

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of controlled medication shift count records, select facility policy, and staff interviews, it was determined the facility failed to consistently implement procedures to maintain accurate controlled medication accountability records on three of three medication carts reviewed (Clover Unit, Bluebell Unit, and Dogwood Unit). Findings include: A review of facility policy entitled Controlled Medication-Receipt, Count, and Secure Storage, last reviewed March 1, 2026, revealed that a controlled drug count for controlled drugs (medications regulated by federal law due to their potential for abuse, misuse, dependence, or diversion which is the unauthorized transfer, use, or theft of a medication Accurate shift-to-shift controlled medication counts and documentation help ensure accountability for controlled substances and promote timely identification of discrepancies) will be made at the beginning of each shift by the nurse responsible for controlled drugs on the outgoing shift with the nurse who will be responsible for controlled drugs on the oncoming shift. Paperwork for shift-to-shift narcotic counts is to be complete with legible dates and initials of staff involved in the count. A review of the facility's Shift Narcotic Count Signature Sheet for the Clover Unit medication cart revealed incomplete controlled medication count documentation on the following dates: May 20, 2026: The evening shift incoming nurse failed to sign that the controlled medication count was completed and accurate. May 20, 2026: The evening shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. May 28, 2026: The day shift incoming nurse failed to sign that the controlled medication count was completed and accurate. During an interview on May 28, 2026, at 8:00 AM Employee 6, Licensed Practical Nurse (LPN), confirmed that the required signatures were missing from the Clover Unit controlled medication count record on the dates identified above. A review of the facility's Shift Narcotic Count Signature Sheet for the Bluebell Unit medication cart revealed incomplete controlled medication count documentation on the following dates: May 23, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. May 24, 2026: The day shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. May 28, 2026: The day shift incoming nurse failed to sign that the controlled medication count was completed and accurate. A review of the facility's Shift Narcotic Count Signature Sheet for the Dogwood Unit medication cart revealed incomplete controlled medication count documentation on the following dates: March 6, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. March 7, 2026: The day shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. March 10, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. March 11, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. April 7, 2026: The evening shift incoming nurse failed to sign that the controlled medication count was (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed and accurate. April 7, 2026: The night shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. April 7, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. April 8, 2026: The day shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. April 18, 2026: The day shift incoming nurse failed to sign that the controlled medication count was completed and accurate. April 18, 2026: The evening shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. April 26, 2026: The night shift incoming nurse failed to sign that the controlled medication count was completed and accurate. April 27, 2026: The day shift outgoing nurse failed to sign that the controlled medication count was completed and accurate. May 28, 2026: The day shift incoming nurse failed to sign that the controlled medication count was completed and accurate. An interview with Employee 7 Licensed Practical Nurse (LPN) on May 28, 2026, at 8:05 AM confirmed that the required signatures were missing from the Bluebell Unit and Dogwood Unit controlled medication count records on the dates identified above. In an interview on May 28, 2026, at 10:30 AM, the Director of Nursing confirmed the facility failed to consistently implement its policy requiring outgoing and incoming nursing staff to complete and sign shift-to-shift controlled medication count records. The facility failed to consistently maintain complete and accurate controlled medication count records on all three medication carts reviewed, which did not demonstrate consistent implementation of procedures designed to ensure accountability for controlled substances and was not consistent with facility policy. 28 Pa Code 211.9 (k) Pharmacy services. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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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 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 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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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 observations, a review of clinical records, and staff interviews, it was determined that the facility failed to consistently implement preventive interventions to avoid the development of pressure injuries for two of 24 residents reviewed (Residents 18 and 126). Findings include: A clinical record review revealed Resident 18 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and 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 the comprehensive individual care plan revealed Resident 18 had potential for pressure related skin failure related to impaired mobility initiated on October 15, 2024. Interventions implemented to ensure Resident 18 will have intact skin integrity include elevating bilateral lower extremities to keep the resident's heels off the bed or chair surface with pillows. A physician's order for Resident 18 to be out of bed to Broda chair (a specialized medical wheelchair and recliner used for individuals with severe mobility issues who spend most of the day seated, prioritizing advanced posture support, pressure relief, and fall prevention) with calf bumpers (a soft padded or plastic device that covers prominences on a wheel chair to prevent injury) at all times initiated on July 30, 2025. A review of Resident 18's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 1, 2026, revealed that Resident 18 BIMS evaluation (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 13 through 15 indicates cognition is intact) was not completed because the resident was rarely or never understood. A review of section C1000 Cognitive Skills for Daily Decision Making revealed Resident 18 was severely impaired regarding making decisions for daily life. During an observation on May 27, 2026, at 11:05 AM Resident 18 was observed sitting outside the Unit 3 nursing station in a Broda chair. The chair's leg rest brackets were exposed and no calf bumpers were applied to the chair as indicated in the physician's orders. There were no observable injuries on Resident 18's bilateral lower extremities at the time of the observation. During an interview on May 27, 2026, at 11:07 AM Employee 1, Registered Nurse (RN), confirmed that Resident 18's physician's orders for calf bumpers were not applied to the resident's chair. A clinical record review revealed Resident 126 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and moderate protein-calorie malnutrition (a state resulting from lack of intake or uptake of nutrition that leads to altered body composition). A review of the baseline care plan revealed Resident 126 had potential for pressure related skin failure related to impaired mobility initiated on May 23, 2026. Interventions implemented to ensure Resident 126's will have intact skin integrity included elevating bilateral lower extremities to keep the resident's heels off the bed or chair surfaces. A review of Resident 126's admission MDS assessment dated [DATE], revealed that Resident 126 was severely cognitively impaired with a BIMS score of 7 (a score of 00 through 07 indicates cognition is severely impaired). A physician's order for Resident 126 to be out of bed in a Broda chair with a padded foot buddy board (a single, flat, solid surface that attaches to the front of the wheelchair to support both the user's legs and feet at the same time) and calf bumpers at all times was initiated on May 26, 2026. During an observation on May 27, 2026, at 11:15 AM Resident 126 was observed in the Unit 3 dining room in a Broda chair. The chair's leg rest brackets were exposed, and no calf bumpers were applied to the chair as indicated in physician's orders. Also, the foot buddy/board utilized to elevate the resident's (continued on next page)		

Department of Health & Human Services
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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 05/29/2026
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bilateral legs were not applied to the wheelchair. There were no observable injuries on Resident 126's bilateral lower extremities at the time of the observation. During an interview on May 27, 2026, at 11:28 AM Employee 2, nurse aide (NA), confirmed that Resident 126's physician's orders for calf bumpers and a foot buddy board were not applied to the resident's chair. During an interview on May 29, 2026, at 10:00 AM the above information was reviewed with the Nursing Home Administrator (NHA). The facility failed to consistently implement preventive interventions ordered by the physician to avoid the development of pressure injuries for Residents 18 and 126.28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, documentation provided by the facility, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to ensure adequate supervision and timely staff assistance for a resident identified as a high risk for falls to prevent a fall (Resident 63) and failed to ensure planned safety interventions were consistently implemented for a resident (Resident 108) for two out of 24 residents reviewed. Findings include: Review of the facility's Fall Management Policy and Procedure last reviewed March 1, 2026, indicated that it is the policy of the facility to ensure the resident's environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. A Fall Risk Evaluation will be completed on admission and readmission (to be completed by the admitting nurse), quarterly, with significant change, and annually by the RNAC (registered nurse assessment coordinator), as well as after each fall by the nurse on duty. Resident and, or family