STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety 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** 46508 Based on review of facility policy, review of facility documentation, review of clinical records, review of video footage and interviews with staff, it was determined that the facility failed to ensure that one of four residents reviewed was free from verbal, physical and psychological abuse from a nursing staff. (Resident R1) This failure resulted in an immediate jeopardy situation for Resident R1 who was rough handled, yelled at with the use of profane language, struck in the chest sustaining injuries to the fourth finger on the right hand and chest area and demonstrated signs of fear when approached by nursing staff. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility policy on Abuse Prevention and Management, with revise date of September 8, 2022, revealed that under section Policy: The facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation, exploitation of resident/patient property by anyone, including staff, family, friends, visitors, etc. The facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected and alleged resident patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. The facility must provide a safe resident environment and protect residents from abuse. This includes, but is not limited to, freedom from corporal punishment and involuntary seclusion. Under section Protocol: Abuse, neglect and misappropriation/exploitation of resident funds and property education is completed upon hire and at least annually for all employees. Advocacy numbers are posted within the facility. The shift supervisor is identified as responsible for immediate initiation of reporting process. The administrator, director of nursing, and risk manager, if applicable, are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect, and/or misappropriation/exploitation of policy standards and procedures: Implementation, ongoing monitoring, reporting, investigation, tracking and trending. Under section definition: The following definitions are pursuant to the Interpretive guidelines for freedom from abuse, neglect and exploitation. Physical abuse includes hitting, slapping, pinching, scratching, spitting, holding, roughly kicking, etc. It also includes controlling behavior through corporal punishment. Staff to resident abuse When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. The facility is responsible to ensure that all staff are trained and are knowledgeable and how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior or to behave professionally and should appropriately understand how to work with the nursing home population. Facility cannot disown the acts of staff since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. Review of facility policy on Dementia dated November 2016, reveals that under section Policy: Our main focus and the care of the resident with dementia is in functioning, not etiology or pathology. It is important to have a basic understanding of dementia and various origins and diagnosis that accompany it. However, the overall goal of our daily work is to improve its resident's function, regardless of the individual's physical and mental diagnosis. It is the responsibility of each staff member to have a sound general knowledge of what is pathologically, happening to the resident and how much medication and treatments affect them. We provide care with dignity, understanding and acceptance. Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Further review of Resident R1's clinical record revealed that Resident R1 had diagnoses of General Anxiety Disorder, Cognitive Communication Deficit, Vascular Dementia (a decline in cognitive abilities that impacts a person's ability to perform everyday activities. This typically involves problems with memory, thinking, and behavior), Unspecified Psychosis, Major Depressive Disorder. Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated October 24, 2023, revealed that the resident was assessed with a BIMS (Brief Interview for Mental Status) score of 2 which suggested that the resident had severe cognitive impairment. Continued review of the assessment revealed that the resident did not demonstrate any physical or verbal behavioral symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nurse Practitioner's note dated December 21, 2023, time stamped at 1:37 p.m. revealed that Pt (patient) in physical altercation on locked memory unit. Pt with significant cognitive impairment and is unable to make all needs clearly known. Answers with confused conversation. Vital signs stable. Scratch to right pointer finger, and redness noted to sternum. Tender to touch upon exam. No other apparent injuries. Plan: 1: monitor VS (vital signs) every shift x 24 hours, 2: neuro checks Every 4 hours x 24 hours, 3: monitor for change in behavior. Contingency Plan: obtain CXR (chest X-ray) if anything changes. Review of clinical nurses note dated December 21, 2023, time