STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395830	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Nursing Center	1404 Hay Street Berlin, PA 15530

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 - 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. Based on review of policies, investigation reports, clinical records, and staff education records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for two of four residents reviewed (Residents 2, 3), resulting in harm to Resident 2 due to a fall that resulted in fractured hip and harm to Resident 3 due to a fall from bed that resulted in a hematoma. This deficiency was cited as past non-compliance. Findings include: The facility's policy regarding abuse and neglect, dated September 1, 2024, indicated that the definition of neglect referred to the failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate, and appropriate services, treatment and care, including but not limited to: nutrition, medication, therapies, and activities of daily living. The absence of reasonable accommodations of individual needs and preferences may result in resident neglect. The facility's policy regarding falls, dated September 1, 2024, indicated that a resident-centered fall prevention plan was to be implemented to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The facility's policy regarding a change in status, dated September 1, 2024, indicated that all nursing staff were responsible to ensure pertinent information was communicated to the charge nurse regarding a resident's change in status and all nursing staff were to communicate to the charge nurse if a resident refused care, medications, or interventions at the time of refusal. The charge nurse would encourage the resident to participate in the plan of care. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 1, 2025, revealed that the resident was confused, required assistance from staff with daily care needs, used a walker, and had a history of falls. The resident's care plan, dated April 17, 2025, revealed that the resident was at risk for falls and was to use hipsters (padded hip protectors used to prevent injuries to the hips) at all times. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A nursing note for Resident 2, dated May 24, 2025, at 12:41 p.m. revealed that staff witnessed the resident going into the bathroom with her walker and left her walker inside the bathroom door. She then walked out to the hallway, lost her balance, and tripped before staff could get to her. The resident was witnessed falling on her left side and was noted to have shortening of the left leg, and complained of pain to her left hip and upper thigh area. The physician was notified and orders were received to transfer the resident to the hospital for evaluation and treatment. At 5:14 p.m. a report was received from the hospital informing the facility that Resident 2 had a left hip fracture. Information submitted by the facility, dated May 30, 2025, revealed that on May 24, 2025, at 3:00 a.m. Resident 2 was witnessed to be resistant to care and combative throughout the shift. She woke up early in the morning, a shower was given to promote improvement of mood/behaviors, and she refused her hipsters. On May 24, 2025, at 11:40 a.m. she had a witnessed fall in the common bathroom on the third floor, was transferred to the hospital, and had a fractured hip. It was discovered that Nurse Aide 1 did not notify any other staff of Resident 2 refusing her hipsters, which prevented the ability to put other interventions in place, substantiating neglect. A written statement from Nurse Aide 1, dated May 24, 2025, revealed that Resident 2 refused to wear her hipsters after receiving a shower at 3:00 a.m. Further interviews, undated, revealed that Nurse Aide 1 confirmed that she did not report to any other staff that the resident refused her hipsters prior to the resident falling. Education records for Nurse Aide 1, dated May 22, 2025, revealed that she received education on abuse and neglect. An interview with the Nursing Home Administrator and Director of Nursing on June 12, 2025, at 4:23 p.m. confirmed that Nurse Aide 1 failed to follow the facility's policy for reporting a resident's refusal of care, which prevented staff from attempting other interventions to prevent injuries from falls, and the Nursing Home Administrator also confirmed that there was no evidence that Nurse Aide 1 re-approached Resident 2 at a later time to apply the hipsters. The facility's policy regarding positioning the resident bed, dated September 1, 2024, revealed that if a one-person assist is utilized the resident should be rolled toward the attendant and not away from them. This also avoids the potential of the resident rolling out of bed. An annual MDS assessment for Resident 3, dated April 17, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included a cerebral vascular accident (CVA - commonly referred to as a stroke). Care plans for the resident, dated August 11, 2022, revealed that the resident was at risk for falls related to impaired mobility, and that the resident was at risk for complications due to her activities of daily living (ADLs) dependence as evidenced by requiring assistance with her ADLs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A nursing note for Resident 3, dated May 28, 2025, at 2:38 p.m., revealed that the writer was notified by staff that the resident fell out of bed. When the writer arrived at the resident's room, she was on the floor on her back with her head facing the top of her bed and her feet toward the