STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395587	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadows Nursing and Rehabilitation Center	4 East Center Street Dallas, PA 18612

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 21738 Based on a review of clinical records, the facility's abuse prohibition policy, and select facility incident investigations, and staff interview, it was determined that the facility neglected to provide the care and services necessary to prevent physical injury or harm for two out of five residents sampled (Residents CR2 and 26). Findings include: A review of the facility's Investigation of Allegations of Abuse, Neglect, or Misappropriation of Resident Policy last reviewed May 2023, indicated as last reviewed by the facility on November 1, 2023, revealed that the facility will provide each resident with the highest practicable physical, mental, and psychological services to meet their individual needs and to promote or maintain the resident at their highest level of well-being. Allegations of abuse, defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish, as well as neglect, financial exploitation or misappropriation of resident property will thoroughly be investigated by the facility. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes, but is not limited to: failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, treatment, and care including but not limited to: nutrition, medication, therapies, and activities of daily living. Clinical record review revealed that Resident CR2 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (disease of the central nervous system that affects movement, often including tremors). A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 14, 2024 indicated that Resident CR2 had severe cognitive impairment with a BIMS score of 07 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment). (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident CR2's care plan, initially dated February 8, 2024, indicated that the resident was at a risk for falls with planned interventions, which included high-low bed maintain in low position when in bed. A nurses note dated February 26, 2024, indicated that Resident CR2 was found on the floor. Resident sustained an open hematoma to left forehead with moderate amount of bleeding. The physician was notified. The resident was transferred to the emergency room . A nurses note dated February 26, 2024, at 5:00 PM indicated that Resident CR2 returned to the facility with a small laceration to right forehead. Neuro checks at resident's baseline. Review of a facility incident report dated February 26, 2024, at 10:45 AM revealed that Resident CR2 was found lying on his right side on the floor between the beds of the resident's room. Prior to the incident Resident CR2 was found self-transferring into bed after breakfast. A statement by Employee 2 (LPN) noted that the resident was last seen in bed after breakfast. Employee 2 (LPN) stated that she responded to the resident's chair alarm and found him in bed. Employee 2 stated that prior to the fall the resident's call bell was in reach and proper footwear was in place. The investigation determined that Employee 2 (LPN) however, did not put the resident's bed in the lowest position at the time of the fall as per the resident's care plan. Interview with the director of nursing on May 21, 2024, at 2:00 PM confirmed that prior to the resident's fall Employee 2 neglected to implement the planned intervention to ensure that Resident CR2's bed was maintained in the lowest position to prevent injury. Clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses, which include diabetes and peripheral vascular disease. A review of an admission Minimum Data Set assessment dated [DATE], indicated that Resident 26 was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognitively intact). Review of a nurses note dated April 10, 2024, at 2:00 PM revealed that the resident's wheelchair fell backwards during transport in the wheelchair van on the way to a medical appointment. The resident struck his head on the floor of the van. 911 was called to transport the resident to the emergency room for evaluation. A nurses note dated April 10, 2024, at 5:00 PM noted that the resident returned to the facility from the emergency room . A 3 cm x 3 cm soft protrusion was present in the mid occipital (back) region of the resident's head. Review of a facility investigation dated April 10, 2024, concluded that while on route to an appointment, the tie downs attached to the front of the wheelchair became unattached, causing the resident's wheelchair to flip backwards, thus causing the resident to hit the back of his head on the floor of the van. Emergency medical services was called to transport the resident to the emergency room . The resident did not have any loss of consciousness. The investigation concluded that Employee 3 (van driver) failed to secure the front tie downs properly on the wheelchair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the director of nursing on May 21, 2024, at 2:30 PM confirmed that the Employee 3 neglected to provide the necessary services to maintain Resident 26 safety during transport to an appointment. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical record and select facility incident reports, and staff interview it was determined that the facility failed to assure that one resident of five sampled (Resident CR1) was free from a significant medication error that compromised the resident's clinical condition and health due to Tacrolimus toxicity. Findings include: Clinical record review revealed that Resident CR1 was admitted from the hospital to the facility on [DATE], with diagnoses, which included pneumonia and history of a kidney transplant. Review of medications listed on Resident CR1's Hospital Discharge Instructions revealed that active medications to continue at the long term care nursing facility included Tacrolimus (immunosuppressive agent used in the prevention and treatment of solid-organ transplant rejection) 0.5 mg capsule, take 2 capsules in the morning, and 1 capsule in the evening. Review of Resident CR1's admission physician orders dated [DATE], revealed an order for Tacrolimus 5 mg 2 capsules by mouth once daily (morning) and Tacrolimus 5 mg one capsule by mouth in the evening for a diagnosis of kidney transplant. Review of Resident CR1's [DATE] Medication Administration Record revealed that from [DATE], through [DATE], Resident CR1 received 4 doses of Tacrolimus 10 mg in the morning and 4 doses of Tacrolimus 5 mg in the evening instead of 1 mg in the AM (2 - 0.5 mg capsules in the AM) and 0.5 mg in the evening as ordered upon discharge from the hospital. Review of a nurses note dated [DATE], at 7:29 PM revealed that Resident CR1 was noted to be cold, with altered mental status, pulse oxygen (blood oxygen saturation, crucial measure of how lungs are working) 80% (normal level is 95 to 100%) on 4 liters/minute oxygen; pulse 60 (normal range 60 to 100 beats per minute). Physician at the bedside and ordered to transport to the emergency room for further evaluation. Resident representative at bedside. A nurses note dated [DATE], noted that Resident CR1 was admitted to the hospital. Review of the hospital Discharge Summary report dated [DATE], revealed that the resident expired on [DATE], and the preliminary cause of death was listed as Tacrolimus toxicity, acute renal failure, and acute hypoxic respiratory failure. The hospital course noted that Resident CR1 received Phenytoin (anticonvulsant medication) for Tacrolimus toxicity. Review of a facility Medication Error Report dated [DATE], indicated that the resident representative contacted the facility on [DATE], at 5:00 PM to notify the facility that the physician at the hospital informed the resident representative that the facility had been administering Resident CR1 the wrong dose of Tacrolimus during the resident's stay. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Further review of the Medication Error Report noted that upon investigation of the resident's representative's claim that the wrong dose of medication had been administered, the facility identified that the Tacrolimus was verified correctly, but transcribed incorrectly by Employee 1 (registered nurse). The physician was notified of the error. The resident representative was informed that the wrong dose of Tacrolimus had been administered to Resident CR1 due to the transcription error. Interview with the Director of Nursing (DON) on [DATE], at 11:00 AM confirmed that from [DATE], through [DATE], Resident CR1 received 4 doses of Tacrolimus 10 mg instead of Tacrolimus 1.0 mg in the morning and 4 doses of Tacrolimus 5 mg in the evening instead of Tacrolimus 0.5 mg in the evening. The DON confirmed that the facility failed to ensure that Resident CR1 was free from significant medication errors. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.5 (f) Medical records