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	05/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on a review of clinical records, facility policy, documentation provided by the facility, and staff and resident interviews, it was determined the facility failed to protect one of 24 sampled residents (Resident 74) from sexual abuse perpetrated by another resident (Resident 12).Findings include: A review of the facility policy titled Investigation of Allegations of Abuse, Neglect, or the Misappropriation of Resident Property, last reviewed by the facility on March 1, 2026, revealed it is the facility policy to provide each resident with the highest practicable physical, mental, and psychological services to meet their individual needs and promote or maintain the resident's highest level of well-being. This includes the protection of residents' rights. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The facility defined sexual abuse as non-consensual sexual contact of any type with a resident, which includes but is not limited to sexual harassment, sexual coercion, or sexual assault. A clinical record review revealed Resident 12 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A comprehensive individualized resident care plan revealed Resident 12 had a behavior problem related to rejection of care with a history of unable or unwilling to care for himself at home, defecating and/or urinating without willingness to clean, watching pornography at a loud volume, on laptop, and inappropriate sexual statements towards staff and other residents initiated on November 7, 2024. Interventions developed to ensure Resident 12 will exhibit appropriate interactions included intervening as necessary to protect the rights and safety of others, redirecting the resident, and removing the resident from situations when necessary. A review of the comprehensive resident-centered care plan revealed Resident 12 had a mood problem initiated on November 7, 2024. Target behaviors identified in Resident 12's care plan include the resident entering other residents' rooms and making inappropriate statements and gestures to male aides. Interventions developed to ensure Resident 12's mood state will not interfere with his daily routine included providing 1:1 (one staff to one resident) support as needed. A review of Resident 12's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 18, 2026, revealed that Resident 12 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 08 through 12 indicates cognition is moderately impaired). A review of facility documentation revealed prior incidents involving sexually inappropriate behavior. A nursing progress note dated July 18, 2025, at 5:09 PM, documented Resident 12 made a vulgar sexual comment to a nurse aide stating he would like to perform oral sex on the nurse aide if he wanted. Staff counseled the resident regarding the inappropriate behavior and notified the physician and (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 - Few	Director of Nursing. A psychosocial progress note dated July 23, 2025, at 6:44 PM documented staff addressed inappropriate conversations involving sexual acts. Resident 12 denied same and stated I just told that guy he was cute. Resident 12 was reminded that staff are available to provide care and support but conversation regarding sexual acts are inappropriate and such conversations were inappropriate in the facility setting. A nursing progress note dated December 1, 2025, at 7:04 PM documented concerns involving Resident 12 invading another resident's personal space. Resident 12 and his roommate (at the time) had a disagreement again over room temperature, lights, TV volume, and space. Resident 12's roommate had complaints about Resident 12 invading his personal space, and again staff requested Resident 12 to not assist or attempt to assist other residents unless it is by activating the call bell for them or going to the hall to get help. A clinical record review revealed no other documentation or behavioral interventions in the electronic clinical record regarding Resident 12's behavior of invading the personal space of others or attempting to provide care for others following the incident with his roommate on December 1, 2025. The facility was unable to provide any additional information regarding this incident. A clinical record review revealed Resident 74 was admitted to the facility on [DATE], with diagnoses that include dementia. A review of Resident 74's quarterly MDS assessment dated [DATE], revealed that Resident 74 was severely cognitively impaired with a BIMS score of 03 (a score of 00 through 07 indicates cognition is severely impaired). A review of Resident 74's quarterly MDS assessment Section GG Functional Abilities dated March 18, 2026, revealed that Resident 74 is dependent on staff for lower body dressing (the ability to dress and undress below the waist) and toileting hygiene (the ability to maintain perineal hygiene and adjust clothes before and after voiding). Dependent means the helper does all of the effort and the resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the task. A review of witness statements provided by the facility revealed that on May 3, 2026, Employee 3, Nurse Aide (NA), entered Resident 74's room to provide care and observed Resident 12 with his hands in Resident 74's groin area. Employee 3 documented that Resident 74's pants were partially removed, his brief was open, and his penis was exposed. Employee 3 documented that Resident 12 was attempting to remove Resident 74's brief and stated he was trying to help change the resident. Employee 3 removed Resident 12 from the situation and notified the Registered Nurse Supervisor (RNS). A witness statement completed by Employee 4, NA, documented that upon entering the room, Resident 74 was partially undressed with his pants down with one leg out of his pants and his brief shredded on the floor. Employee 4 documented that Resident 12 was seated beside Resident 74 with his hand on Resident 74's upper thigh. Employee 4 further documented that Resident 12 refused to leave when directed and continued to state he was helping Resident 74. The registered nurse supervisor was notified, and it was addressed. During an interview on May 27, 2026, at 1:20 PM, Employee 4, Nurse Aide (NA), indicated that on May 3, 2026, Employee 3, NA, informed