

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  06/10/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</b></p> <p>Based on observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, homelike environment on three of five nursing units(A, B, E Nursing Units) E unit shower room.</p> <p>Findings include:</p> <p>Facility Policy titled Bathroom Cleaning unknown date, indicated under option 5 clean and sanitize toilet (including raised toilet seats) using infectable cleaner.</p> <p>Facility Policy titled Resident's Room Cleaning unknown date, indicated to provide a detailed description of the steps that are to be completed daily in the cleaning of a resident room. Daily cleaning will ensure optimum levels of cleanliness and sanitation, prohibit the spread of infections and bacteria, and maintain the outward appearance of the facility.</p> <p>Observation of facility B nursing unit on June 5, 2024, 10:22 a.m. revealed the following observations,</p> <p>In room B 101 there was CPAP (a respiratory equipment) tubing on the floor.</p> <p>In room B 106 there was dried brown substance on the floor, it appeared like dried tube feeding which was hanging right above. Interview with Employee E28, Housekeeper stated the substance was dried tube feeding at it was there from 6/4/24. She stated it was hard for her to remove when she cleaned the area on 6/4/24. Interview with Housekeeping Director, Employee E25, stated the substance could be removed using chemical and he would remove it right away.</p> <p>Observation of room B 118 revealed there was strong odor appeared like urine inside the room and at the doorway next to the room. Observation made inside the room revealed that there were no sheets on the bed. There was linen, tissue, and food particles on the floor.</p> <p>Observation of room B 113 revealed that there were two oxygen concentrators inside the room one undated and one dated March 2024 next to the window side, food particles, paper towel on the floor, dirty cloths on the chair and open hamper with lid on the chair.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On June 5, 2024, at 10:45 an interview was held with Resident R202 who reported that her toilet had yellow brown stains inside the toilet, and it has not been cleaned up since her admission. The shower room is like a storage with briefs and other equipment, briefs are stored in moist environment.</p> <p>On June 5, 2024, at approximately 10:59 a.m. observation was taken place with license unit manager, Employee E3 confirmed the following observations in shower room on the E unit indicated 3 shower stalls. The shower stalls and shower room were used as storage and only one stall was available for shower use . The second stall was packed with 2 resident's trays, unknown random resident's clothing was stacked up, extra wheelchair rests on the floor, and 3 compartments laundry bins, the third stall had a Hoyer lift with wheelchair rest observed on the grown and extra shower chairs. Next to the sink there was approximately 20 boxes of different size briefs stacked up on the floor exposed to shower steam. Then it had shelf with additional brief that were open and unprotected from the showers steam. The shower sink had two shower chairs which was blocking the entrance to the sink. Sink also had extra hygiene body washes stored on the top of the sink.</p> <p>On June 5, 2024, at 12:07 interview with Resident R524 revealed that she did not have a chair in her room to sit. Also, there was a need of a crab bar inside her bathroom on the wall when she transitions from wheelchair to the toilet that she would have stability and safety.</p> <p>On June 5, 2024, at 12:16 p.m. interview with Resident R 212 revealed that his toilet was stained with yellow, orange and brown drains, the bathroom sealing had cracks, and bathroom light was flickering.</p> <p>On June 5, 2024, at 12:34 p.m. a regional maintenance director, Employee E6 with Housekeeping Director, Employee E25 confirmed the stained toiles and reported the stains are from a water what does not have a softer and used a rock cleaning supply to brush and removed the toilet stain. The following rooms were identified to have the same issue of yellow, orange and brown stains in the toilet: room [ROOM NUMBER]. 520, 513, 511, 510, 504.</p> <p>28 Pa. Code: 201.29(j)(k) Resident rights.</p> <p>28 Pa. Code: 207.2(a) Administrator's responsibility.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on review of facility policies and documentation, clinical record review and interviews with staff, it was determined that the facility failed to ensure a resident was free from misappropriation related to missing medication for one of 35 residents reviewed (Resident R205).</p> <p>Findings include:</p> <p>Review of facility policy, Abuse Policy - Prevention and Management dated reviewed September 2023, revealed, 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. Continued review revealed, Examples of misappropriation of resident property include . Diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain.</p> <p>Review of facility policy, Narcotic Management dated revised July 1, 2023, revealed, Control/schedule II-V medication will be counted with two professional nurses at the beginning and end of each shift. Documentation that a count was completed and accurate will be completed at the beginning and end of each shift. Control/schedule II-V medications will be logged into a bound book or separate master index page once received from the pharmacy as well as individual countdown records. Any discrepancy in a shift to shift narcotic count must be immediately communicated to the Director of Nursing. Continued review revealed, If a controlled medication is to be destroyed, complete the medication destruction section of the page and dispose of per facility policy. The master index must also reflect the destruction of the medication and is no longer part of the narcotic count. Two nurses must be involved in the destruction of a controlled substance. Further review revealed, Records of personnel access, usage and disposition of all controlled medications with sufficient detail to allow reconciliation (e.g. the MAR [Medication Administration Record], proof-of-use sheets, or declining inventory sheets), including destruction, wastage, return to the pharmacy/manufacturer, or disposal will be maintained in accordance with applicable State requirements.</p> <p>Review of Resident R205's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool) dated November 1, 2023, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids) and respiratory failure (not enough oxygen passes from your lungs to your blood). Continued review revealed that the resident had frequent pain and received pain medications on an as needed basis.</p> <p>Review of Resident R205's care plan, dated initiated November 14, 2023, revealed that the resident has pain, with interventions including to administer pain medication as prescribed and evaluate the effectiveness of pain interventions.</p> <p>Review of physician's orders for Resident R205 revealed an order, dated November 13, 2023, for oxycodone (opioid pain medication) 5 m.g (milligram) tablets, give one tablet by mouth every four hours as needed for pain.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Medication Administration Records for Resident R205 for December 2023 revealed that there were no documented doses of oxycodone administered on December 24, 2023. Continued review revealed that one dose of oxycodone was documented as administered on December 25, 2023, at 10:31 a.m. and the next dose of oxycodone was documented as administered on December 26, 2023, at 3:24 p.m.