

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Meadowview Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</b></p> <p>Based on review of facility policy, review of facility documentation, review of clinical records, observations, and staff interview, it was determined that the facility failed to maintain appropriate supervision for two of three residents reviewed (Resident R1 and R6).</p> <p>Findings Include:</p> <p>Review of facility policy Suicide Prevention, reviewed September 2023, revealed it is the policy of the facility to ensure that residents who voice and/or display suicidal ideation actions receive services and interventions to help them manage feelings and maintain their psychosocial wellbeing. Procedure includes implement 1:1 oversight until resident does not exhibit any suicidal ideations. Place resident on close observation as needed after 1:1 observation determined not needed.</p> <p>Review of Resident R1's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 29, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS - assessment used to monitor cognition) score of 12 (can range from 0 to 15 - indicating moderate cognitive impairment). Further review of the MDS revealed Resident R1 had a diagnosis of depression (mood disorder that causes persistent feeling of sadness and loss of interest).</p> <p>Review of Resident R1's clinical record revealed the resident was assessed by Employee E3, Nurse Practitioner, on April 29, 2024. Review of documentation by Employee E3, Nurse Practitioner, revealed Resident R1 expressed suicidal ideation stating, feels like I have been waiting forever for my eye doctor appointment . if I can't get this taken care of soon, I will commit suicide.</p> <p>Further review of Resident R1's clinical record revealed the resident was thoroughly evaluated by Employee E3, Nurse Practitioner, and Employee E4, Psych Nurse Practitioner, who determined Resident R1 would be on 1:1 supervision.</p> <p>Review of Resident R1's physician order summary revealed an order dated April 29, 2024, for 1:1 supervision.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility documentation reported to the Pennsylvania State Survey Agency dated May 1, 2024, revealed on April 30, 2024, Resident R1 was taken to the [hospital] emergency room via facility van and facility van driver, Employee E5. Per facility documentation Resident R1 was brought into the triage area by van driver, Employee E5, where Resident R1 was left awaiting intake from emergency room staff.</p> <p>Continued review of facility documentation revealed the van driver, Employee E5, returned to the van in the parking lot area after leaving Resident R1 in the triage area. Shortly thereafter the van driver, Employee E5, observed Resident R1 walking out of the hospital doors. The van driver, Employee E5, subsequently approached Resident R1 who refused to return to the hospital.</p> <p>Interview on May 10, 2024, at 11:00 a.m. with van driver, Employee E5, revealed the employee could not recall if information was relayed that Resident R1 was on 1:1 supervision prior to taking Resident R1 to the hospital. Van driver, Employee E5, revealed Resident R1 was left in the triage area waiting to be admitted to the hospital.</p> <p>Further interview with van driver, Employee E5, confirmed Resident R1 was not handed off to a staff member before leaving Resident R1 in the triage area of the hospital to ensure the 1:1 supervision was maintained.</p> <p>Review of Resident R6's 5-day MDS dated [DATE], revealed the resident had a BIMS of 10 (indicating moderate cognitive impairment) and diagnoses of anxiety (a feeling of worry, nervousness, or unease), schizophrenia (severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal), and depression.</p> <p>Review of Resident R6's care plan revised January 22, 2024, revealed Resident R6 was prescribed medication related agitation, mood, and behaviors. Behaviors include suicidal ideations. Intervention dated November 18, 2023, included 1:1 supervision at all times.</p> <p>Review of Resident R6's physician order summary revealed an order dated March 28, 2024, for 1:1 for behaviors.</p> <p>Interview on May 10, 2024, at 12:05 p.m. with Licensed Nurse, Employee E6, revealed Resident R6 should be on 1:1 supervision. Subsequent observations with Licensed Nurse, Employee E6, revealed Resident R6 was in her room alone without 1:1 supervision.</p> <p>28 Pa Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		