

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Meadows Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0622</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a clinical record review and staff interview, it was determined the facility failed to ensure that necessary resident information was communicated to the receiving health care provider for one resident out of 23 residents sampled with facility-initiated transfers (Residents 27).</p> <p>Findings include:</p> <p>A review of Resident 27's clinical record revealed that the resident was transferred (the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility) to the hospital on August 28, 2024, and returned to the facility on [DATE].</p> <p>There was no documented evidence the facility had communicated specific information to the receiving health care provider for the resident transferred and expected to return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on September 20, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) confirmed there was no evidence the necessary information was communicated to the receiving health care institution or provider for Resident 27's transfer on August 28, 2024.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of clinical records and staff interview it was determined that the facility failed to provide residents or their representatives with written information of the facility's bed hold policy upon transfer to the hospital of two residents out of 23 residents sampled (Residents 96 and 27).</p> <p>Findings include:</p> <p>A review of Resident 96's clinical record revealed the resident was transferred to the hospital on July 4, 2024, and returned to the facility on [DATE].</p> <p>A review of Resident 27's clinical record revealed the resident was transferred to the hospital on August 28, 2024, and returned to the facility on [DATE].</p> <p>There was no documented evidence the facility provided these residents and/or their representatives written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of the transfer.</p> <p>Interview with the administrator on September 19, 2024, at approximately 1:00 PM confirmed the facility was unable to provide documented evidence of the provision of written notice of the facility's bed hold policy upon hospital transfer.</p> <p>28 Pa Code 201.18 (e)(1) Management</p> <p>28 Pa Code 201.29 (b) Resident rights</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on clinical record review, observation, and staff interviews, it was determined the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical needs for one of 23 residents reviewed (Residents 34).</p> <p>Findings include:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>A clinical record review revealed Resident 34 was admitted to the facility on [DATE], with diagnoses that include degenerative disease of the nervous system (a condition that affects many of the body's activities, such as balance, movement, talking, breathing, and heart function) and ataxia (progressive - affecting a person's ability to walk, talk, and use fine motor skills).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 23, 2024, revealed that Resident 34 is severely cognitively impaired with a BIMS score of 4 (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 01-07 indicates severe cognitive impairment).</p> <p>A progress note dated August 7, 2024, indicated Resident 34 was observed with a skin tear to her upper right arm measuring 2.0 cm x 0.5 cm x 0.1 cm.</p> <p>A progress note dated August 22, 2024, at 9:17 PM indicated Resident 34 became combative and hit her right forearm with her left nail, causing a 1.0 cm x 4.0 cm skin tear on her right forearm.</p> <p>A physician's order for Resident 34 to have Geri Sleeves (fabric worn over the arms to protect the skin from skin tears and abrasions) on bilateral upper extremities (arms) at all times was initiated on August 23, 2024.</p> <p>A care plan indicating Resident 34 has potential for pressure-related skin failure related to impaired mobility and general weakness was initiated on July 27, 2021. An intervention implemented to assist Resident 34 to maintain intact skin integrity included skin sleeves to bilateral upper extremities initiated on August 23, 2024.</p> <p>During an observation on September 17, 2024, at 10:40 AM, Resident 34 was seen sitting in her room wearing a short-sleeve shirt. Her arms were uncovered, and no protective skin devices were observed on her arms.</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>In a follow-up observation on September 18, 2024, at 1:25 PM, Resident 34 was seen participating in a therapy session. Her arms were bare, and no protective skin devices were observed.</p> <p>Another observation on September 20, 2024, at 9:50 AM revealed Resident 34 sitting in her room wearing a short-sleeve shirt. Her arms were bare, and no protective skin devices were observed.</p> <p>During an interview on September 20, 2024, at 9:55 AM, Employee #3, Registered Nurse, confirmed Resident 34 was not wearing her bilateral protective skin devices. Employee 3 was unable to explain why the resident was not wearing the protective devices and was unable to locate the resident's protective sleeves.</p> <p>During an interview on September 20, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical needs, including interventions and physician's orders to be implemented to maintain residents' skin integrity.