resident's room, and noticed coarse breathing sounds and soiled drainage gauze and attempted to provide trach care. Resident R1 became agitated, swiping and swinging a grabber at the therapist while refusing care. The therapist tried to explain the need for treatment, but the resident continued resisting. A nurse entered the room, was informed of the situation, and instructed the therapist to stop and document the resident's refusal of care. The therapist later acknowledged forgetting to document the interaction. Interview with Director of Nursing, Employee E3, on Wednesday, May 27, 2026, at 10:00 am, confirmed that Respiratory therapist, Employee E1 should have treated Resident R1 as an individual and that allegations of abuse were substantiated by facility. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.29 (c) Resident rights 28 Pa. Code 211.12(d)(1) Nursing services