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	02/11/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, facility-provided documentation, and staff interviews, it was determined the facility failed to ensure timely, comprehensive assessment and monitoring of wounds and failed to ensure implementation of necessary practices to prevent worsening skin breakdown for 1 of 7 residents reviewed (Resident 1).Findings include:According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the best pressure ulcer practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of a facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol revealed the nursing staff will assess and document an individual's significant risk factors for developing pressure sores. In addition, the nurse shall assess and document and report vital signs, a full assessment of the pressure sore including location, stage (the classification of a pressure injury based on the depth and extent of tissue damage), length, width, depth, and presence of exudates(fluid) or necrotic tissue (dead tissue). A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], 2025, with diagnoses to include dementia (decline in mental ability such as memory, reasoning, and communication severe enough to interfere with daily life), and peripheral vascular disease (blood circulation disorder causing narrowed, blocked, or spasming vessels arteries or veins outside the heart and brain and increases risk for wounds). A review of the resident's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 10, 2025, revealed the resident was cognitively intact as evidence by a BIMS score of 09 (Brief Interview for Mental Status is 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 08-12 indicates moderately impairment). Additionally, this MDS indicated Resident 1 used a wheelchair for mobility, required substantial/maximal assistance with upper dressing and personal hygiene, lower body dressing, bed mobility, and toileting. A review of Resident 1's clinical record revealed an ongoing skin integrity issue related to vascular wounds of bilateral lower extremities. A review of Resident 1's progress notes revealed the following documentation:October 30, 2025, at 8:26 AM: Left lower extremity (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound partially covered with slough (non-viable tissue), scant serous (thin clear to pale yellow fluid) drainage noted, no infection. Wounds noted to be improving, the note documented no signs of infection were observed, the note then indicated continue treatment at this time.November 7, 2025, at 12:12 PM: Documentation identical to October 30 entry.December 24, 2025, at 8:51 AM: Discontinue the current wound treatment and a new order was documented to cleanse the upper shin with antiseptic spray, pat dry, and apply Silvadene (topical cream containing silver to prevent and treat infection), cover the wound with a dressing and secure with tape. The note directed to document the condition of the wound daily.January 6, 2026, at 12:01PM: documented the resident's left shin was observed to have five open areas, scattered with scabs, scant serous drainage was noted with no signs of infection.January 14, 2026, at 11:08 AM: Documentation identical to January 6 entry.A progress note dated January 15, 2026, at 12:41 PM documented the resident's left shin as vascular in appearance (relating to blood vessels or circulation) with five open areas and scattered scabs. The wound beds were described as pink with granulation tissue (new healthy tissue indicating healing), with scant serous drainage (a very small amount of thin, clear fluid) and no signs of infection documented. A progress note dated January 20, 2026, at 2:05 PM contained documentation identical to the January 15, 2026, entry, with no additional or updated wound assessment information recorded. A progress note dated January 22, 2026, at 11:58 AM again documented the same assessment findings as the entries dated January 15 and January 20, 2026, without change or added detail. A progress note dated January 27, 2026, at 11:22 AM also contained the same exact wording as the prior entries dated January 15, January 20, and January 22, 2026, with no updated assessment findings documented.The record did not contain documentation of required wound measurements, staging, or complete weekly assessments between October 2025 and February 2, 2026.An interview with the Nursing Home Administrator (NHA) on February 11, 2026, at 10:15 AM revealed the facility utilized an outside provider for in-house wound management services. The NHA stated the contracted wound management company performed full-body skin assessments on all residents on February 2, 2026. Review of Resident 1's clinical record revealed no documentation of a comprehensive lower extremity wound assessment until February 2, 2026, despite documentation indicating the wound had been present since October 2025.An interview with Employee 1 (facility-designated wound nurse) on February 11, 2026, at 12:00 PM revealed it is the facility's expectation that the wound nurse complete and document a full wound assessment weekly for each wound. Employee 1 stated required documentation should include wound location, stage (classification of wound severity based on tissue damage depth), length, width, depth, and presence of exudate (drainage fluid) or necrotic tissue (dead tissue). Employee 1 was unable to provide an explanation as to why Resident 1's lower extremity wounds had not received a complete documented assessment since October 2025 and stated she assessed the wounds but had not documented all required elements in the clinical record.The facility was unable to provide documentation demonstrating that a Registered Nurse completed timely and comprehensive wound assessments for Resident 1's venous ulcer (a wound caused by impaired blood circulation in the veins) including measurements and staging prior to February 2, 2026During an interview with the NHA and Director of Nursing (DON) on February 11, 2026, at 1:45 PM, the above findings were reviewed. No additional documentation was provided. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.