</p> <p>Review of facility documentation submitted to the Department of Health on December 28, 2023, revealed that on December 26, 2023, a licensed nurse discovered a discrepancy with Resident R205's oxycodone medication. The resident received a dose on December 25, 2023, at 2:30 p.m. by the assigned licensed agency nurse leaving an end count of 102 tablets. The narcotic sign out page was X'd out and transferred to another page with a count of only 73 tablets leaving a discrepancy of 29 tablets. On the new page, doses were signed out on December 25, 2023, at 6:00 p.m. and 10:00 p.m. and on December 26, 2023, at 2:00 a.m. by another licensed agency nurse. The facility notified the local police and Adult Protective Services of the drug diversion.</p> <p>Review of the Narcotic Shift Count Record revealed that on December 24, 2023, there was no signature from the nurses who came on duty for the day (7 a.m. to 3 p.m.) and evening (3 p.m. to 11 p.m.) shifts, as well as no signature from the nurses who went off duty for the evening and night (11 p.m. to 7 a.m.) shifts. Continued review revealed that on December 25, 2023, there were no signatures from any of the nurses who came on duty for all shifts (day, evening and night) that day, as well as no signatures from the nurses who went off duty for the evening and night shifts. Further review revealed that on December 26, 2023, there was no signature from the nurse who went off duty for the day shift.</p> <p>Review of Narcotic Inventory Records for Resident R205 revealed that 119 tablets of oxycodone 5 m.g tablets were received, however, the date of the receipt was not documented. The first dose was documented as administered on December 12, 2023, at 11 a.m. Continued review revealed that on December 24, 2023, doses were administered at 9 a.m. and 3 p.m. by Employee E12, licensed nurse. Continued review revealed that on December 25, 2023, doses were administered at 9 a.m. and 2:30 p.m. by Employee E13, licensed agency nurse. The medication count on the page after the 2:30 p.m. dose was administered was 102 tablets. Further review revealed that a large X was written on the page, with a note indicating Rewritten. There was no indication that the medication was reordered, discontinued or destroyed, nor which page the medication was transferred to. There was no indication why the inventory record was rewritten.</p> <p>Continued review of Narcotic Inventory Records for Resident R205 revealed a new page for the resident's oxycodone 5 m.g medication was initiated on December 24, 2023. The record noted that on December 24, 2023, 73 tablets were received. Continued review revealed that on December 25, 2023, doses were administered at 6:00 p.m. and 10:00 p.m. and on December 26, 2023, at 2:00 a.m. by Employee E14, licensed agency nurse.</p> <p>Review of facility documentation revealed a statement written by Employee E13, licensed agency nurse, dated December 27, 2023, which stated, On Christmas day 12/25/23, I worked 7-3 on C wing and 3-11 shift on E wing. At the end of the first shift, I took the keys with me to get signed out. I came on the C wing unit and saw only one nurse [Employee E15, licensed nurse] and she agreed to count me out. I gave her report, she counted me out, agreed the count was correct and took the keys. I then worked 3-11 p.m. on E wing. We counted out at about 2:15 p.m. and that was the last I was on C wing.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility documentation revealed a statement written by Employee E15, licensed nurse, dated December 28, 2023, which stated, On December the 25th, I worked 3-11 p.m. on C wing. I counted with the leaving nurse [Employee E13, licensed agency nurse] who worked 7-3 p.m., the count was okay (fine). Around 4 p.m. when the nurse on duty [Employee E14, licensed agency nurse] come and ask me for the keys. I asked her are you the nurse? She says yes. She asked me if I counted already? I said yes I counted but we still need to count together. She says I'm okay you don't need to count with me. I said we have to count, and she repeat again, I'm fine you don't need to, and I handle to her the keys. After that I don't know anything until I went home.</p> <p>Review of facility documentation revealed a statement written by Employee E14, licensed agency nurse, dated December 28, 2023, which stated, I arrived late to shift on Christmas Day from another facility. I was told to go to C wing, Front Hall. I immediately started my med pass. I worked beside a nurse [Employee E15, licensed nurse]. She gave me the keys to the cart. Everything appeared to be fine. Continued review revealed that Resident R205 requested pain medications at 6 p.m., 10 p.m. and 2 a.m. and that Employee E14, licensed agency nurse, administered the medication to the resident at those times. Employee E14, licensed agency nurse, stated that she was unable to document the medication administration in the electronic medical record or medication administration record because the computers were cutting off and glitchy. Employee E14, licensed agency nurse, stated that, When the 7-3 nurse came in and we were counting the meds I stopped on this page and showed her that this resident was requesting his pain med every 4 hours and that I gave 3 doses during the 14 hours I was on the floor and I showed her when I gave the last dose. The reason I did this is because it was not charted in PCC [electronic medical record] because it was either freezing or I was booted out of the system so I wanted her to know the doses I gave were documented in the narc book.</p> <p>Review of facility documentation revealed a statement written by Employee E12, licensed nurse, undated, which stated, On December 26, 2023, I came in at 07:00 and did narcotics count with the night shift nurse. The count was correct. I began my shift and medication pass at around 10:00 a.m. [Resident R205] asked for his PRN [as needed] oxycodone, when I went in to get it I noticed that there was a new page created for him and the old page was crossed out. On December 24, 2023, I gave [Resident R205] his PRN oxycodone and when I counted with 3-11 nurse the count was at 104 tab left and when I looked on the new page on December 26 it was 73 tabs left when I noticed it. I immediately alerted my unit manager that the tablets were missing.</p> <p>Interview on June 7, 2024, at 10:10 a.m. the Nursing Home Administrator confirmed that the licensed nurses, including Employees E12, E13 and E14, did not follow proper policies and protocols regarding shift counts, narcotic inventory logs, medication administration documentation and proper handling of narcotic medications.</p> <p>28 Pa Code 201.18(b)(2) Management</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based on review of clinical records, facility policies and procedures, and interviews with staff, it was determined that the facility failed to conduct a complete and thorough investigation of an alleged violation for one of 35 residents reviewed. (Resident R81).