| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395587 | A. Building<br>B. Wing | 05/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadows Nursing and Rehabilitation Center | 4 East Center Street<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on a review of clinical records, the facility's abuse prohibition policy, select investigative documentation, and interviews with the resident and facility staff, it was determined the facility failed to protect one of five sampled residents (Resident 18) from neglect by not implementing the physician-ordered use of a mechanical lift for all transfers, resulting in actual harm in the form of a comminuted right tibia and fibula fracture requiring surgical intervention.<br><br>Findings include:<br><br>A review of the facility policy titled Investigation of Allegations of Abuse, Neglect or Misappropriation of Resident Property provided on May 30, 2025, revealed the facility will provide each resident with the highest practicable physical, mental and psychological services to meet their individual needs and promote or maintain the resident at their highest level of wellbeing. This includes the protection of Resident's Rights. Allegations of abuse will be thoroughly 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.<br><br>A review of Resident 18's clinical record revealed admission to the facility on November 6, 2023 with diagnosis that included osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down), rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing joint pain, stiffness, inflammation, and eventually joint damage), and a periprosthetic fracture around the internal prosthetic right knee joint (a bone fracture that occurs near the knee replacement implant).<br><br>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 7, 2025, revealed that Resident 18 was moderately cognitively impaired with a BIMS score of 11 (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 8-12 indicates moderate cognitive impairment). Continued review revealed the resident required total staff assistance to shower and total staff assistance for transfers.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident's plan of care dated November 6, 2023, indicated that Resident 18 had an ADL self-care performance deficit related to impaired balance, rheumatoid arthritis, osteoarthritis, and periprosthetic fracture of the right knee. Interventions included non-weight bearing to the right lower extremity (leg), and use of a Hoyer lift with a green sling (a lift that uses hydraulic power to transfer a person while cradled in a sling).<br><br>A physician's order dated February 18, 2024, revealed an order for Resident 18 to maintain non-weight bearing through the right lower extremity and to use a Hoyer lift with a green sling for transfers.<br><br>Review of Resident 18's electronic Kardex (quick reference for staff that includes summary of resident information to provide care) also noted the resident was non-weight bearing to the right lower extremity and the resident transfers using a Hoyer lift with a green sling.<br><br>Nursing documentation dated May 13, 2025, at 12:08 AM revealed Resident 18 was complaining of pain in her right shin and foot on the 11PM-7AM shift. The resident told the night shift nurse she had hurt it while getting a shower on the 3PM- 11PM shift the prior evening, May 12, 2025. The night shift supervisor contacted the physician and an X-ray was obtained, which showed a moderately comminuted fracture of the mid shaft of the right tibia and mildly displaced slightly angulated and comminuted fracture of the mid shaft of the right fibula. The resident was transferred to the emergency department and underwent an open reduction and internal fixation (ORIF) with intramedullary nailing (intramedullary nail-a metal rod that is inserted into the bone to stabilize fractures) and anteromedial plating (surgical implant used in the fixation of fractures) on May 14, 2025.<br><br>A review of facility-provided investigative documentation dated May 13, 2025, at 11:40 AM revealed the nurse aides involved did not follow the physician-ordered plan of care requiring the use of a full body mechanical lift for transfers. The documentation indicated the facility initiated an internal investigation into the incident, and the staff members were suspended from duty pending the outcome of that investigation.<br><br>Review of the witness statement provided by Employee 1 (nurse aide) via telephone interview, by the facility, dated May 13, 2025, at 10:10 AM revealed the following: We transferred (Resident 18) from her wheelchair into the shower chair. When questioned as to whether the nurse aide knew Resident 18 was a mechanical lift, Employee 1 replied Yes, she was aware, and the lift was in the shower room at the time. When asked why the mechanical lift was not utilized, Employee 1 responded I don't know. Employee 1 stated she and Employee 3 (nurse aide) lifted the resident while Employee 2 (nurse aide) pulled the resident's pants down to put her in the shower chair.