education regarding falls and person-centered fall prevention strategies will be provided on admission and as needed. A review of the clinical record revealed that Resident 63 was admitted to the facility on [DATE], with diagnoses that included acute on chronic congestive heart failure (CHF, sudden, severe, worsening of symptoms of compromised heart function such as acute fluid buildup or severe shortness of breath), chronic obstructive pulmonary disease (COPD, lung condition which restricts airflow and makes breathing difficult), benign paroxysmal vertigo (common inner ear issue that causes sudden, brief feelings of spinning triggered by changes in head position, vertigo spells typically last less than one minute and come on suddenly), and atrial fibrillation (irregular heartbeat). A review of Resident 63's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 1, 2026, revealed that Resident 63 was cognitively intact with a BIMS score of 14 (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 13 through 15 indicates cognition is intact), required partial to moderate assistance (helper does less than half the effort) for toileting hygiene, required supervision or touching assistance to get on and off the toilet or commode, and had no falls in the last six months. The resident's Fall Risk Evaluation dated April 25, 2026, indicated the resident scored a 20 (a score of 10 or greater indicates a high risk for falls). A review of Resident 63's current comprehensive care plan initially dated April 25, 2026, indicated the resident had a self care performance deficit due to impaired balance and heart failure. Interventions to improve the resident's current level of function included to ambulate with the assistance of one staff with rolling walker (mobility aid with wheels) and gait belt (strap made of canvas placed around the resident's waste to assist staff to help steady, support, or safely transfer residents who have balance or mobility issues) to and from the bathroom. A review of a health status note for Resident 63 dated May 20, 2026, at 3:34 PM documented increased shortness of breath and +3 edema (severe pitting edema, which indicates a significant accumulation of excess fluid within body tissues) to both lower extremities. The note documented physician notification and new orders to increase Lasix (a medication used to remove excess fluid from the body) to 40 milligrams by mouth twice daily, administer oxygen at 2 liters per minute as needed, and obtain a Basic Metabolic Panel (BMP, a blood test used to evaluate general health, kidney function, fluid balance, and metabolism) within one week. A review of nursing documentation dated May 20, 2026, at 10:45 PM revealed staff found the resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lying face down on the floor, partially inside the bathroom doorway. The documentation indicated a Licensed Practical Nurse (LPN) was applying pressure to the resident's head due to significant bleeding. The note described an approximately 12 cm (centimeter) by 12 cm deep laceration (a tear or cut in the skin) with a skin flap located on the top of the head extending toward the forehead. Nursing staff documented repositioning the skin flap, approximating the wound edges, applying Steri-Strips (thin sterile adhesive strips used to assist with wound closure), covering the area with gauze dressings, and maintaining manual pressure and ice application until Emergency Medical Services (EMS) arrived. The note further documented that blood observed on the inside of the bathroom door suggested the resident fell forward and struck her head on the door. Nursing staff notified the physician, obtained an order for emergency room transfer, and notified the resident representative. A review of hospital emergency department records dated May 21, 2026, revealed the resident reported experiencing dizziness described as vertigo (a sensation of spinning or loss of balance), tripping over her own foot, and falling forward with a head strike. Hospital documentation indicated the resident sustained a head laceration requiring ten staples for closure. The emergency department also diagnosed the resident with acute respiratory failure with hypoxia (a sudden condition in which the lungs cannot adequately deliver oxygen into the bloodstream), resulting in hospital admission. A review of facility investigative documentation related to the fall revealed the resident reportedly stated at the time of the incident on May 20, 2026, that she knew she was not supposed to get up by herself. A written witness statement completed by Employee 12, Nurse Aide, documented that the aide assisted the resident to the bathroom, provided privacy, instructed the resident to use the call bell when finished, and reported to nursing staff prior to the fall that the resident was not herself. Additional facility documentation indicated the resident had been placed on the toilet approximately five minutes before the fall occurred. Although the call bell was documented as being within reach, records indicated it was not activated at the time staff discovered the resident on the floor. During an interview conducted on May 28, 2026, at 1:40 PM, in the presence of Employee 11, Registered Nurse Supervisor (RNS), Resident 63 stated that she rang the call bell before the