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(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 - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records, resident council meeting minutes, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence for one resident out of 23 sampled (Resident 40) and experiences expressed by two residents during a group interview (Residents 78 and 79).</p> <p>Findings include:</p> <p>A review of policy titled Restorative Nursing Policy, last reviewed by the facility on April 3, 2024, revealed it is the policy of the facility to provide a restorative nursing program that focuses on achieving and maintaining optimal function in accordance with the comprehensive assessment and plan of care. The policy indicates that residents who are referred by physical therapy, physician, or nursing will be evaluated by the restorative nurse for a restorative program. Also, it is the commitment of the facility to assist residents to restore or maintain their functional capacities to improve their overall quality of living.</p> <p>A review of resident council meeting minutes dated April 25, 2024, revealed that residents in attendance had concerns regarding staff changes to the restorative nursing programs. The minutes indicated the Director of Nursing (DON) would discuss the changes with individual residents.</p> <p>A response to concerns raised during the April 25, 2024, resident council meeting indicated the facility will no longer have designated restorative aides, related to changes in budgeting. Nurse aides are now responsible for walking any of the residents on walking programs (restorative nursing ambulation). Residents were informed that if they are not being walked, then inform the nurse aide and nurse for that shift.</p> <p>A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood). A review of an annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 21, 2024 revealed that Resident 79 is moderately cognitively impaired with a BIMS score of 12 (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).</p> <p>A review of Resident 79 ' s physical therapy discharge instructions dated January 2, 2024, revealed the resident is discharged (from physical therapy) to the facility with a restorative nursing program for ambulation up to 150 feet with a rollator walker(a mobility device).</p> <p>Further review of the clinical record revealed a care plan, initiated on January 4, 2024, indicating Resident 79 is unable to walk independently and requires assistance. An intervention implemented to increase Resident 79 ' s self-performance and stamina when walking is to include her in a restorative nursing program for ambulation of 150 feet with a rollator walker.</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 - Some</p>	<p>A review of Resident 79 ' s restorative ambulation participation record indicated Resident 79 declined participation on 36 occasions, and it was documented that ambulation was not applicable on 3 occasions from August 22, 2024, through September 20, 2024. The record indicated Resident 79 participated in 19 restorative ambulation sessions.</p> <p>A clinical record review revealed Resident 78 was admitted to the facility on [DATE], with diagnoses that included muscle wasting and atrophy (reduction in muscle mass and strength due to the loss of muscle tissue) and inflammatory polyarthropathy (a condition characterized by inflammation affecting multiple joints). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 30, 2024, revealed that Resident 78 is moderately cognitively impaired with a BIMS score of 12 (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).</p> <p>A review of Resident 78's Physical Therapy Discharge Summary dated June 24, 2024, revealed the resident is to continue with her current restorative program and indicated her prognosis to maintain her current level of functioning is good with consistent staff follow-through.</p> <p>A review of Resident 78's care plan, initiated on November 23, 2022, revealed she is unable to walk around the unit independently. An intervention implemented to maintain Resident 78 ' s ability to ambulate is a restorative nursing program for ambulation a the rollator walker up to 100 feet.</p> <p>A review of Resident 78 ' s restorative ambulation participation record indicated Resident 78 declined participation on 30 occasions, and it was documented that ambulation was not applicable on 4 occasions from August 22, 2024, through September 20, 2024. The record indicated Resident 78 participated in 25 restorative ambulation sessions.</p> <p>During a group interview on September 18, 2024, with alert and oriented residents, Resident 78 and 79 indicated they are upset because they are not receiving their scheduled ambulation program.</p> <p>During the group interview, Resident 78 indicated that she has not walked with nursing for months since the restorative nurse staff changed positions at the facility. Resident 78 explained that nursing staff does not provide ambulation therapy, and she has brought this up to everyone that will listen to me. Resident 78 expressed frustration as walking and being independent is a personal goal and important for her well-being.</p> <p>During the group interview, Resident 79 indicated she only receives restorative services when she has physical therapy. She explained it has been a few months since she was discharged from therapy. Resident 79 indicated her restorative nursing program for ambulation is not occurring.</p> <p>A review of Resident 40's clinical record revealed admission to the facility on [DATE], with diagnoses which included polyosteoarthritis (any type of arthritis that involves 5 or more joints simultaneously), diabetes with diabetic autonomic neuropathy (damage to nerves that control automatic body functions caused by diabetes), and peripheral vascular disease.