him that Resident 12 was in Resident 74's room. Employee 4 stated that upon entering the room, he observed Resident 74 seated in his Broda chair (a specialized wheelchair designed for individuals requiring extensive positioning and mobility assistance) with his pants pulled down, his brief torn, and his penis exposed. Employee 4 stated that Resident 12 was seated next to Resident 74 with his hand on Resident 74's upper thigh and that he observed Resident 12's hand touching Resident 74's testicles and upper thigh. Employee 4 indicated that he directed Resident 12 to leave the room; however, Resident 12 did not comply and stated, I am helping. Employee 4 reported that Resident 12 remained in the room until Employee 5, Registered Nurse Supervisor (RNS), entered and directed Resident 12 to leave. Employee 4 further stated that Resident 12's hands were covered with absorbent gel beads from the inside of the disposable brief. A review of a witness statement provided by the facility revealed that Employee 5, Registered Nurse Supervisor (RNS), documented that on May 3, 2026, Employee 3, Nurse Aide (NA), notified her that Resident 12 was in Resident 74's room and was attempting to change the resident's brief and clothing. Employee 5 documented that upon entering the room, she observed Resident 12 seated in a chair next to Resident 74, who was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seated in a Broda chair. The witness statement indicated that Resident 74's pants were partially pulled down in the front. According to the statement, Resident 12 reported that he was attempting to help Resident 74 by changing him. Employee 5 documented that she directed Resident 12 to leave the room, and Resident 12 complied. The witness statement further documented that Resident 74 stated Resident 12 had saved his life and responded no when asked whether Resident 12 had touched his private parts. Employee 5 additionally documented that she observed no signs of sexual arousal and described Resident 12's demeanor as calm and relaxed. During a telephone interview on May 27, 2026, at 2:20 PM, Employee 3, Nurse Aide (NA), indicated that on May 3, 2026, she entered Resident 74's room and observed Resident 74 seated in his wheelchair with his pants pulled down, one leg out of his pants, and his brief open. Employee 3 stated that Resident 12 was seated next to Resident 74 with both hands underneath Resident 74's brief in the area of his genitals. Employee 3 indicated that although Resident 12's hands were covered by the brief and she could not directly observe contact, it appeared to her that Resident 12 was touching Resident 74's penis. Employee 3 stated that she directed Resident 12 to stop touching Resident 74; however, Resident 12 responded, I am changing his brief. Employee 3 further stated that based on her observations, it did not appear that Resident 12 was attempting to provide personal care or change Resident 74's brief and instead appeared to be touching Resident 74's penis and groin area. Employee 3 indicated that she again instructed Resident 12 to stop, but Resident 12 did not comply. Employee 3 stated that she then left the room, ran into the hallway, and called for assistance. Employee 3 recalled that when she returned to the room with assistance, Resident 74's penis was exposed and appeared bright red. During a telephone interview on May 27, 2026, at 2:48 PM, Employee 5, Registered Nurse Supervisor (RNS), indicated that on May 3, 2026, she responded to Resident 74's room after being notified that Resident 12 was present in the room. Employee 5 stated that upon entering the room, she observed Resident 74 seated in his Broda chair with his pants pulled down and his genitals exposed. Employee 5 stated that Resident 12 was seated next to Resident 74. Employee 5 indicated that she did not personally observe Resident 12 touching Resident 74. According to Employee 5, Resident 12 stated, I am trying to help. Employee 5 reported that she directed Resident 12 to leave the room, and Resident 12 complied with the direction. Employee 5 stated that Resident 74 did not appear distressed and that she observed no visible signs of injury. Employee 5 recalled that Resident 74 stated, He saved my life, and did not indicate that Resident 12 had touched him. Employee 5 stated that she instructed the nurse aides to provide care to Resident 74 and later observed Resident 74 seated near the nursing station without signs of distress. Employee 5 further stated that, based upon her observations of both residents, their statements, and the absence of visible injury, she did not believe the incident constituted sexual abuse. Employee 5 acknowledged that she did not debrief or interview Employee 3, Nurse Aide (NA), or Employee 4, NA, regarding their observations of the incident involving Resident 12 and Resident 74. A clinical record review revealed no documented evidence that the facility completed assessments, evaluations, behavioral reviews, or nursing documentation regarding the observations reported by Employee 3 and Employee 4. The clinical records for both residents lacked documentation regarding the incident, follow-up observations, psychosocial impact, or resident-specific evaluations following the event on May 3, 2026. During an interview on May 27, 2026, at 1:53 PM, Resident 74 was unable to identify any resident by name or recall specific details of the May 3, 2026, incident. However, when asked whether he had experienced any problems with other residents in the facility, Resident 74 stated, There is a guy trying to feel me up. Every time I turned around, he was bothering me. Resident 74 further stated that the resident tried to embrace me and that he told the individual, This is not my way of doing things. Resident 74 indicated that the resident's actions made him feel utterly sick to my stomach and disgusted. Resident 74 stated, I am not looking for someone to play with, especially not a male, and I have no wish to be with him. Resident 74 further indicated that he was not interested in a relationship with the resident and did not want others to get the wrong idea. Resident 74 stated that he told the resident to stop and recalled telling him, I'd smash his head in. During an interview on May (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28, 2026, at 12:30 PM, Resident 12 indicated that on