stamped at 1:44 p.m. revealed that a police officer arrived at the facility. The Director of Nursing, Employee E2 spoke with the police officer and informed him of the details of the incident. The police officer collected copies of all statements obtained and was provided a copy of the photos of resident's chest, arm and hand. Facility will continue to monitor resident's skin for any further discoloration or bruising that may occur. Review of clinical nurses note dated December 21, 2023, time stamped at 3:53 p.m. revealed that Resident R1 was S/P (status/post) physical altercation. At approximately 12 pm staff was preparing residents for lunch. Resident R1 was noted being resistive with staff when being redirected. A CNA (nurse aide) was observed forcefully pushing resident into the dayroom and down into the chair. Staff then observed CNA punch the resident in the chest. The incident was immediately reported to the DON (Director of Nursing) 911 (Emergency Medical Services) was called and adult protective services made aware. The unit manager and the nurse practitioner assessed resident and noted with redness to upper chest area and skin tear to left 4th finger. Area cleaned and treatment applied. Resident expressed pain to chest area on assessment. PRN (as needed) pain management given and tolerated well. Observation of the Unit-D layout conducted on December 28, 2023, at 10:50 a.m. revealed that the entrance to Unit D was locked and a code was needed to open the door. Further, there was a hallway leading from the entrance of the unit towards the nurse's station. Further, at an angle to the left, the hallway continues towards the far end of Unit D. Further observation revealed a day room (resident lounge) in front of the nurse's station and another room labelled Day Room was to the right next to the nurse's station. Observation of the facility's Video footage for Unit D conducted on December 28, 2023, at 12:38 p.m. with the Maintenance Director, Employee E6, revealed that there were two video footages covering Unit D (camera #1 and camera #2). Interview with the Maintencance Director, Employee E6 revealed that one camera (camera#1 was at the end of the hallway facing towards the nurse's station and the other camera (Camera #2) was located in front on the nurse's station facing the entrance of the Unit. Further, Employee E6 revealed that there was no camera in the resident's lounge in front of the nurse's station and that there was no camera in the dayroom located next to the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of the footage from Camera #1 located on the far end of Unit-D hallway, oriented towards the direction of the nurse's station revealed that on December 21, 2023, at: 12:07 p.m. a male employee wearing a blue top who was identified by Assistant Director of Nursing as nurse aide, Employee E4, was observed coming out of a room and walking down the hall (with his back from the camera and walking away from the camera) with Resident R1. Further observation revealed that Resident R1 was right in front of nurse aide, Employee E4 and Employee E4 was holding Resident R1's arm from behind and roughly handling him and pushing him causing him to stumble. Further, Resident R1 was observed, in a half-running pace with unsteady gait while nurse aide, Employee E4 was pushing him along. Nurse aide, Employee E4 and Resident R1 were eventually observed going into a doorway which was the resident lounge. Observation of the footage from Camera #2 located in front of the nurse's station oriented towards the entrance of Unit-D revealed that on December 21, 2023, at: 12:10 p.m., a female staff member identified by the Maintenance Director, Employee E6 as nurse aide, Employee E5 taking Resident R1 by the hand to the hallway. Nurse aide, Employee E5 then and left resident in front of the nurse's station and Employee E5 walked out of view of the camera. At 12:11 p.m , two females, one wearing a beige top (identified by Employee E6 as the Nursing supervisor, Employee E7) and one wearing a gray top with a black over coat and light blue pants walked into the unit and met Resident R1 in the hallway where Employee E5 left him. Both Employee E7 and the other female, stopped on front of the Resident R1. At 12:12 p.m., nurse aide, Employee E5 returned wearing blue gloves took resident to a room (Employee E6 identified the doorway as Resident R1's room) with Nursing supervisor, Employee E7. At 12:28 p.m., Employee E5 left the unit. At 12:39 p.m., DON (Director of Nursing) Employee E2 walked into the unit. At 12:47 p.m., Employee E2 and Employee E4 was observed leaving the unit. Based on the video footage nurse aide, Employee E4 was observed passing meal trays. Nurse aide, Employee E4 was on the D-unit from 12:10 p.m. to 12:47 p.m. Review of Nurse aide, Employee E5's written statement dated December 21, 2023, revealed that Employee E5 was in the Day Room (lounge). Nurse aide, Employee E4 came in with Resident R1 and Employee E4 was yelling at