<br><br>Review of the witness statement provided by Employee 2 via a telephone interview by the facility, dated May 13, 2025, at 10:25 AM revealed the following: Employee 1, Employee 2 and Employee 3 transferred Resident 18 into the shower chair. The resident was complaining of her leg hurting before the shower and after the shower, so I told Employee 4 (licensed practical nurse). Employee 4 gave her a pain medication. Resident 18 complains of pain on and off, all the time. When we transferred her, we did not use a Hoyer, three of us transferred her. The resident was thankful for the shower. When questioned as to whether the nurse aide knew Resident 18 was a mechanical lift, the aide replied that it was her mistake, I am sorry. Resident 18 was on the edge of her chair; there was no way to get the sling under her. When questioned why the nurse aides did not boost Resident 18 back in her wheelchair if she was on the edge. Employee replied, we didn't have time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the witness statement provided by Employee 3 via a telephone interview by the facility, dated May 13, 2025, at 4:45 PM revealed the following: I was doing a shower (for another resident), and they asked me to help stand her up (Resident 18). I know she is a Hoyer lift. The asked me to stand her up. They brought her in the shower room, and we put her in the shower chair. We lifted her. Employee 2 pulled out the wheelchair and pushed the shower chair under the resident. When we lifted her up, she was okay. When her pants were coming down, she yelled out. When we sat her down, she started complaining about the right side of her leg. They asked me to lift her, I knew she required a Hoyer lift. Resident said Ow after the transfer. The leg she complained of pain was her right leg. Employee 1 was on her right side. Resident 18 was sitting normal in her wheelchair; she did not turn or twist. I then proceeded to give the other resident a shower after Resident 18 was in the shower chair. When questioned about why the mechanical lift was not in use, Employee 3 replied, I know better, I use the lifts. It is in her chart to use it. They asked for my help, and they just wanted to get her in the shower chair. I did not want the girls to be mad at me. I just didn't want to throw anyone under the bus. They told me to say we used the Hoyer. When questioned about the location of the lift at the time of the transfer, Employee 3 reported that Employee 1 got the lift after Resident 18 was in the shower chair. I'm sorry, Resident 18 does not like to use the machine, they brought her to the shower and needed my help quick.<br><br>Review of the facility's investigative documentation provided by the facility dated May 15, 2025, at 2:00 PM revealed the incident occurred on May 12, 2025, at 4:00 PM. Findings of the facility investigation are as follows: After interviewing the resident and the nurse aides it was concluded that Employee 1 and Employee 2 brought Resident 18 to the shower room in her wheelchair. Employee 3 was already in the shower room providing a shower to another resident when Employee 1 and Employee 2 asked Employee 3 for help to transfer Resident 18. Employee 3 and Employee 1 stood Resident 18 while Employee 2 pulled down her pants. Employee 1 and Employee 3 proceeded to transfer the resident onto the shower chair. During the transfer Resident 18 stated she felt her leg give out and then felt severe pain and she yelled out. Employee 3 confirmed the resident yelled out in pain with the transfer and that she was complaining of right leg pain. After the resident was transferred to the shower chair, Employee 3 stated that Employee 1 went and got the full body mechanical lift and sling and brought it into the shower room and told Employee 3 that if anyone asks, they used the lift.<br><br>Continued review confirmed that Resident 18 had a physician order to be transferred with use of a full body mechanical lift and non-weight bearing on the right lower extremity. All three nurse aides admitted to not following the physician order and not using the mechanical lift to transfer Resident 18 to the shower chair. Resident 18 has the following diagnosis which increase her risk of injury: osteoarthritis, osteoporosis, rheumatoid arthritis, periprosthetic fracture around the internal prosthetic right knee joint and right knee pain.<br><br>Further review of the facility's documented conclusion of the investigation revealed the three nurse aides had not followed the physician order for the use of the full body mechanical lift and the non-weight bearing status to Resident 18's right lower extremity, which resulted in fractures to her right tibia and fibula with hospital admittance for surgical repair. The investigation substantiated caregiver neglect causing serious physical injury.<br><br>During an interview with Resident 18 on May 30, 2025, at 10:45 AM, the resident reported that she requires the use of the lift to get in and out of her wheelchair. She stated, That's where they were wrong, they never used the lift. She continued I was falling, and they said, we have you and I said, no you don't. I told them I was falling, and they said you're all right, but I wasn't all right.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A voicemail message was left for Employee 1, 2, and 3 on May 30, 2025, between 11:00 -11:10 AM in an attempt to conduct a telephone interview, however, the surveyor's messages were not returned.<br><br>The facility's investigation substantiated neglect resulting in serious physical injury. All three aides involved were suspended during the investigation and subsequently terminated, as confirmed by the Nursing Home Administrator (NHA) during an interview on May 30, 2025. The NHA acknowledged that the nurse aides knowingly failed to implement required safety protocols, resulting in actual harm, right tibia and fibula fracture to Resident 18, requiring hospitalization and surgical repair.<br><br>28 Pa. Code 201.14 (a) Responsibility of licensee<br><br>28 Pa. Code 201.18 (e)(1) Management<br><br>28 Pa. Code 201.29 (a) Resident Rights<br><br>28 Pa. Code 211.12 (d)(5) Nursing Services |