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Reporting and Investigation dated, [DATE], revealed, . The Administrator, Director of Nursing, and Risk Manager, if applicable are responsible for Investigation and reporting. Upon receiving an incident or suspected incident of resident abuse, Neglect, misappropriation of resident property, or injury of an unknown source, the Administrator/DON/designee will conduct an investigation to include but not limited to the Following: Complete paperwork for investigation of abuse, neglect, misappropriation;</p> <p>Interview the person(s) reporting the incident;</p> <p>Interview any witnesses to the incident;</p> <p>Interview the resident, if able;</p> <p>Interview the resident ' s attending physician and review of the resident ' s record;</p> <p>Interview staff members (on all shifts) having contact with the resident during the period of The alleged incident;</p> <p>Review of facility investigation dated [DATE] from Register Nurse (RN) Employee E26 stated a nursing aide stated Resident R81 was in his room in bed and then she observed the resident rushing into the dining room because it was mealtime. When resident went into the dining room, he was observed by staff taking food from another resident's tray which was not his diet. Staff instructed resident to stop and slow down. Staff stated that the resident just kept shoving food in his mouth and when the staff attempted to approach him, he got up and slipped on the food that he dropped on the floor. The resident fell into the table he was sitting at and hit his head falling to the floor. Nursing staff was in dining room and responded and observed him turning cyanotic. RN who was present did an abdominal thrust causing resident to vomit the rest of food he had in his mouth. Staff stated resident vomited again and RN called 911. The resident was assessed with a laceration to his head. When 911 arrived, the resident was back to his baseline. The resident was transferred to the hospital diagnosed with aspiration pneumonia,</p> <p>Further review of the investigation revealed a witness statement by Employee E26 indicating she was the assigned charge nurse and during dinner stated the resident stood up with a mouth full of food and slipped and started choking. The nurse stated the resident needed to be revived and sustained a laceration to his eye. Witness statement from Licensed Practical Nurse (LPN) who was sitting at the nurses' station observed Resident R81 in the dining room Stuffing his mouth with food. The LPN statement stated that when the resident stood up and fell to the floor, This nurse assisted with CPR.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continue review of the investigation revealed the facility did not obtain further statements or conduct interviews with other staff present during dinner when the incident occurred.</p> <p>Interview with the Nursing Home Administrator(NHA) on [DATE]. at approximately 10:00 a.m. could not provide any additional documents at that time related to the facility's investigation. In addition, the Nursing Home Administrator indicated most were from agency nursing and no longer work at the facility.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on clinical record reviews, review of facility policies and staff interviews, it was determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed according to the resident assessment for two of three residents reviewed related to PASRR assessments (Residents R25 and R208).</p> <p>Findings include:</p> <p>The PASRR (Preadmission Screening Resident Review) was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability.</p> <p>The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASRR evaluation must be completed if the Level 1 PASRR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate.</p> <p>Review of facility policy, Social Service assessment dated revised February 6, 2024, revealed, Social Services is responsible for the Level 1 screening process . The PASRR Level 1 form is completed by the nursing facility, the hospital or the Area Agency on Aging office no later than the day of admission . Nursing facilities are responsible to make sure the form is filled out correctly at the time of admission.</p> <p>Review of Resident R25's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 6, 2023, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including bipolar disorder (also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior) and psychotic disorder (mental illness associated with loss of contact with reality).</p> <p>Review of Resident R25's PASRR Level 1 assessment, dated August 31, 2023, revealed that the resident did not have any serious mental illnesses listed on the assessment. Continued review revealed that the assessment was signed as completed by staff from the nursing facility.</p> <p>Review of Resident R208's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including schizophrenia (mental illness associated with loss of reality contact, delusions and hallucinations).</p> <p>Review of Resident R208's PASRR Level 1 assessment, dated February 29, 2024, revealed that the resident did not have any serious mental illnesses listed on the assessment. Continued review revealed that the assessment was signed as completed by staff from the nursing facility.</p> <p>(continued on next page)</p>		

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F 0645  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Interview on June 7, 2024, at 11:32 a.m. Employee E10, Director of Social Work, confirmed that the PASRR Level 1 assessments for Residents R25 and R208 were not completed accurately and that the assessments should have included that the residents had diagnoses of serious mental illnesses.  28 Pa. Code 201.8(b)(1) Management  28 Pa. Code 201.8(e)(1) Management  28 Pa. Code 211.10(a) Resident care policies		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41471</p> <p>Based on the review of facility policy, review of clinical records and interview with staff, it was determined that the facility did not develop a baseline care plan for a newly admitted residents with history of drug abuse for one of 35 residents reviewed. (Resident R527)</p> <p>Findings Include:</p> <p>Review of clinical record for Resident R527 revealed that the resident was admitted to the facility on [DATE], with diagnosis including opioid abuse, psychoactive substance abuse and schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>Review of a physician progress note for Resident R527 dated March 5, 2024 revealed that the resident had history of opioid( heroin) abuse.</p> <p>A review of baseline care plan for Resident R 527 dated March 4, 2024, revealed that there was evidence that the facility developed a care plan with intervention for drug abuse and behavioral concerns.</p> <p>Continued review of baseline care plan under social service section revealed that the mental health needs, social service needs, behavioral concerns and social service goals were not completed.</p> <p>Interview with Employee E29, Assistant Director of Nursing, on June 10, 2024, confirmed that the there was no baseline care plan developed and interventions implemented for Resident R527 for drug abuse concerns.</p> <p>28 Pa. Code 211.11(a)(d) Resident care plans</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</b></p> <p>Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure a comprehensive resident care plan was developed and implemented related to adaptive equipment required for swallowing liquids properly (Resident R40) and failed to implement care and services identified on a comprehensive care plan regarding unwanted behaviors and mealtime (Resident R81) for two of 35 residents reviewed.