Resident R1. Nurse aide, Employee E4 sat Resident R1 in a chair and punched him in the chest. He then proceeded to say I will light you the F*** Up in here! Stop playing with me! Nurse aide, Employee E4 then walked out. Nurse aide, Employee E5 got up to take a minute to process what she had just witnessed. As Employee E5 walked past Resident R1, the resident flinched and put his hands over his face. Employee E5 noticed he was bleeding from his right hand and blood was all over Resident R1's pants. Employee E5 took Resident R1 to clean him up and Employee E5 bandaged Resident R1's hand up and informed the charge nurse of what she saw. Employee E5 then took a 10-minute break to collect her thoughts and bringing her anger down and reported the incident to the DON (Director of Nursing), Employee E2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Licensed nurse, Employee E8's witness statement dated December 21, 2023, revealed that at approximately at 11:30 a.m. on December 21, 2023, Employee E8 saw nurse aide, Employee E4 trying to guide Resident R1 out of the hallway into the day room by his arm. Resident R1 was screaming and resisting. Nurse aide, Employee E4 was trying to move Resident R1 so that the maintenance staff can move the beds. Employee E4 was able to get the patient inside the day room by holding him. A few minutes later Licensed nurse, Employee E8 saw nurse aide, Employee E5 coming out of the same day room, and she stated that the other nurse aide did something to Resident R1, but she was not specific. Resident R1 had blood on his pants. Nurse aide, Employee E4 walked past licensed nurse, Employee E8 and stated: There patients are acting new today because there's new stuff here. Like I won't F*** them up! Telephone interview with Nursing Supervisor, Employee E7 conducted on December 28, 2023, at 11:22 a.m. revealed that on December 21, 2023, at approximately 12:00 p.m. to 12:30 p.m. Employee E7 went out of the facility to get food. Further Nursing Supervisor, Employee E7 revealed that during her break at 12:37 p. m. Employee E7 received a call from the Director of Nursing instructing her to return to the facility because of the abuse incident. Employee E7 walked into the building at approximately 12:50 p.m. to 12:55 p.m. Employee E7 saw nurse aide, Employee E4 sitting in the nursing office. Further, interview with Nursing Supervisor, Employee E7 revealed that the abuse was not reported to her and that she didn't know about the abuse until Employee E2 called her and informed her about it. Telephone interview with Licensed nurse, Employee E8 conducted on December 28, 2023, at 1:01 p.m revealed that Employee E8 was working on Unit-D on December 21, 2023. Further Employee E8 revealed that he was on his first day of orientation on December 21, 2023, and that he didn't know the staff and residents. Further interview with Licensed nurse, Employee E8 revealed that he was not aware of what happened until the supervisor came to tell him. Further, Employee E8 revealed that nurse aide, Employee E5 did not report to him that a resident was abused by a staff member. Further Employee E8 revealed that he knew something happened because he can hear commotion but wasn't sure what it was. He did not witness nurse aide, Employee E4 hit Resident R1. Interview with Nursing Home Administrator, Employee E1 conducted on December 28, 2023, at 9:35 a.m. confirmed that nurse aide, Employee E4 struck Resident R1 on the chest on December 21, 2023, and that Employee E4 had since been terminated. Interview with Assistant Director of Nursing, Employee E3 conducted on December 28, 2023, at 9:55 a.m. confirmed that nurse aide, Employee E4 struck Resident R1 on the chest on December 21, 2023. Further Employee E3 also revealed that nurse aide, Employee E4 handled Resident R1 roughly and pushing Resident R1 while he was taking him to the lounge where Employee E4 was witnessed striking Resident R1 after. Further interview with Assistant Director of Nursing, Employee E3 revealed that Resident R1 sustained redness on his chest area. Further Employee E3 produced and showed surveyor a photo from Employee E3's telephone of a person's chest with redness on it. Employee E3 identified the photo as that of Resident R1's chest taken after Resident R1 was alleged struck by Employee E5 on the chest. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse aide, Employee E5 was called on December 28, 2023, at 10:17 p.m. via telephone to conduct a telephone interview. A message was left on Employee E5's voicemail requesting for her to return the call. No returned called was received. The above investigation revealed that Resident R1was verbally abused by nurse aide, Employee E4 as evidenced by Employee E4's using profane language directed towards Resident R1 as witnessed by Employee E5. Resident R1 was handled roughly by nurse aide, Employee E4 and was subsequently struck by Employee E4 in the chest. Resident R1 sustained injuries to the fourth finger on his right hand and chest area as evidenced by the redness observed during an examination following alleged physical abuse. Resident R1 also showed signs of pain to the chest area as evidence by tenderness of the area when touched during physical examination. Further, although Resident R1 was not able to communicate due to his cognitive deficits, Resident R1 showed signs of fear after the alleged physical abuse as evidenced by his reaction as described by nurse aide, Employee E5 in her witness statement as Employee E5 walked past Resident R1 the resident flinched and put his hands over his face. Based on the above findings, an Immediate Jeopardy was identified to the Nursing Home Administrator on January 4, 2024, at 9:15 a.m. for failure to ensure that a resident was free from verbal, physical and psychological abuse from a nursing staff. The Immediate Jeopardy template was provided to the Administrator and Director of Nursing on January 4, 2024 at 9:33 a.m. and an immediate action plan was requested. On January 4, 2024, at 3:54 p.m. the facility provided the following corrective action plan: Facility will ensure that all residents are protected from verbal, physical and psychological abuse. 1. The resident was immediately removed from the area and was taken to the day room across from the nurses station to be assessed for any injuries. Resident was medicated with pain medication as needed and left fourth finger skin tear was treated and bandaged. 2. DON was notified of abuse, she informed nursing staff to watch the perpetrator until assessment was completed. Perpetrator (nurse aide) was escorted off the unit and then escorted out of the facility and then terminated. Statements received from staff who witnessed the abuse incident as part of the investigation. 3. All staff will be educated on our abuse prevention policy prior to the start shift including recognizing and reporting of abuse. 100% education to all staff will be completed today 1-4-24 either in person or by phone. 4. All newly hired employees will attend general Orientation prior to working on the unit and are educated on abuse prevention and reporting abuse immediately. All new hires will be assigned to a mentor on the unit for 3 days and competency will be completed. No new hires since the occurrence on 12-21-23. 5. Agency staff receive orientation to include abuse training prior to the start of shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Complete House audit 100% conducted today 1-4-24 by nursing and social service department to ensure residents have not experienced abuse or any signs of physical or psychological abuse. 7. Random resident interviews/skin checks by social service or nursing staff will be conducted daily x1 week then weekly x 4 weeks and then monthly x 2 months. To ensure there are no signs of abuse. 8. Random staff will be given competencies prior to their shift to complete on Abuse Prevention/Reporting to ensure staff understand importance of abuse prevention and reporting. 9. Audits will be reviewed at Quality Assurance monthly by Nursing and Social Service to determine if further action is needed. On January 5, 2024, at 3:37 p.m. a second telephone interview was attempted with nurse aide, Employee E5 in regard to the incident that occurred with Resident R1 on December 21, 2023. Attempt was successful and Employee E5 stated that day she was working a double and she was inside of the day room that the resident watch television in. Employee E5 stated she was in the day room doing paperwork on her IPAD, because they bring in their own Ipad's to do paperwork as the facility computers are slow. Employee E5 stated that she heard some commotion in the hallway and she saw nurse aide Employee E4 come into the day room with Resident R1 and forcefully sat him down into the chair. Employee E5 stated that Employee E4 then began to doink Resident R1 in his head I will light you the F*** Up in here! Stop playing with me. Employee E5 stated she got up and said something to Employee E4 and Employee E4 started to pass out the lunch trays. Employee E5 then stated she got up to go to Resident R1 and he flinched and put his hands to his face. Employee E5 stated that she was able to talk with him and get him out of the day room. Once she got Resident R1 out of the day room she proceeded to talk the Resident R1 and she went to take him to the shower room to clean him off. Employee E5 stated Employee E7 was walking back and saw I was upset and stuff but I told her to give me a few minutes and Employee E7 said okay. Employee E5 stated she was in the shower room cleaning up Resident R1 and Employee E7 was initially outside the shower room door waiting for her. Employee E5 stated she was talking to Resident R1 to calm him down and bandaged his finger which took approximately twenty minutes. After coming out of the shower room Employee E5 stated Employee E7 was no longer there so she put Resident R1 in the other day room across from the nurse's station and asked Employee E8 to watch the