</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 - Some</p>	<p>An Annual Minimum Data Set assessment (MDS a standardized assessment completed at specific intervals to identify specific resident care needs) dated July 28, 2024, indicated the resident was moderately cognitively impaired with a BIMS score of 12 and required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with ambulation and toileting hygiene.</p> <p>Interview with Resident 40 on September 17, 2024, at 10:39 AM indicated that nursing staff does not provide her restorative ambulation nursing services. She stated that she was excited for the nursing students to come into the facility, because that's when she gets to walk.</p> <p>A review of Physical Therapy Discharge Summary dated July 29, 2024, indicated that Resident 40 required setup/clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with ambulation.</p> <p>A review of Resident 40's Kardex (a nursing worksheet that provides a summary of patient's information) on September 19, 2024, indicated the resident was on a restorative ambulation program with a rollator and was Supervision/SBA (stand-by assistance) of one staff member for up to 150 feet.</p> <p>A review of Resident 40's Documentation Survey Report dated September 2024, indicated from September 1, 2024, through September 18, 2024, the resident's RNP ambulation program with rollator walker and supervision for 150 feet was only provided by nursing staff 5 times out of 36 opportunities.</p> <p>During an interview on September 20, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) and DON were unable to explain why residents were indicating they were not receiving their restorative ambulation program. The NHA confirmed it is the facility's responsibility and policy to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence.</p> <p>28 Pa. Code: 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on review of clinical records, select facility policy review, and staff interview it was determined the facility failed to ensure a physician ordered fluid restriction was maintained for one of 23 sampled residents (Resident 1).</p> <p>Findings include:</p> <p>Review of the facility Intake and Output Monitoring Policy, last reviewed April 3, 2024, indicated that intake and output (intake refers to the amount of fluids the resident ingests, and output refers to the amount of fluids that leave the body) will be monitored on residents as necessary with documentation in the Electronic Medical Record. All residents on fluid restrictions will remain on intake and output if specifically ordered, and as clinical needs indicate. Intakes will be reviewed daily by the 3:00 PM to 11:00 PM RN Charge Nurse/designee to see if resident is meeting estimated fluid requirement or is over fluid restriction. The physician is to be made aware if the resident is over fluid restriction times two days or is under estimated fluid requirement times three days.</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and congestive heart failure (a chronic condition in which the heart does not pump as well as it should causing shortness of breath).</p> <p>A quarterly Minimum Data Assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 7, 2024, indicated the resident is moderately cognitively impaired with a BIMS (brief interview for mental status) score of 10 (8 to 12 indicates moderate cognitive impairment), received dialysis treatment and required assistance of staff for activities of daily living.</p> <p>A physician order dated June 24, 2024, noted an order for 1500 mL fluid restriction per 24 hr. Indicating 960 mL of fluids provided/allowed by dietary (360 mL breakfast, 300mL lunch, 300mL dinner) and 540 mL provided/allowed by nursing staff (180 mL 7-3 shift; 180 mL 3-11 shift; 180 mL 11-7 shiftt) related to acute and chronic congestive heart failure.</p> <p>A review of Resident 1's daily calculated Fluid Requirement Monitoring Record from August 25 through September 18, 2024, revealed Resident 1 exceeded the physician ordered fluid restriction on the following days:</p> <p>August 29, 2024 2040 cc (ml) daily total</p> <p>August 30, 2024 16000 cc (ml) daily total</p> <p>September 2, 2024 1900 cc (ml) daily total</p> <p>September 3, 2024 1920 cc (ml) daily total</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>September 4, 2024 1710 cc (ml) daily total</p> <p>September 5, 2024 1710 cc (ml) daily total</p> <p>September 6, 2024 1710 cc (ml) daily total</p> <p>September 7, 2024 1788 cc (ml) daily total</p> <p>September 8, 2024 2145 cc (ml) daily total</p> <p>September 12, 2024 1900 cc (ml) daily total</p> <p>September 13, 2024 1740 cc (ml) daily total</p> <p>September 15, 2024 1900 cc (ml) daily total</p> <p>September 16, 2024 1780 cc (ml) daily total</p> <p>September 17, 2024 2390 cc (ml) daily total</p> <p>September 18, 2024 2250 cc (ml) daily total</p> <p>Further review of the clinical record revealed no documented evidence the physician was notified of the resident exceeding the fluid restriction as per facility policy. There was no documented evidence the fluid restriction was evaluated for reasons to explain how the resident, who is dependent on staff to provide fluids was exceeding the fluid restriction.</p> <p>Interview with the director of nursing on September 19, 2024, at approximately 11:30 AM failed to provide documented evidence that Resident 1's fluid restriction was maintained as per physician order. The director of nursing (DON) failed to provide documented evidence the physician was notified of the resident exceeding the fluid restriction as per facility policy.