</p> <p>Findings include:</p> <p>Review of facility policy titled Care Planning Process and Care Conference last revised [DATE], indicated that the care plan is a working tool that provides a profile of the needs of the individual resident/patient; the resident/patient care plan will be available for use by staff caring for the resident. The interdisciplinary team will meet within 21 days of admission, readmission, when a change of condition occurs and annually to develop the comprehensive, resident centered plan of care for each resident. Once the initial MDS is completed, the Clinical Reimbursement Specialist will initiate any care plan triggered by a CAA. Each care plan need/problem must have a goal and interventions to address the need of the resident/patient. Realistic target dates should be established to meet goals.</p> <p>Review of resident R 40's clinical record revealed that resident R40 had diagnosis's of Type 2 diabetes (long term medical condition which the body does not use insulin properly, resulting in unusual blood sugar levels), obesity, Barrett's esophagus with dysplasia,(a change in the lining of the esophagus, the cells are muted into precancerous state and indicate disease), panic disorder (a type of anxiety disorder), cardiomegaly(enlarged heart), depression (mood disorder that causes persistent feeling of sadness), chronic kidney disease(gradual loss of kidney function) and schizoaffective disorder(mental health condition characterized by symptoms of hallucinations or delusions), perforation of intestine ,major depressive disorder, gastro esophageal reflux disease (condition in which the stomach acid move up into the esophagus), bi polar disease(mood disorder that caused intense mood swings).</p> <p>Review of resident Minimum Data Set (MDS A periodic assessment of resident care needs) dated [DATE], indicated Brief interview for mental status (BIMS) indicated Resident R 40 had a score of 13 (measured , d+[DATE], 15 being cognitively intact) .</p> <p>Further review of resident R 40 clinical record speech therapy plan of care notes dated [DATE], revealed that resident R 40 has had increased signs and symptoms of aspiration while using a straw. The speech therapist employee E 17 recommendation no straws for this resident.</p> <p>Review of resident R 40's clinical record physician orders, revealed an order dated [DATE], declaring no straws with thin liquids for this resident.</p> <p>Interview with speech therapist Employee E 17, on [DATE], at 09:25 a.m. revealed that she had assessed resident R 40 and determined that resident R 40 was at risk for aspiration and recommended no straws for thin liquids.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident care plan revealed no documented evidence of a person-centered comprehensive care plan was developed related to the care and management of residents R 40 swallowing difficulties.</p> <p>Observation of resident R 40 [DATE], at 10:06 a.m., revealed the resident coughing while drinking orange juice from a straw. Further observation during this this time noticed was a clear sign above the resident bed stating NO STRAWS. The above observation was confirmed but unit manager E 21.</p> <p>Interview with speech therapist Employee E 17 at time of the above observation confirmed that resident R 40 was not allowed to have a straw. Employee took the straw from resident R 40 and stated that it was unknown where or how he received the straw.</p> <p>Review of Resident R81 clinical record revealed the resident was admitted in [DATE] diagnosed with anxiety, depression and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), psychosis severe cognitive impairment and poor safety awareness.</p> <p>Review of Resident R81 physician orders dated [DATE] revealed the resident was ordered a pureed texture diet requiring 1:1 for all meals secondary to poor safety, staff to cue for small bites at a slow pace and aspiration precautions.</p> <p>Review of Resident R81 clinical record revealed the resident was care planed for his agitation, mood and behaviors that included wandering on the unit, running down the halls, not following direction, stealing other resident's food, and ambulating and transferring without assistance. Interventions iniated on [DATE], involved reassuring and redirecting the resident instructing resident not to steal other resident's food that are not consistent with the resident's diet of puree foods, Staff will provide 1:1 supervision during mealtime, Staff will remove resident from common area during meal times to ensure that resident does not steal other resident's food.</p> <p>Review of clinical nursing note dated [DATE], from Registered Nurse Employee E26 revealed Resident R81 Rushed into the dining room started eating food from other resident's tray, His tray was then placed in front of him and he started spooning the food in his mouth non-stop without swallowing. One of the staff, noticed how fast he was eating kept telling him to slow down and swallow, but the resident did not comply. The resident stood up and slipped on the food he had spilled and banged his face on another resident's table and started choking. The same note indicated the resident became cyanotic and the nurse Employee E26 and Licensed Practical Nurse Employee E27 were able to revive him. The resident was assessed with a laceration on the top on of the right eyelid, 911 was called and the resident was transferred to the hospital diagnosed with aspiration pneumonia.</p> <p>Interview with the Nursing Home Administrator on [DATE]. at approximately 10:00 a.m. could not recollect the details of the incident and Employee E26 no longer worked at the facility to interview. The NHA stated the care plan's interventions were for mealtime and during the incident Employee E26 was in the dining room to feed the resident but before that could occur the resident was showing behaviors enabling the nurse to properly feed him.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</b></p> <p>Based on clinical review, staff interviews and medication manufacture's medication insert, it was determined the facility failed to ensure care and services were provided in accordance with professional standards of practice for one of 35 residents reviewed (resident R 96) regarding proper medication order.</p> <p>Findingsinclude:</p> <p>The Pennsylvania Code, Title 49, Chapter 21 physician assistant and certified registered nurse practitioners. Profession, and vocational standards, Standards, subpart A Chapter 18 The State Board of Medical Practitioners other than medical doctors, indicates that a CRNP(certified nurse practitioner) with prescriptive authority approval may, when acting in collaboration with a physician as set forth in a prescriptive authority collaborative agreement and within the CRNP's specialty, prescribe and dispense drugs and give written or oral orders for drugs and other medical therapeutic or corrective measures. These orders may include: orders for drugs, total parenteral nutrition and lipids, in accordance with S S 21.284 and 21.285 (relating to prescribing and dispensing parameters; and prescriptive authority collaborative agreements).