fall, but no one responded. The resident stated she believed she had waited long enough, attempted to transfer herself from the toilet, began losing her balance due to vertigo, fell, and then yelled for assistance. The resident stated that some staff members remained with her during toileting while others did not. The resident indicated she did not object to staff remaining with her in the bathroom and stated that she knows staff are busy but at times she waits too long for the call bell to be answered. During an interview on May 29, 2026, at 10:00 AM, the Director of Nursing confirmed the facility failed to provide the supervision necessary to ensure Resident 63's safety and prevent the avoidable fall. Review of the facility's policy entitled, Elopement/Wandering Protocol, last reviewed March 1, 2026, revealed the facility required application of a Wander guard device (an electronic monitoring device used to alert staff when a resident at risk for wandering or elopement approaches an exit) for residents identified as attempting to wander or elope, quarterly reevaluation of the intervention, and maintenance of a resident photograph at the receptionist area for identification purposes. A review of Resident 108's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis that included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to parts of the brain, depriving them of oxygen and nutrients) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A review of Resident 108's quarterly MDS dated [DATE], revealed the resident was severely cognitively impaired with a BIMS score of 03 (a score of 0 through 7 indicates severe cognitive impairment). A review of an elopement risk assessment completed on September 7, 2025, identified (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 108 as being at high risk for elopement. Documentation indicated the resident had a history of wandering in the community prior to facility admission and had required relocation on two occasions before placement in the nursing facility. A physician order dated September 7, 2025, directed staff to maintain a Wander guard bracelet on the resident's right lower extremity and wheelchair and required staff to verify placement and proper functioning every shift. Clinical record review for Resident 108 revealed continued evidence of wandering behavior. A nursing progress note dated October 22, 2025, documented the resident wandering through facility hallways and entering and exiting other residents' rooms. A nursing progress note dated January 22, 2026, documented that the resident wandered during nighttime hours. A review of the May 2026 Task Administration Record (TAR) revealed staff documented on May 28, 2026, at 7:00 AM that Resident 108 was wearing a Wander guard device on the right lower extremity. However, direct observation conducted on May 28, 2026, at 1:45 PM revealed no Wander guard device present on the resident's right leg or any other extremity. The resident did not have a personal wheelchair present in the room. Employee 7, Licensed Practical Nurse (LPN), confirmed the absence of the device during the observation and was unable to locate the Wander guard within the resident's room. Employee 7 stated that Wander guard devices are not easily removed. A review of the receptionist's Wander guard monitoring log conducted on May 29, 2026, at 1:25 PM revealed Resident 108 remained listed as requiring Wander guard monitoring; however, no resident photograph was maintained as required by facility policy. During an interview on May 29, 2026, at 1:30 PM, the Director of Nursing reviewed the above findings and confirmed the facility failed to consistently implement and monitor the resident's planned elopement prevention interventions, including maintenance of the Wander guard device and required identification photograph. 28 Pa. Code 201.18 (b) (1) Management 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (d) (1) (3) (5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per a physician's orders for one resident out of 24 residents reviewed (Resident 123). Findings include: A review of the facility's policy titled Oxygen Administration, last reviewed on March 1, 2026, revealed the purpose of the policy was to provide guidelines for safe oxygen administration. The policy directed staff to check the oxygen delivery system, including the mask, oxygen tank, and humidifier bottle (also known as humidifier reservoir, the container that holds sterile or distilled water through which oxygen passes to add moisture before being delivered to the resident) to ensure they were in good working order and securely fastened. The policy required staff to verify there was an adequate water level in the humidifier bottle so that the water bubbled as oxygen flowed through and to periodically re-check the water level to ensure proper humidification. A clinical record review revealed that Resident 123 was admitted to the facility on [DATE], with a diagnosis to include respiratory failure (a serious condition that makes it difficult to breathe) with hypoxia (a condition where there is inadequate supply of oxygen to the body's tissues). A review of Resident 123's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 26, 2026, revealed the resident had moderately impaired cognition 