resident. Employee E5 stated she then went upstairs to calm down after what she had just saw and as she was going to go outside Employee E23 asked what was wrong and said she would go report for me. I then went outside to cool down and a few minutes later the Director of Nursing Employee E2 and nurse aide Employee E23 came outside to get me. I then came back in and spoke to the Director of Nursing and wrote my statement. The implementation of the action plan was verified on January 5, 2024. Interviews conducted with facility staff from various department on January 5, 2024, reported they had all been in-serviced on the facility resident abuse prohibition policy, recognizing the signs of resident abuse, to whom to immediately report an allegation of resident abuse. The Immediate Jeopardy was lifted on January 5, 2023, at 4:08 p.m. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 47975 Based on a review of clinical records, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility to make certain that residents were protected from verbal, physical and psychological abuse from a nursing staff for one of four residents reviewed. (Resident R1) This failure resulted in an immediate jeopardy situation for Resident R1. Findings include: Review of the job description for the Nursing Home Administrator (NHA) state that the NHA is responsible to establish and maintaining systems that are efficient and effective to operate the nursing home in a manner to safely meet residents' needs in accordance with federal,state and local regulations. Develop and enforce a monitoring program to assure compliance with federal, state, and local requirements. Review of the job description for the Director of Nursing (DON) state that the DON functions as the administrative authority for the Department of Nursing. The Director will be responsible for the organization and oversight of all nursing operations and for the supervision of care for all residents at the facility. Review of Resident R1's clinical record revealed that Resident R1 had diagnoses of General Anxiety Disorder, Cognitive Communication Deficit, Vascular Dementia (a decline in cognitive abilities that impacts a person's ability to perform everyday activities. This typically involves problems with memory, thinking, and behavior), Unspecified Psychosis, and Major Depressive Disorder. Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated October 24, 2023, revealed that the resident was assessed with a BIMS (Brief Interview for Mental Status) score of 2 which suggested that the resident had severe cognitive impairment. Review of clinical nurses note dated December 21, 2023, time stamped at 3:53 p.m. revealed that Resident R1 was S/P (status/post) physical altercation. At approximately 12 p.m. staff was preparing residents for lunch. Resident R1 was noted being resistive with staff when being redirected. A CNA (nurse aide) was observed forcefully pushing resident into the dayroom and down into the chair. Staff then observed CNA punch the resident in the chest. The incident was immediately reported to the DON (Director of Nursing) 911 (Emergency Medical Services) was called and adult protective services made aware. The unit manager and the nurse practitioner assessed resident and noted with redness to upper chest area and skin tear to left 4th finger. Area cleaned and treatment applied. Resident expressed pain to chest area on assessment. PRN (as needed) pain management given and tolerated well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation revealed a written statement from Nurse aide, Employee E5's dated December 21, 2023, which indicated that Employee E5 was in the Day Room (lounge). Nurse aide, Employee E4 came in with Resident R1 and Employee E4 was yelling at Resident R1. Nurse aide, Employee E4 sat Resident R1 in a chair and punched him in the chest. He then proceeded to say I will light you the F*** Up in here! Stop playing with me! Nurse aide, Employee E4 then walked out. Nurse aide, Employee E5 got up to take a minute to process what she had just witnessed. As Employee E5 walked past Resident R1, the resident flinched and put his hands over his face. Employee E5 noticed he was bleeding from his right hand and blood was all over Resident R1's pants. Employee E5 took Resident R1 to clean him up and Employee E5 bandaged Resident R1's hand up and informed the charge nurse of what she saw. Employee E5 then took a 10-minute break to collect her thoughts and bringing her anger down and reported the incident to the DON (Director of Nursing), Employee E2. Continue review of facility document revealed Licensed nurse, Employee E8's witness statement dated December 21, 2023, which indicated that at approximately at 11:30 a.m. on December 21, 2023, Employee E8 saw nurse aide, Employee E4 trying to guide Resident R1 out of the hallway into the day room by his arm. Resident R1 was screaming and resisting. Nurse aide, Employee E4 was trying to move Resident R1 so that the maintenance staff can move