</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that a non-physician practitioner, maintained professional standards of quality care for one resident receiving an antidiabetic medication. (Resident R 96)</p> <p>Review of resident R96 clinical record revealed that this resident was admitted to the facility on [DATE] with diagnosis of bipolar disorder(a mental disorder that causes unusual shifts in a person's mood), right knee osteoarthritis(also known as degenerative joint disease, loss of cartilage), cognitive communication deficit/9attention, concentration and communication difficulty) ,peripheral vascular disease (disease that occurs in the leg veins causing blood to pool in the legs),left leg above knee amputation ,hypertension(high blood pressure),anxiety(disorder of persistent worrying), major depression(mood disorder that causes a persistent feeling of sadness),</p> <p>Review of Resident R 96's progress notes/physician notes dated May 15, 2024, revealed that patient seen by requests for concerns of weight. Resident blood sugar 260. Morning labs blood sugar 350. Accu check 250. Patient would like medication to help with weight loss. A1c is 6.4 Ozempic ordered low dose 2 mg every Thursday, counseled patient about seeing endocrinology. Written by non-physician practitioner, Employee E 18.</p> <p>Further review of Resident R 96 progress note/ physician note signed by non-physician practitioner Employee E 18 on May 16, 2024, revealed patient seen today by request of rn for medication clarification on Ozempic : ordered Ozempic 2 mg every Thursday on 5/15 due to patient hgb a1c 6.4 and having a hard time losing weight, RN wants clarification on how to administer dose for Ozempic, medication education given to unit manager and RN, patient is on 2mg which is low dose, injection pen comes in low concentration warranting for injections to meet the total dose of 2mg weekly. Called pharmacy to see if there is a higher concentration pen available.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of resident R96's progress notes indicate that on May 16, 2024, resident R96 received first dose of Ozempic 2 mg at 3:15 pm. Resident expressed pain during administration of medication.</p> <p>Further Review of Resident R96 clinical record revealed a physician note signed by Employee E 18 on May 17, 2024, revealed that the patient seen today for follow up of first dose of Ozempic given, during eval patient offers complaints of nausea. LOWERED DOSE TO 0.25 , Zofran ordered.</p> <p>Review of The Manufacture, Novo Nordisk, of Ozempic, (semaglutide )Novo Nordic medication insert for the drug Ozempic revealed that the current dosage are injections 0.5, 1mg and 2mg an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes.</p> <p>Continued review of the manufacture instruction revealed the Dosage and administration is to administer once weekly at any time of day with or without meals. Start at 0.25 mg once weekly. After four weeks increase dose to 0.5 mg once weekly.</p> <p>If additional glycemic control is needed, increase the dosage to 1 mg once weekly after at least four weeks on the 0.5 mg dose.</p> <p>If additional glycemic control is needed, increase the dosage to 2 mg once weekly only after at least four weeks on the 1 mg dose.</p> <p>In the event of an overdose. Appropriate supportive treatment should be initiated according to the patients' clinical signs and symptoms. Consider calling poison Help Line or a medical toxicologist for additional overdosage management recommendations. A prolonged period of observation and treatment may be necessary, taking into account the long half-life (a drugs half-life estimates the time it takes an initial concentration of the medication to be reduced by half in the body) of Ozempic of approximately of one week.</p> <p>Interview with Employee E 18 on June 7, 2024, at 11:21a.m., confirmed that she mistakenly ordered the wrong dose for the resident.</p> <p>28 Pa. Code 201.18(a)(1) Management</p> <p>28 Pa. Code 211.2(d)(10) Medical director</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39344</p> <p>Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that physician orders were followed related to insulin for two residents (Residents R6 and R42) and adaptive equipment for one resident (Resident R40) of 35 residents reviewed.</p> <p>Findings include:</p> <p>Review of facility policy, Diabetes Mellitus, Guidelines for dated reviewed June 2023, revealed, Glucose monitoring guidelines: Blood sugar level and frequency measured when ordered . Facility protocol in place for physician notification with specific parameters for notification.</p> <p>Review of facility policy, Medication Administration/Disposition dated revised September 6, 2023, revealed, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the corresponding code on the EMAR [electronic medication administration record] to indicate the medication was not given and the reason for not administering.</p> <p>Review of Resident R6's care plan, dated initiated January 13, 2024, revealed that the resident has diabetes (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose). Goals include for the resident to have blood sugars within the physician's acceptable range. Interventions include to administer diabetes medications as ordered, administer insulin as ordered, and to monitor, document and report any signs of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar).</p> <p>Review of active physician orders for Resident R6 revealed an order, dated January 13, 2024, for aspart insulin (rapid acting medication used to lower blood sugar levels) inject as per sliding scale subcutaneously (under the skin) with meals and to notify the physician for blood sugar levels above 400. Continued review revealed another order, dated January 13, 2024, for glargine insulin (long-acting medication used to lower blood sugar levels) inject 20 units subcutaneously in the evening.</p> <p>Review of blood sugar levels for Resident R6 revealed that on May 13, 2024, at 9:41 p.m. the resident's blood sugar was 413 mg/d (milligrams per deciliter). Continued review revealed that on May 20, 2024, at 8:40 p.m. the resident's blood sugar was 459 mg/dL.</p> <p>Review of progress notes for Resident R6 revealed that no documentation was available for review at the time of the survey to indicate if the physician was notified of the resident's elevated blood sugar levels.</p> <p>Review of Resident R42's care plan, dated initiated August 7, 2019, revealed that the resident was at risk for complications related to being non-compliant with diagnosis of diabetes. Interventions include to administer diabetic medications as prescribed and to check the resident's blood sugar levels for signs and symptoms of hyperglycemia or hypoglycemia and to notify the physician if the resident's blood sugar levels are less than 70 or greater than 400.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician orders for Resident R42 revealed an order, dated December 9, 2021, to check the resident's blood sugar level as needed for signs and symptoms of hyperglycemia or hypoglycemia and to call the physician if less than 70 or greater than 400. Continued review revealed an order, dated December 9, 2021, to obtain the resident's blood sugar level before breakfast for monitoring and to call the physician if less than 70 or greater than 400. Further review revealed an order, dated February 29, 2024, for Levemir insulin (long-acting medication used to lower blood sugar levels) inject 25 units subcutaneously at bedtime.</p> <p>Review of Medication Administration Records (MARs) for May 2024, for Resident R42 revealed that the resident's Levemir was not administered on May 30, 2024, and documented as Hold/See Nurse Notes.</p> <p>Review of EMAR notes for Resident R42 revealed a note, dated May 30, 2024, at 9:08 p.m. which stated that the medication was held and that the resident's blood sugar was 167.