May 3, 2026, he was walking down the hallway when he observed Resident 74 in his room waving him in and asking for help. Resident 12 stated that he entered the room because he believed Resident 74 needed assistance. Resident 12 denied touching Resident 74 and stated that he did not provide any care or assistance to him. Resident 12 indicated that he only entered the room to determine what was occurring. Resident 12 further stated that Resident 74 pulled his own pants down. According to Resident 12, when staff entered the room, he left. The reasonable person concept is an objective legal and regulatory standard used to evaluate the degree of actual or potential harm, pain, or mental anguish that a reasonable person would experience under similar circumstances. Although Resident 74 was unable to identify Resident 12 by name or fully recall the events of May 3, 2026, Resident 74 provided statements regarding unwanted interactions with a male resident. These statements were considered together with staff interviews, witness statements, observations, and other evidence obtained during the investigation. During an interview on May 29, 2026, at 10:00 AM, the above information, including clinical record review, witness statements, staff interviews, resident interviews, and observations regarding the May 3, 2026, incident involving Resident 12 and Resident 74, was reviewed with the Nursing Home Administrator (NHA). The facility failed to protect Resident 74 from non-consensual sexual contact by another resident. Refer F60728 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, documentation provided by the facility, and staff interviews, it was determined the facility failed to implement abuse prevention and investigation procedures for one of 24 residents reviewed (Resident 74) following an allegation of resident-to-resident sexual abuse involving Resident 12.Findings include: A review of the facility policy titled Investigation of Allegations of Abuse, Neglect, or the Misappropriation of Resident Property, last reviewed by the facility on March 1, 2026, revealed it is the facility policy to implement residents' rights to the fullest intent of the law. To protect the resident and determine the direction of the investigation, the policy requires facility staff to: Immediately separate residents and assess for possible injury.Immediately initiate an investigation and remove the alleged perpetrator.Arrange for medical attention, including a forensic rape exam for suspected sexual abuse.Obtain written statements from appropriate individuals on duty at the time of the incident.Notify the administrator, physician, resident representative, and law enforcement.Report the incident to the Pennsylvania Department of Health and local Area on Aging within 24 hours. A clinical record review revealed Resident 12 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of Resident 12's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 18, 2026, revealed that Resident 12 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 08 through 12 indicates cognition is moderately impaired). A clinical record review revealed Resident 74 was admitted to the facility on [DATE], with diagnoses including dementia.A review of Resident 74's quarterly MDS assessment dated [DATE], revealed that Resident 74 was severely cognitively impaired with a BIMS score of 03 (a score of 00 through 07 indicates cognition is severely impaired). A review of facility-provided documentation, witness statements, and staff interviews revealed that on May 3, 2026, Employees 3 and 4, Nurse Aides (NAs), reported observing Resident 12 with his hands inside Resident 74's brief in the area of Resident 74's genitals, resulting in an allegation of resident-to-resident sexual abuse. During an interview on May 27, 2026, at 1:20 PM, Employee 4, NA, indicated he was not asked to provide a written statement regarding his observations on May 3, 2026. Employee 4 stated that he was asked to provide information regarding the event on the following workday. During a telephone interview on May 27, 2026, at 2:20 PM, Employee 3, NA, indicated she was not asked to provide a statement on May 3, 2026, regarding her observations of the incident involving Residents 12 and 74. Employee 3 stated that administration contacted her on a later date to obtain information regarding the event. During a telephone interview on May 27, 2026, at 2:48 PM, Employee 5, Registered Nurse Supervisor (RNS), indicated that she did not interview or debrief Employee 3 or Employee 4 regarding their observations of the incident. Employee 5 stated that administration requested a statement from her several days after the event occurred. A clinical record review revealed no documented evidence in either Resident 12's or Resident 74's clinical record that nursing staff completed resident-specific observations, evaluations, assessments, or investigative documentation at the time of the May 3, 2026, incident. Additional review revealed no documented evidence that physicians or resident representatives were notified of the allegation. The clinical records also lacked documented evidence that additional interventions were implemented following the allegation to address Resident 12's behavior or to protect Resident 74 and other residents from further unwanted contact. During an interview on May 29, 2026, at 10:00 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence that the facility fully (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented its abuse investigation and prevention procedures following the May 3, 2026, allegation. Specifically, the facility was unable to provide documented evidence that it immediately initiated and completed a thorough investigation, obtained detailed witness statements at the time of the incident, completed resident evaluations or assessments related to the allegation, notified all required individuals and agencies in accordance with facility policy, or implemented timely interventions to address Resident 12's behavior and ensure ongoing resident safety. The facility was further unable to provide documented evidence that additional protective interventions were implemented following the allegation until Resident 12 was transferred to another nursing unit approximately 16 days later. Refer F60028 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.