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 through 12 indicates moderate cognitive impairment). A review of physician's orders dated May 21, 2026, directed that Resident 123 receive oxygen with humidified water at 5.0 liters per minute (L/min) by nasal cannula (a flexible medical tube with two prongs that fit into the nostrils, used to deliver supplemental oxygen), to check oxygen humidification every shift and refill as needed, and directed nightshift staff to fill the humidifier bottle daily. A review of Resident 123's Treatment Administration Record (TAR) for May 2026 revealed that on May 26, 2026, at 11:00 PM, it was signed off that the humidifier bottle was filled, and on May 27, 2026, at 7:00 AM, it was signed off that the water humidification level was checked. An observation on May 27, 2026, at 11:15 AM revealed the resident was in bed receiving oxygen at 5.0 liters per minute (L/min) via nasal cannula, with no water in the humidifier bottle attached to the oxygen flowmeter. The humidification bottle was dated May 24, 2026. This observation was confirmed, and humidification water was replaced by Employee 8, a Licensed Practical Nurse, on May 27, 2026, at 11:30 AM. A follow-up observation on May 29, 2026, at 8:00 AM revealed the resident was in bed receiving oxygen at 5.0 liters per minute (L/min) via nasal cannula, with a quarter of the bottle filled with water that was attached to the oxygen flowmeter. The humidification bottle was dated May 27, 2026. During an interview with the Director of Nursing on May 29, at 8:30 AM, the above findings were reviewed and confirmed it is the facility's responsibility to ensure oxygen therapy is administered in accordance with the physician's order. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and resident and staff interviews, it was determined that the facility failed to comprehensively evaluate, monitor, communicate, and implement appropriate interventions for new onset and worsening pain in accordance with physician orders and facility policy for one of 24 residents reviewed (Resident 41). Findings include: Review of the facility's Pain Assessment and Management policy, last reviewed March 1, 2026, revealed that the purpose of the policy was to help staff identify resident pain and to help develop interventions that are consistent with resident goals. The policy indicated the facility was to conduct a comprehensive pain assessment upon admission to the facility and whenever a resident experienced new pain or worsening pain. Clinical record review revealed that Resident 41 was admitted to the facility on [DATE], with a diagnosis of diabetes (medical condition in which the body is unable to properly regulate blood sugar levels) and fractures of the mid-back area. A review of Resident 41's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 18, 2026, revealed that Resident 41 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 through 12 indicates moderate cognitive impairment). The MDS also indicated that over the past 5 days, the resident experienced a moderate degree of pain (pain levels between 4 and 6). A numerical pain scale ranging from 0 to 10 is commonly used to assess pain intensity, with 0 representing no pain, 1 through 3 representing mild pain, 4 through 6 representing moderate pain, and 7 through 10 representing severe pain. Review of the resident's admission pain evaluation revealed documentation indicating the resident was able to respond appropriately and reported no pain during the five-day period prior to admission. Review of physician orders initiated upon admission on [DATE], revealed an order for acetaminophen (a non-opioid pain-relieving medication) to be administered for resident-reported pain levels of 1 through 3, consistent with mild pain. Review of the May 2026 Medication Administration Record (MAR) revealed documented pain assessments on May 14, May 21, May 22, and May 28, 2026, indicating the resident experienced pain that had not been identified on admission. Despite evidence of new onset pain, there was no documented evidence the facility completed a comprehensive pain re-evaluation as required by facility policy. Clinical record review revealed the resident reported a pain level of 4 on May 21 and May 22, 2026, indicating moderate pain that exceeded the parameters of the existing physician order, which only addressed mild pain levels of 1 through 3. There was no documented evidence that the physician was notified of the resident's increased pain level, no evidence the resident's pain management regimen was re-evaluated, and no evidence new or revised physician orders were obtained to address the resident's moderate pain. During an interview conducted on May 28, 2026, at 1:00 PM, and again on May 29, 2026, at 8:45 AM, Resident 41 reported experiencing pain in the neck and mid-back region and rated the pain as an 8 on a 0-to-10 pain scale, indicating severe pain. The resident stated staff occasionally administered something for pain, but it is not effective. Review of Resident 41's comprehensive care plan failed to identify the resident's pain, the location of the pain, or interventions utilized to monitor or alleviate the pain. Documentation reflected pain-related information was not added to the care plan until after surveyor inquiry. It was not until after surveyor notification on May 29, 2026, at approximately 9:15 AM that the facility re-evaluated the resident's pain and obtained additional physician orders, including a stronger pain medication, to (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	address pain levels greater than 3. During an interview on May 29, 2026, at 9:30 AM, the Director of Nursing was unable to provide evidence that the facility had timely re-evaluated the resident's new onset pain in accordance with facility policy, notified the physician of pain levels exceeding the resident's current treatment parameters, or obtained timely physician intervention to address the resident's ongoing pain complaints. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, review of select facility policy, documentation provided by the facility, and staff interview, it was determined the facility failed to ensure that food was served in a form to meet the individual needs of one of 24 residents reviewed. (Resident 94) Findings include: Review of the facility's Thickened Liquids and Pureed Food Policy last reviewed March 1, 2026, indicated that the diet order must include the dysphagia (difficulty swallowing) level of solid foods and the liquid consistency. Never serve regular texture food to a resident ordered a pureed diet. When in doubt about a diet order, verify before serving. The Key Safety Rule is to always serve the correct texture and observe the resident while eating to reduce the risk of choking and aspiration (accidentally breathing food or liquid into the airway or lungs instead of swallowing them). A review of the clinical record revealed that Resident 94 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF-the heart muscle becomes too weak or stiff to pump blood efficiently) and oropharyngeal dysphagia (swallowing problems occurring in the mouth and, or throat). A physician order initially dated March 24, 2026, documented an order for a puree diet (foods that are blended, whipped, or mashed into a smooth, lump-free, and uniform texture that reduces the risk of choking and aspiration) no added salt regular thin liquid consistency diet. A review of Resident 94's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 3, 2026, revealed that Resident 94 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 through 12 indicates moderately cognitively impaired) and required setup or clean-up assistance for meals (the helper sets up or cleans up and the resident completes the activity with the helper assisting only prior to or following the activity). A health status note dated May 14, 2026, documented that the resident was sitting at the nurses station eating a peanut butter and jelly sandwich. The resident started coughing and Employee 9 Licensed Practical Nurse (LPN) and Employee 10 Registered Nurse (RN) assessed the resident. The resident had a piece of sandwich in her throat. Employee 9 LPN stood up the resident while Employee 10 RN did Heimlich maneuver (first aid technique for someone who is choking because food or another swallowed object is obstructing his or her airway. Using an upward abdominal thrust, the Heimlich maneuver compresses the lungs and forces air up into the windpipe until the object causing the choking is ejected from the throat). The sandwich piece popped out. The physician and resident representative were notified. An incident note dated May 14, 2026, noted that the resident was able to breathe and talk without difficulty following the incident. Lung sounds were clear and vital signs (measurements of the body's most basic functions and include body temperature, pulse rate, rate of breathing, and blood pressure) were stable. Staff were to continue to monitor the resident's breathing and lung sounds. Review of documentation provided by the facility dated May 14, 2026, at 12:30 AM revealed that Resident 94 was provided with a peanut butter and jelly sandwich as a snack by Employee 9 LPN) which was not a pureed food item as required based on the resident's prescribed physician diet order. Employee 9 LPN failed to check the resident's diet order prior to providing the sandwich. Staff education was initiated following the incident related to checking for the appropriate diet consistency before providing food, snacks, or drinks at any time to residents. Employee 9 LPN who provided the sandwich was disciplined and reeducated. The physician was (continued on next page)		

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No. 0938-0391

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified and a chest xray was ordered. The physician also ordered to monitor the resident's temperature and lung sounds every shift for 72 hours. The facility will provide the resident a puree peanut butter and jelly sandwich for the resident nightly. Interview with the Nursing Home Administrator (NHA) on May 28, 2026, at 1:00 PM confirmed the facility failed to follow Resident 94's physician ordered diet to ensure an appropriate snack in the correct form was provided to the resident. The NHA confirmed the facility failed to provide a peanut butter and jelly sandwich in a form to meet Resident 94's needs for safe swallowing to prevent a choking episode. 28 Pa. Code 201.18 (b) (1) Management. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d) (3) (5) Nursing services.		