</p> <p>Further review of progress notes revealed that there was no documentation available for review at the time of the survey to indicate why the medication was held or if the physician was notified that the dose was not given.</p> <p>Interview on June 7, 2024, at 2:51 p.m. Employee E11, Regional Nurse, revealed that the nurses should have notified the physician of Resident R6's elevated blood sugar levels. Further interview revealed that Employee E11, Regional Nurse, was unable to explain why Resident R42's Levemir was held because the resident's blood sugars levels were within the prescribed parameters.</p> <p>Review of resident R 40's clinical record revealed that resident R40 had diagnosis's of Type 2 diabetes(long term medical condition which the body does not use insulin properly, resulting in unusual blood sugar levels), obesity, Barrett's esophagus with dysplasia,(a change in the lining of the esophagus, the cells are muted into precancerous state and indicate disease),panic disorder(a type of anxiety disorder), cardiomegaly(enlarged heart), depression (mood disorder that causes persistent feeling of sadness), chronic kidney disease(gradual loss of kidney function) and schizoaffective disorder(mental health condition characterized by symptoms of hallucinations or delusions), perforation of intestine ,major depressive disorder, gastro esophageal reflux disease( condition in which the stomach acid move up into the esophagus), bi polar disease(mood disorder that caused intense mood swings).</p> <p>Review of resident [NAME] Data Set(MDS A periodic assessment of resident care needs) dated May 27, 2024, indicated Brief interview for mental status(BIMS) indicated Resident R 40 had a score of 13(measured 1-15, 15 being cognitively intact) .</p> <p>Further review of resident R 40 clinical record speech therapy plan of care notes dated May 13, 2024, revealed that resident R 40 has had increased signs and symptoms of aspiration while using a straw. The speech therapist employee E 17 recommendation is no straws for this resident.</p> <p>Review of resident R 40's clinical record physician orders, revealed an order dated May 13, 2024, declaring no straws with thin liquids for this resident.</p> <p>Interview with speech therapist Employee E 17 on June 10, 2024, at 09:25 a.m. revealed that she had assessed resident R 40 and determined that resident R 40 was at risk for aspiration and recommended no straws for thin liquids.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident care plan revealed no documented evidence of a person-centered comprehensive care plan was developed related to the care and management of residents R 40 swallowing difficulties.</p> <p>Observation of resident R 40 on June 5, 2024, at 10:06 a.m., revealed the resident coughing while drinking orange juice from a straw. Further observation during this this time noticed was a clear sign above the resident bed stating NO STAWS. The above observation was confirmed but unit manager E 21.</p> <p>Interview with speech therapist Employee E 17 at time of the above observation confirmed that resident R 40 was not allowed to have a straw. Employee took the straw from resident R 40 and stated that it was unknown where or how he received the straw.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41471</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to implement treatment and services to prevent pressure ulcers for two of 35 sampled residents reviewed. (Resident R59 and Resident R177)</p> <p>Findings include:</p> <p>Review of facility policy Risk assessment and prevention dated October 6, 2023, revealed that The facility will strive to ensure that a resident entering the facility without pressure ulcers/pressure injuries does not develop pressure ulcer/injuries. Unless the clinical condition demonstrates unavoidable skin breakdown. Prevention of pressure ulcer/injuries requires early identification of at-risk residents and the implementation of preventions strategies.</p> <p>Manage pressure.</p> <ul style="list-style-type: none"> <li>-Use support surface on bed and or wheelchair.</li> <li>-Use turning and positioning plan if indicated</li> <li>-Off load heel pressure</li> </ul> <p>Clinical record review revealed that Resident R59 had diagnoses that included cognitive communication deficit and severe protein calorie malnutrition.</p> <p>The Minimum Data Set assessment (Assessment of resident care needs) dated March 28, 2024, indicated that the resident required moderate assistance from the staff on staff for transferring in and out of bed and bed mobility. The resident was at risk for developing pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin).</p> <p>Review of physician orders for Resident R59 dated April 22, 2024, revealed an order to off load left heel at all times.</p> <p>Review of care plan for Resident R59 dated September 22, 2023, revealed an intervention to not leave bony areas or in one position for longer periods of time.</p> <p>Observation of Resident R59 on June 5, 2024, from 10:40 a.m. through 12:00 p.m. revealed that the resident was lying flat in bed. It was observed that Resident R59's left heels were placed against the foot board of the bed. There was a pillow next to the resident which did not off load the heels. Interview with Resident R59 at the time of the observation stated he had pain to the left heel. He stated he had a wound at the left heel and it was improving.</p> <p>Interview with Employee E20, Nurse Aide, on June 5, 2024, from 11:40 a.m. confirmed the above observation.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident R59 on June 7, 2024, at 2:00 p.m. with Assistant Director of Nursing, Employee E29 revealed that Resident R59's left heels were placed against the foot board of the bed there was a pillow underneath resident's foot, but it was not positioned in a way to off load the heels. Employee E29 stated Resident R59's foot was not off loaded as ordered.</p> <p>Review of clinical record revealed that Resident R177 had diagnoses that included cognitive communication deficit and severe protein calorie malnutrition and pressure ulcer of left heel.</p> <p>Review of physician orders for Resident R177 dated January 31, 2024, revealed an order to off load heels at all times.</p> <p>Observation of Resident R177 on June 5, 2024, at 0:45 a.m. revealed that the resident was lying flat in the bed. It was observed that Resident R177's heels were placed on the bed without any offloading measures. It was also observed that one heel boot was placed on the nightstand and the other heel boot was outside the room on the linen cart. This observation was also confirmed by Employee E30, Licensed Practical Nurse.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>41471</p> <p>Based on the observations, review of clinical records, facility policies, and interview with staff, it was determined that the facility failed to ensure that a resident with limited range of motion, received appropriate services to prevent further decline in range of motion and maintain appropriate positioning for one of 35 resident s reviewed. (Resident R70).