bottom. Per the nurse aide the resident was being provided peri care (the cleaning and care of the genitals and anal area) when she rolled off the bed. The resident hit the left side of her head off the trash can. The resident was unable to answer questions currently. The resident's pupils were sluggish; the resident could not follow the writer's finger. The resident has a one-inch scratch mark on top of her head and a hematoma (a localized collection of blood outside of blood vessels, typically caused by trauma or injury) just above her left temporal (the side of the head between the eyes and the ear) area. The resident had an emesis after hitting floor and was rolled onto her left side. The resident was lifted back up into bed by the mechanical lift and 911 was called at 2:00 p.m. A nursing note at 8:05 p.m. revealed that the resident returned to the facility from the hospital. The resident expressed a complaint of a headache related to the temporal area hematoma that measures four centimeters (cm) by three cm. A statement completed by Nurse Aide 2, dated May 28, 2025, revealed that she was providing care to Resident 3. She had rolled the resident towards the wall. She was on her right side, and as Nurse Aide 2 was changing her, the resident rolled off the bed and onto the floor. Nurse Aide 2 attempted to catch the resident but could not grab her in time. When she fell, she hit her head off the garbage can. Investigative documents for Resident 3, dated May 28, 2025, revealed that on May 28, 2025, at approximately 1:55 p.m. Nurse Aide 2 was providing care to the resident. While providing care, Nurse Aide 2 rolled the resident away from herself and the resident rolled from the bed onto the floor. The resident was sent out to the hospital for evaluation. The resident was noted to have a hematoma to her head. The investigation revealed that Nurse Aide 2 rolled the resident away from herself, which did not follow the standard of care as taught in the Nurse Aide program, which Nurse Aide 2 participated in August 2024. The facility investigation revealed that Nurse Aide 2 failed to follow the standard of care by rolling the resident away from herself, and the allegation of neglect was substantiated. Nurse Aide 2 was terminated due to the allegation of neglect being substantiated. Education records for Nurse Aide 2, dated July 30, 2024, revealed that she received education on abuse and neglect. Interview with the Director of Nursing on June 12, 2025, at 4:23 p.m. confirmed that the facility's investigation substantiated neglect because Nurse Aide 2 did not follow the facility's policy by rolling Resident 3 away from her and not towards her since she was the only one assisting the resident. Following the investigation on May 28, 2025, the facility's corrective actions included: Nurse Aide 2 was terminated from employment at the facility. Staff education on abuse was completed. Audits to identify any issues with abuse were started. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on June 4, 2025. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policies, clinical records, and facility investigation reports, as well as staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards for residents who were at risk for falls by failing to follow care-planned interventions and facility policies for two of four residents reviewed (Residents 2, 3), resulting in harm to Resident 2 due to a fall that resulted in fractured hip and harm to Resident 3 due to a fall from bed that resulted in a hematoma. This deficiency was cited as past non-compliance. Findings include: The facility's policy regarding falls, dated September 1, 2024, indicated that a resident-centered fall prevention plan was to be implemented to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The facility's policy regarding a change in status, dated September 1, 2024, indicated that all nursing staff were responsible to ensure pertinent information was communicated to the charge nurse regarding a resident's change in status and all nursing staff were to communicate to the charge nurse if a resident refused care, medications, or interventions at the time of refusal. The charge nurse would encourage the resident to participate in the plan of care. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 1, 2025, revealed that the resident was confused, required assistance from staff with daily care needs, used a walker, and had a history of falls. The resident's care plan, dated April 17, 2025, revealed that the resident was at risk for falls and was to use hipsters (padded hip protectors used to prevent injuries to the hips) at all times. A nursing note for Resident 2, dated May 24, 2025, at 12:41 p.m. revealed that staff witnessed the resident going into the bathroom with her walker and left her walker inside the bathroom door. She then walked out to the hallway, lost her balance, and tripped before staff could get to her. The resident was witnessed falling on her left side and was noted to have shortening of the left leg, and complained of pain to her left hip and upper thigh area. The physician was notified and orders were received to transfer the resident to the hospital for evaluation and treatment. At 5:14 p.m. a report was received from the hospital informing the facility that Resident 2 had a left hip fracture. Information submitted by the facility, dated May 30, 2025, revealed that on May 24, 2025, at 3:00 a.m. Resident 2 was witnessed to be resistant to care and combative throughout the shift. She woke up early in the morning, a shower was given to promote