the beds. Employee E4 was able to get the patient inside the day room by holding him. A few minutes later Licensed nurse, Employee E8 saw nurse aide, Employee E5 coming out of the same day room, and she stated that the other nurse aide did something to Resident R1, but she was not specific. Resident R1 had blood on his pants. Nurse aide, Employee E4 walked past licensed nurse, Employee E8 and stated: There patients are acting new today because there's new stuff here. Like I won't Fuck them up! Interview with Nursing Home Administrator, Employee E1 conducted on December 28, 2023, at 9:35 a.m. confirmed that nurse aide, Employee E4 struck Resident R1 on the chest on December 21, 2023, and that Employee E4 had since been terminated. Interview with Assistant Director of Nursing, Employee E3 conducted on December 28, 2023, at 9:55 a.m. confirmed that nurse aide, Employee E4 struck Resident R1 on the chest on December 21, 2023. Further Employee E3 also revealed that nurse aide, Employee E4 handled Resident R1 roughly and pushing Resident R1 while he was taking him to the lounge where Employee E4 was witnessed striking Resident R1 after. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview held on January 5, 2024, at 3:37 p.m. with nurse aide, Employee E5 in regard to the incident that occurred with Resident R1 on December 21, 2023. Employee E5 stated that day she was working a double and she was inside of the day room that the resident watch television in. Employee E5 stated she was in the day room doing paperwork on her IPAD, because they bring in their own Ipad's to do paperwork as the facility computers are slow. Employee E5 stated that she heard some commotion in the hallway and she saw nurse aide Employee E4 come into the day room with Resident R1 and forcefully sat him down into the chair. Employee E5 stated that Employee E4 then began to doink Resident R1 in his head I will light you the F*** Up in here! Stop playing with me. Employee E5 stated she got up and said something to Employee E4 and Employee E4 started to pass out the lunch trays. Employee E5 then stated she got up to go to Resident R1 and he flinched and put his hands to his face. Employee E5 stated that she was able to talk with him and get him out of the day room. Once she got Resident R1 out of the day room she proceeded to talk the Resident R1 and she went to take him to the shower room to clean him off. Employee E5 stated Employee E7 was walking back and saw I was upset and stuff but I told her to give me a few minutes and Employee E7 said okay. Employee E5 stated she was in the shower room cleaning up Resident R1 and Employee E7 was initially outside the shower room door waiting for her. Employee E5 stated she was talking to Resident R1 to calm him down and bandaged his finger which took approximately twenty minutes. After coming out of the shower room Employee E5 stated Employee E7 was no longer there so she put Resident R1 in the other day room across from the nurse's station and asked Employee E8 to watch the resident. Employee E5 stated she then went upstairs to calm down after what she had just saw and as she was going to go outside Employee E23 asked what was wrong and said she would go report for me. I then went outside to cool down and a few minutes later the Director of Nursing Employee E2 and nurse aide Employee E23 came outside to get me. I then came back in and spoke to the Director of Nursing and wrote my statement. Interview held on January 5, 2024 at 2:46 p.m with nurse aide, Employee E23 in regards to the incident that occurred on December 21, 2023. Employee E23 stated that she saw nurse aide, Employee E5 come off the floor through the doors and she looked teary eyed like she had been crying. I asked her what was wrong, and she told me that she had witnessed a staff member punch a resident in the middle of their chest. Employee E5 told Employee E23 she was on her fifteen-minute break sitting behind the door doing her paperwork and nurse aide, Employee E4 didn't know she was behind door on her break. Employee E5 told Employee E23 she heard Employee E4 talking rudely to Resident R1 and then she saw him punch in the middle of the chest. Employee E23 stated after she heard this she went from the pantry area where she was getting ice and went and told the Director of Nursing. The Director of Nursing, Employee E2 and Employee E23 then went outside to get Employee E5. They walked back into the building and as walking back in Employee E5 went into the office with the Director of Nursing. Employee E23 then stated she went back to her unit and continued to care for her residents. Based on the deficiencies identified in this report, the NHA and DON failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate Jeopardy situation. Refer to F600. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 201.18(d) Management (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(b) Resident care policies 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services