</p> <p>28 Pa. Code 211.5 (f)(ii) Medical Records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observations, review of clinical records, review of select facility policy, and staff interview it was determined the facility failed to provide person-centered care as prescribed to meet the current clinical needs by failing to monitor intravenous therapy (way of giving medication or fluids through a needle or tube inserted into a vein) in accordance with professional standards of practice for two of two reviewed residents receiving intravenous therapy (Residents 94 and 1)</p> <p>Findings include:</p> <p>A review of the facility Insertion of Peripheral IV (Over the needle, Peripheral Short) catheter policy last reviewed April 3,2024, indicated that all IV insertions should be labeled with date and time of insertion. Further review of the Insertion of Peripheral IV (Over the needle, Peripheral Short) catheter policy revealed the IV is to be removed after medication therapy is completed or discontinued.</p> <p>A review of clinical records revealed that Resident 94 was admitted to the facility on [DATE], with diagnoses which included Pleural effusion (a condition where excess fluid accumulates between the lungs and the chest wall), cystitis (an inflammation of the bladder), and muscle wasting and atrophy (a wasting or thinning of muscle mass).</p> <p>A nurses note dated September 11, 2024, indicated the physician was in and examined the resident. After review of a chest Xray, Resident 94 with suspected pneumonia (infection of the lungs).</p> <p>A physician order dated September 11, 2024, noted an order to insert IV line (soft flexible tube place inside a vein, usually in the hand or arm for administration of IV antibiotic). A physician order dated September 11, 2024 indicated administer Ceftriaxone Sodium Intravenous Solution Reconstituted 1 GM (antibiotic used to treat bacterial infections) Use 1 gram intravenously in the evening for 5 days.</p> <p>Observation of Resident 94 on September 17, 2024, at 11:30 AM, September 18, 2024, at 10:00 AM and 1:00 PM revealed the IV catheter was present in the resident's right forearm. The dressing on the IV site was not dated indicating date of insertion, during any of the three observations.</p> <p>An interview with Employee 2, RN, on September 18, 2024, at 1:08 PM confirmed the IV site was not dated when inserted.</p> <p>Further review of the clinical record revealed no documented evidence of a dressing change to the IV site.</p> <p>Interview with Employee 2, RN, on September 18, 2024, at 1:08 PM also confirmed that Resident 94 completed the prescribed medication Ceftriaxone Sodium Intravenous Solution on September 16, 2024. During the interview with Employee 2 on September 18th, 2024, it was also confirmed the IV catheter was not removed on the completion of therapy on September 16, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the clinical record revealed no documented evidence of a physician order for care and monitoring of Resident 94's IV site.</p> <p>A review of clinical records revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and osteoarthritis (degenerative joint disease in which the tissues in the joint break down over time).</p> <p>A nurses note dated September 16, 2024, indicated the physician examined the resident. Resident's right elbow and suspected septic arthritis (infection of the joint).</p> <p>A physician order dated September 16, 2024, noted an order to insert IV line (soft flexible tube place inside a vein, usually in the hand or arm for administration of IV antibiotic). A physician order dated September 16, 2024, noted an order for Linezolid (an antibiotic) Intravenous solution 600 mg intravenously every 12 hours for suspected septic arthritis.</p> <p>A nurses note dated September 17, 2024, at 10:11 AM noted staff was unable to flush the IV site to left hand. An IV catheter was inserted into left forearm and was infusing the antibiotic without a problem</p> <p>A physician order dated September 19, 2024, noted an order to continue Linezolid 600 mg intravenously every 12 hours until September 23, 2024.</p> <p>Observation of Resident 1 on September 17, 2024, at 11:30 AM, September 18, 2024, at 10:15 AM and 1:00 PM revealed the IV catheter was present in the resident's left forearm. The dressing on the IV site was not dated during any of the three observations.</p> <p>Observation on September 19, 2024, at 10:00 AM revealed the dressing on the IV site was dated September 18, 2024 although this was not observed during observation on September 18, 2024</p> <p>Further review of the clinical record revealed no documented evidence of a dressing change to the IV site on September 18, 2024.</p> <p>Interview with employee 1 (RN) on September 19, 2024, at 10:15 AM confirmed that although the dressing was dated September 18, 2024, there was no documented evidence in the clinical record of a dressing or IV change on September 18, 2024.</p> <p>Further review of the clinical record revealed no documented evidence of a physician order for care and monitoring of Resident 1's IV.</p> <p>Interview with the Director of Nursing (DON) on September 19, 2024, at approximately 11:00 AM confirmed that Resident 94's and Resident 1's IV dressings should have been dated. The DON failed to provide documented evidence of required care and monitoring related to the IV as per facility policy.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f)(iii)(viii) Medical records.</p>		