</p> <p>Finding Include:</p> <p>Review of facility policy ADL Care, Contractures, Preventative Care and Treatment and Restorative ROM Program, dated March 12, 2024, revealed that A plan of care will be developed based on the resident's individual ADL ROM/impaired joint mobility Needs. -There must be a clearly defined problem statement that identifies the restorative need; -The restorative nursing program is not the problem statement, it is an intervention; -There must be a measurable goal related to the problem; measurable objectives describe what The resident is expected to achieve, such as ROM goals/measurements to be achieved within a Specific timeframe; - There must be individualized Interventions; care plan interventions must include the provision of Necessary equipment and/or services necessary; and =Resident/resident representative should be included in the development of the care plan, if able.</p> <p>The Nursing Assistant will communicate to the Unit Manager/Charge Nurse of the need for an Evaluation as changes in ROM/joint immobility occur. These changes could be: i. A resident's strength has improved such that they may be able to participate more during ROM/joint immobility programs; ii. resident's strength has declined such that they may need more assistance while Performing ROM/joint immobility programs; iii. There is a question about the safest means of care related to a specific ROM/joint immobility Program.</p> <p>As changes in resident condition occur the changes are communicated to the care giving staff with the updated information and the resident's care plan is revised as necessary</p> <p>Observation of Resident R70 on June 5, 2024, at 10:53 a.m. revealed that the resident was seated in Geri-chair (a large, padded chair that is designed to help seniors with limited mobility). It was observed that residents head was tilted to right side, appeared to be contracted to the right side. Residents head was not supported, and the resident was not using any positioning devices.</p> <p>Observation of Resident R70 on June 6, 2024, at 1:26 p.m. revealed that the resident was being fed by a nurse aide in the dining room. Resident's head was tilted to the right side, head was unsupported. The aide was feeding the resident in same position.</p> <p>Review of care plan for Resident R70 dated October 23, 2023, revealed that the resident was on restorative nursing program related to the prevention of functional decline through daily activities. Resident had ADL self-care deficit related to decline in overall function, decreased activity tolerance.</p> <p>Continued review of resident R70's care plan revealed no care plan intervention or services for head/neck positioning.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee E31, Rehab director, on June 10, 2024, at 10:57 a.m. stated the resident have contracture to the neck. Employee E31 confirmed that there was no intervention or services for head/neck positioning or prevent further decline in functional range of motion.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code: 201.18 (b)(2) Management</p> <p>28 Pa. Code: 211.10 (d) Resident care policies</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>41471</p> <p>Based on the review of facility records, observations, and interviews with staff, it was determined that the facility failed to ensure accurate accounting of controlled drugs for one of three medication storage rooms reviewed (B unit medication room).</p> <p>Finding Include</p> <p>Observation of facility B unit medication room with Employee E32, Licensed Practical Nurse, on June 6, 2024, at 9:17 a.m., revealed a bottle of lorazepam liquid medication in the refrigerator. The bottle contained 14 ml of medications left in the bottle. Employee E32 confirmed the amount of medication left in the bottle.</p> <p>Review of narcotic count sheet for the lorazepam medication revealed that the amount should have been left should have been 4.5 ml. Employee E32 stated noticed the discrepancy 2 days ago and the amount was almost 10 ml extra that what was accounted for.</p> <p>Interview with Director of Nursing on June 6, 2024, at 12:17 p.m., confirmed that there was discrepancy with Lorazepam liquid on B nursing unit.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy Services</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</b></p> <p>Based on the review of clinical records, interviews with resident and staff, it was determined that the facility failed to ensure that residents drug regimen was free of unnecessary drugs related to the use of antipsychotic medication without adequate monitoring for one of five resident reviewed for drug regimen. (Resident R207.)</p> <p>Findings Include:</p> <p>Review of physician order for Resident R207 dated April 3, 2024, revealed an order for Quetiapine Fumarate 25 mg, half tablet by mouth at bedtime for schizophrenia.</p> <p>Review of pharmacy review of Resident R207 dated May 19, 2024, revealed that Please watch for ataxia and falls secondary to Seroquel. Seroquel may cause extra pyramidal symptoms ([NAME] effects of some medications, such as antipsychotic drugs, that can affect movement.), tardive dyskinesia (a chronic, drug-induced movement disorder that causes involuntary, repetitive body movements.), akathisia (a neuropsychiatric movement disorder that makes it difficult to sit still and causes an uncontrollable urge to move.), hypoglycemia, hyperprolactinemia and hyperlipidemia.</p> <p>Review of Resident R207's current care plan for June 2024 revealed an intervention to monitor that the medication was effective and treating the symptoms and that the resident was tolerating it without any side effects or adverse reactions. Report abnormal findings to RN and physician.</p> <p>Review of clinical record for Resident R207 revealed no evidence that the facility monitored Resident R207 consistently for the adverse effects for the antipsychotic medication as recommended by the pharmacy consultant.</p> <p>Interview with Employee E29, Assistant Director of Nursing, on June 10, 2024, at 12:20 p.m. confirmed that Resident R207 was not monitored for the adverse effects for the antipsychotic medication as recommended by the pharmacy consultant. Employee E29 stated resident should have an order to monitor the side effects/adverse effects for antipsychotic medication.</p> <p>28 Pa. Code 211.12(d)(1)(3) (5) Nursing services</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>43923</p> <p>Based on observations and staff interviews it was determined that the facility failed to provide accurate meal trays for one of two residents and failed to provide food products based on the resident's food preference for three of 35 residents (Resident R88, 107, R212).</p> <p>Review of facility policy Resident Preferences, last revised January 2024, indicates Residents' individual choices including religious, cultural, and ethnic needs and preferences are obtained. Residents are served meals that offer choices and comply with food preferences.</p> <p>On June 5, 2024, at 12:13 p.m. Resident R212 reported that food preferences are not being honored. His/her ticket is preference for double portions protein, and he/she is not getting them during meals times.</p> <p>On June 5, 2024, at 12:25 p.m. Resident's R212 lunch arrived, and lunch ticket indicated double meat sandwich to meals tray. Lunch tray was missing sandwich. Licensed Dietician, Employee E5 confirmed that resident's preference did not reflect the lunch tray.</p> <p>On June 6, 2024, at 10:21 a.m. Resident Council Meeting was held with 11 alert and oriented (R108, R125, R475, R139, R116, R60, R75, R194, R217, R193, R168) residents who reported that their meal tickets would be missing items on the meal tray and when French fries are being served or potatoe tots, the facility would run out and not everyone would get those items when they are scheduled to be served.