improvement of mood/behaviors, and she refused her hipsters. On May 24, 2025, at 11:40 a.m. Resident 2 had a witnessed fall in the common bathroom on the third floor, was transferred to the hospital, and had a fractured hip. It was discovered that Nurse Aide 1 did not notify any other staff of Resident 2 refusing her hipsters, which prevented the ability to put other interventions in place to prevent injuries from a fall. A written statement from Nurse Aide 1, dated May 24, 2025, revealed that Resident 2 refused to wear her hipsters after receiving a shower at 3:00 a.m. Further interviews, undated, revealed that Nurse Aide 1 confirmed that she did not report to any other staff that the resident refused her hipsters prior to the resident falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with the Nursing Home Administrator and Director of Nursing on June 12, 2025, at 4:23 p.m. confirmed that Nurse Aide 1 failed to follow the facility's policy for reporting a resident's refusal of care, which prevented staff from attempting other interventions to prevent injuries from falls, and the Nursing Home Administrator also confirmed that there was no evidence that Nurse Aide 1 re-approached Resident 2 at a later time to apply the hipsters. The facility's policy regarding positioning the resident bed, dated September 1, 2024, revealed that if a one-person assist is utilized the resident should be rolled toward the attendant and not away from them. This also avoids the potential of the resident rolling out of bed. An annual MDS assessment for Resident 3, dated April 17, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included a cerebral vascular accident (CVA - commonly referred to as a stroke). Care plans for the resident, dated August 11, 2022, revealed that the resident was at risk for falls related to impaired mobility, and that the resident was at risk for complications due to her activities of daily living (ADLs) dependence as evidenced by requiring assistance with her ADLs. A nursing note for Resident 3, dated May 28, 2025, at 2:38 p.m. revealed that the writer was notified by staff that the resident fell out of bed. When the writer arrived at the resident's room, she was on the floor on her back with her head facing the top of her bed and her feet toward the bottom. Per the nurse aide the resident was being provided peri care (the cleaning and care of the genitals and anal area) when she rolled off the bed. The resident hit the left side of her head off the trash can. The resident was unable to answer questions currently. The resident's pupils were sluggish; the resident could not follow the writer's finger. The resident had a one-inch scratch mark on top of her head and a hematoma (a localized collection of blood outside of blood vessels, typically caused by trauma or injury) just above her left temporal (the side of the head between the eyes and the ear) area. The resident had an emesis after hitting floor and was rolled onto her left side. The resident was lifted back up into bed by the mechanical lift and 911 was called at 2:00 p.m. A nursing note at 8:05 p.m. revealed that the resident returned to the facility from the hospital. The resident expressed a complaint of a headache related to the temporal area hematoma that measures four centimeters (cm) by three cm. A statement completed by Nurse Aide 2, dated May 28, 2025, revealed that she was providing care to Resident 3. She had rolled the resident towards the wall. She was on her right side, and as Nurse Aide 2 was changing her, the resident rolled off the bed and onto the floor. Nurse Aide 2 attempted to catch the resident but could not grab her in time. When she fell, she hit her head off the garbage can. Investigative documents for Resident 3, date May 28, 2025, revealed that on May 28, 2025, at approximately 1:55 p.m. Nurse Aide 2 was providing care to the resident. While providing care, Nurse Aide 2 rolled the resident away from herself and the resident rolled from the bed onto the floor. The resident was sent out to the hospital for evaluation. The resident was noted to have a hematoma to her head. The investigation revealed that Nurse Aide 2 rolled the resident away from herself, which did not follow the standard of care as taught in the Nurse Aide program, which Nurse Aide 2 participated in August 2024. The facility investigation revealed that Nurse Aide 2 failed to follow the standard of care by rolling the resident away from herself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing on June 12, 2025, at 4:23 p.m. confirmed that because Nurse Aide 2 did not follow the facility's policy by rolling Resident 3 away from her and not towards her since she was the only one assisting the resident. Following the investigation on May 28, 2025, the facility's corrective actions included: Nurse Aide 2 was terminated from employment at the facility. Preformed audits of residents' bed mobility. Any residents with questionable bed mobility status are being evaluated by therapy to determine recommendations. Staff education on bed mobility policy, techniques for transfer, and moving, was completed. Specific bed mobility recommendations were added to the care plan and Kardex (a system, either paper-based or electronic, used by nurses to track and manage key patient information). Audits to identify any issues with care provided to residents were started. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on June 4, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(10 Management. 28 Pa. Code 201.24(e)(4) admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.