

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Meadow View Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  225 Park Street Montrose, PA 18801	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41581</p> <p>Based on a review of clinical records, resident council meeting minutes, grievances, resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two residents out of 8 residents sampled (Residents 2 and 6).</p> <p>Findings include:</p> <p>A review of Resident Council meeting minutes dated March 5, 2025, revealed residents in attendance raised concerns regarding call bell response times. The residents indicated there was an issue with receiving staff assistance for toileting. Residents in attendance raised concerns indicating call bells are not answered when residents ring for assistance.</p> <p>A review of the facility grievances for the month of March 2025 revealed a grievance filed March 9, 2025 noting that residents are complaining of call bell response times. The grievance revealed the facility's plan to resolve this was to conduct call bell audits on all shifts.</p> <p>The results of the action taken was as follows:</p> <p>Day Shift: Average call bell times: 2-45 minutes</p> <p>Evening shift: 2-45 mins</p> <p>Night shift: 2-10 minutes.</p> <p>Per the grievance form, management reports the staff members were re-educated on the need to respond to call bells more timely.</p> <p>An interview with Resident 2 on March 19, 2025, at approximately 12:00 PM, revealed concerns regarding delayed call bell responses. The resident stated that response times can extend up to 45 minutes to an hour, with longer delays occurring at night. The resident further explained that if assistance is not provided in a timely manner, she may remain in a soiled brief for an extended period before staff is available to assist with hygiene needs.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident 6 on March 19, 2025, at approximately 12:30 PM, revealed concerns regarding call bell response times. The resident stated that call bells often go unanswered for 45 minutes to an hour, attributing the delays to insufficient staffing. The resident further shared that, on some occasions, prolonged wait times have resulted in incontinence before assistance could be provided.</p> <p>During an interview on March 21, 2025, at approximately 9:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified that all residents at the facility should be treated with dignity and respect and provided care in a manner that promotes each resident's quality of life. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41581</p> <p>Based on review of clinical records, and staff interview, it was determined the facility failed to implement individualized approaches for incontinence and provide maintenance care to the extent possible for two out of eight sampled residents (Resident 4 and 5).</p> <p>Findings include:</p> <p>A review of Resident 4's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included overactive bladder and muscle weakness.</p> <p>A review of Resident 4's quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 6, 2024, revealed the resident was incontinent of bowel and bladder and was a poor candidate for retraining/scheduled toileting due to cognitive status.</p> <p>A review of the resident's care plan for Bladder and Bowel Incontinence, initiated on December 4, 2024, documented an intervention for the resident to be checked and changed every two hours and as needed (PRN). The term check and change refers to the routine monitoring and changing of a resident's incontinence products (such as adult briefs or absorbent pads) to maintain skin integrity, promote comfort, and prevent complications such as skin breakdown, moisture-associated skin damage (MASD), and urinary tract infections (UTIs).</p> <p>A review of the resident's Bowel and Bladder assessment dated [DATE], confirmed the resident was to be checked and changed every two hours.</p> <p>However, a review of the resident's clinical record did not reveal documented evidence the resident was checked and changed every two hours per the plan of care.</p> <p>An interview with the Nursing Home Administrator (NHA) on March 19, 2025, at approximately 1:45 PM, confirmed that the facility failed to provide documented evidence that incontinence care was provided to Resident 4.</p> <p>A review of Resident 5's clinical record revealed that the resident was admitted to the facility January 4, 2024, with diagnoses including dementia (decline in mental ability that interferes with daily life) and muscle weakness.</p> <p>A review of Resident 5's Bowel and Bladder assessment dated [DATE], revealed Resident 5 remained incontinent of bowel and bladder was not appropriate for retraining/scheduled toileting due to cognitive status.</p> <p>A review of the resident's care plan for Bladder and Bowel Incontinence, initiated on February 23, 2024, documented an intervention for the resident to be checked and changed every two hours and as needed (PRN).</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 5's progress notes revealed:</p> <p>January 15, 2025 - The resident experienced hematuria (blood in urine) while toileting at 5:00 PM.</p> <p>January 17, 2025 - A urine culture was obtained at 6:30 AM.</p> <p>January 18, 2025 - The resident was placed on an antibiotic due to a confirmed urinary tract infection (UTI) via lab results dated January 17, 2025.</p> <p>A review of the resident's January 2025 Documentation Survey Report revealed that on the following dates the resident was not checked every 2 hours per the care plan intervention recommendations</p> <p>A review of the resident's Documentation Survey Report for January, February, and March 2025 revealed multiple dates during various shift on which the resident was not checked and changed every two hours per the care plan intervention, including:</p> <p>January 4, 5, 7, 10, 17, 19, and 31, 2025</p> <p>February 16, 20, and 23, 2025</p> <p>March 14, 15, 16, and 17, 2025</p> <p>An interview with the Nursing Home Administrator (NHA) on March 19, 2025, at approximately 1:45 PM, confirmed that the facility failed to carry out incontinence checks as planned for these residents to maintain or improve urinary continence and prevent incontinence related complications</p> <p>The facility failed to provide scheduled incontinence care as outlined in the residents' care plans.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41581</p> <p>Based on a review of clinical records and staff interviews it was determined the facility failed to implement procedures to ensure the timely acquisition and administration of a prescribed medication to one of 7 sampled residents (Resident 1).</p> <p>Findings include:</p> <p>A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis of one side of the body) following a cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die).</p> <p>A review of hospital discharge instructions revealed the resident was to receive diazepam 2mg (Valium an antianxiety medication) one tablet by mouth every night.</p> <p>A review of physician's orders dated February 6, 2025, revealed the physician prescribed diazepam 2mg one tablet by mouth at bedtime for anxiety beginning on February 6, 2025.</p> <p>A review of the Resident's MAR (medication administration record) showed the diazepam was not administered on February 6 and 7, 2025, as ordered. There were no nurse signatures or documentation indicating the dose was given on those dates.</p> <p>A nursing progress note dated February 7, 2025, at 8:40 PM indicated the bedtime dose of diazepam was not given because the medication was unavailable. Further record review revealed the facility had not received the diazepam from the pharmacy in time for the scheduled doses on February 6 and 7, 2025.</p> <p>An interview with the Nursing Home Administrator on March 19, 2025, at approximately 1:45 PM acknowledged that the facility did not have adequate procedures in place to ensure medications were obtained and administered in a timely manner.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.9 (f)(2) Pharmacy services</p>