</p> <p>On June 6, 2024, at 1:26 p.m. Resident R88's lunch was observed, and resident's lunch ticket had preference for canned fruit and it was not on the lunch tray. Resident R107's ticket preference had extra source gravy and there was no gravy available on the tray. Nursing Aid, Employee E9 confirmed the observations.</p> <p>Pa Code: 211.6(a) Dietary services</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based upon observations, interviews and review of clinical records and facility policy, determined the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of Multidrug-resistant organism (MDRO) transmission for three residents with indwelling medical devices and hand hygiene for one resident during medication administration (Resident R21, R87 and R129) of 35 residents records reviewed.</p> <p>Findings include:</p> <p>Review of the facility 's policy Transmission Based Precautions revised in April 2024, states Transmission Based Precautions (TBP) will be initiated when there is a reason to believe a resident has a communicable infectious disease, which may include using Enhanced-Barrier Precautions (EBP). EBP are designed to reduce the transmission of multidrug-resistant organisms (MDRO) in facilities by using targeted gown and glove during high contact resident care activities to reduce transmission of infections. The policy further states, EBP are indicated for residents with any wounds and/or indwelling medical device (including feeding tubes and foley catheters), even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Resident R129 was admitted on [DATE] diagnosed with a gastrostomy (a surgical opening into the stomach used for nutrition). Review of the residents care plan dated April 17, 2023, indicated the resident required the gastrostomy due to dysphagia (inability to swallow). On June 6, 2024 at 11:35 a.m. it was observed and confirmed with the Unit Manager, Employee E7 that the facility was not utilizing Enhanced Barrier Precautions with the resident.</p> <p>Observations on June 5, 2024, at 10:48 a.m. and on June 6, 2024, at 12:57 p.m. revealed that Resident R21 was resting in bed. Resident R21 was observed to have a gastrostomy tube and had tube feeding equipment and supplies at her bedside. Further observation revealed no evidence of any enhanced barrier precautions available or implemented for the resident.</p> <p>Review of Resident R21's care plan, dated initiated February 21, 2017, revealed that the resident was risk for alteration in nutrition/hydration related to her need for artificial nutrition through a feeding tube.</p> <p>Review of physician orders for Resident R21 revealed an order dated February 28, 2024, for a gastrostomy tube (a surgical opening and placement of a tube though a person's abdominal wall into their stomach). Continued review revealed another order, dated March 20, 2024, for Diabetasource AC (artificial nutrition) 40 ml (milliliters) per hour for 20 hours or until 800 ml infused.</p> <p>Further review of Resident R21's clinical record revealed that no documentation was available for review at the time of the survey to indicate if enhanced barrier precautions were implemented for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled Medication Administration and Disposition last revised September 6, 2023, indicated that the Staff shall follow established facility infection control procedures (e.g., hand hygiene, gloves, Isolation precautions, etc.) for the administration of medications prior to and after medication administration.</p> <p>Observation of medication pass on June 6, 2024, at 08:05a.m. revealed Employee E22 administering medication on the nursing unit A back hall. Employee E 22 was observed preparing the resident medication, entering the resident room, and passed the medication to the resident. Employee E22 exited the room and began to prepare medication for another resident. Employee E 22 did not practice hand hygiene by sanitizing or washing her hands between residents.</p> <p>Observation of medication pass on June 6, 2024, at 08:50 a.m. revealed Employee E 25 preparing to administer medication on the nursing unit A front hall. Employee E 25 was observed preparing medication. The employee entered the room and passed the medication to the resident. Employee E 25 exited the room and began to prepare medication for another resident. Employee E25 then entered another resident's room, confirmed the resident, passed the medication then exited the room. Employee E 25 was then instructed by unit manager Employee E 21 to sanitize her hands. Interview with Employee E 25 at the time of observation confirmed she did not sanitize her hands, to practice proper infection control.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>41471</p> <p>Based on a review of facility documentation, facility policies and staff interviews, it was determined that the facility failed to maintain an effective antibiotic stewardship program that includes a system that includes antibiotic use protocols and a system to effectively monitor antibiotic usage for three of four months of antibiotic stewardship program data reviewed. (January 2024, February 2024, March 2024 and April 2024).</p> <p>Findings Include:</p> <p>Review of facility policy Antibiotic Stewardship-Surveillance dated February 8, 2024, revealed the Antibiotic usage and outcome data will be collected and documented using a facility: approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. The facility's antibiotic stewardship program will promote the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program (i , infection preventionist).</p> <p>1. As part of he facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee.</p> <p>2. The IP, or designee, will review all antibiotic starts within 48 hours to determine if continued therapy is justified, justified with needed intervention, or not justified. Utilizing facility line listings and Antibiotic Dashboard maintained by the chosen EHR.</p> <p>a. Therapy is NOT justified if: 1) The organism is not susceptible to antibiotic chosen; (2) The organism is susceptible to narrower spectrum antibiotic; (3) Therapy was ordered for prolonged surgical prophylaxis; or (4) Therapy was started awaiting culture, but no organism was isolated after 72 hours .</p> <p>b. Interventions that may resolve unjustified therapy: (1) Dosage change; (2) Switch from IV to PO route; (3) Duration change; (4) Additional antibiotic added; (5) Obtain cultures; and (6) Check levels.</p> <p>c. If therapy remains NOT justified, proceed with: (1) Alternative antibiotic regimen; or (2) Discontinue therapy.</p> <p>3.At the conclusion of the review, the provider will be notified of the review findings and recommendations. His or her response will be documented as follows: a. Agrees to make change; b: Needs to discuss with team before making change; or c. Will not make change because: 1. He or she does not agree with recommendations; and or 2. Team does not agree with recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility documentation from the month of January 2024 to April 2024 revealed that the facility used antibiotics to treat infection for 73 residents. Further review of facility documentation revealed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>Interview with the Infection Control Nurse, Employee E33, June 7, 2024, at 12:24 p.m. confirmed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		