

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Meadow View Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with staff it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for two of three ice machines observed. Findings include: Observations of the ice machine in the second floor nutrition room on February 4, 2026, at 8:48 a.m. revealed a dark, removable substance around the seal of the ice machine lid. The parts in the ice machine that the ice dispenses from were covered with a faint black removable substance. Observations of the ice machine in the third floor nutrition room on February 4, 2026, at 8:58 a.m. revealed that the parts in the ice machine that the ice dispenses from were covered with a brown removable substance that had water tracks leading into the ice. Interview with the Environmental Services/Maintenance Director on February 4, 2026, at 9:14 a.m. confirmed the above-mentioned observations. He stated that the ice machines are on a cleaning schedule quarterly and that the first floor ice machine was cleaned January 28, 2026, as per the cleaning schedule. He indicated that the second and third floor ice machines were due to be cleaned last week; however, they were not. 28 Pa. Code 211.6 Dietary		

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include:.The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending February 7, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending February 5, 2026, identified repeated deficiencies related to professional nursing services, safe environment free of accident hazards, proper intravenous care, and timely nurse aide performance reviews. The facility's plan of correction for a deficiency regarding quality of care cited during the survey ending February 7, 2025, revealed that quality of care would be monitored by QAPI. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding quality of care. The facility's plan of correction for deficiencies regarding providing a safe environment free of accident hazards, cited during the survey ending February 7, 2025, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding safety and accident-free environment.The facility's plan of corrections for deficiencies regarding proper intravenous care, cited during the survey ending February 7, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F694, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding intravenous care.The facility's plan of correction for a deficiency regarding documentation of nurse aides annual performance evaluations, cited during the survey ending February 7, 2025, revealed that audits of care plans would be completed, and the results would be reported to the QAPI committee for review. The results of the current survey, cited under F730, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding nurse aide performance reviews.Refer to F684, F689 F694 and F730. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident representative in advance of the risks and benefits of psychotropic medication (medications that affect the persons mental state, emotions and behavior) use and the treatment alternatives prior to initiating the administration of the medication for four of 40 residents reviewed (Residents 6, 31, 50 and 92). Findings include: A facility policy related to psychotropic medications, dated January 19, 2026, indicated that prior to initiating antipsychotic medications, the facility will evaluate the resident's physical, behavioral, mental, and psychosocial signs and symptoms to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment and review the risks versus benefits with the resident and/or responsible party and obtain consent. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated November 7, 2025, revealed that the resident was cognitively impaired, received psychotropic medications, including antipsychotic, antidepressant and antianxiety medications, and had diagnoses that included bipolar disorder, anxiety, and dementia. Physician's orders for Resident 6, dated January 30, 2026, included an order for the resident to receive one milligram (mg) of Haldol Decanoate (an antipsychotic medication) intramuscularly (injection in the muscle) one time only for agitation and anxiety. There was no documented evidence in Resident 6's clinical record to indicate that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the Haldol Decanoate. Interview with the Nursing Home Administrator on February 5, 2026, at 11:19 a.m., confirmed that there was no documented evidence in Resident 6's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the Haldol Decanoate. A significant change MDS assessment for Resident 31, dated January 14, 2026, revealed that the resident was severely cognitively impaired, had moderately impaired speech and vision, was sometimes understood and sometimes understands, received antipsychotic medications, and had diagnoses that included, dementia, bipolar disorder, major depressive delusional disorder, behavior disturbances/agitation and Alzheimer's disease. Physician's orders for Resident 31, dated January 8, 2026, included an order for the resident to receive 1.5 mg of Brexpiprazole (antipsychotic medication) by mouth at bedtime related to recurrent major depressive disorder, history of mental and behavioral disorders with depression and delusions. There was no documented evidence in the resident's clinical record to indicate that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating Brexpiprazole. Interview with the Director of Nursing on February 5, 2026, at 2:23 p.m., confirmed that there was no documented evidence in Resident 31's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating Brexpiprazole, and there should have been. An annual MDS assessment for Resident 50, dated January 7, 2026, revealed that the resident was cognitively intact, received psychotropic medications, including antidepressant medications, and had diagnoses that included anxiety, depression and Alzheimer's disease. A nursing note for Resident 50, dated December 18, 2025, at 10:51 a.m. revealed that the resident was seen by the Certified Registered Nurse Practitioner (CRNP) and recommended to increase the resident's Sertraline (an antidepressant) to 100 mg daily. Physician's orders for Resident 50, dated December 18, 2025, included an order for the resident to receive 100 mg of Sertraline daily at bedtime for depression. A nursing note for Resident 50, dated January 27, 2026, at 1:02 p.m. revealed that the resident was seen by the CRNP and recommended to increase the resident's Mirtazapine (an antidepressant) to 30 mg daily. Physician's orders for Resident 50, dated January 27, 2026, included an order for the resident to receive 30 mg of Mirtazapine daily at bedtime for depression. There was no documented evidence in Resident 50's clinical record to indicate that the resident's representative was informed in advance of (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the risks and benefits and treatment alternatives prior to initiating the increased doses of Sertraline and Mirtazapine. Interview with the Nursing Home Administrator on February 5, 2026, at 11:19 a.m., confirmed that there was no documented evidence in Resident 50's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased doses of Sertraline and Mirtazapine. A quarterly MDS assessment for Resident 92, dated January 15, 2026, revealed that the resident was cognitively impaired, received psychotropic medications, including antipsychotic and antidepressant medications, and had diagnoses that included depression and schizoaffective disorder. A nursing note for Resident 92, dated December 18, 2025, at 1:02 p.m. revealed that the resident was seen by the CRNP and recommended to increase the resident's Mirtazapine (an antidepressant) to 15 mg daily. Physician's orders for Resident 92, dated December 18, 2025, included an order for the resident to receive 15 mg of Mirtazapine daily at bedtime for depression. Interview with the Nursing Home Administrator on February 5, 2026, at 11:19 a.m., confirmed that there was no documented evidence in Resident 92's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased dose of Mirtazapine. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and interviews with residents and staff, it was determined that the facility failed to ensure that call bells were within reach for three of 40 residents reviewed (Residents 50, 95 and 97). Findings include: A review of the facility's call bell policy, dated January 19, 2026, indicated that every resident living at the facility will have a means of communicating with staff from their room when they are in need of assistance. Every resident should have the peace of mind knowing that they can summon assistance regardless of their physical limitations. Each call bell is to be strategically located so that it is within the reach of the resident whether lying on their bed or sitting in a chair in their room. Pressure sensitive call bells are available for those residents who have limited dexterity and cannot push the call bell button. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 50, dated January 7, 2026, revealed that the resident was cognitively intact, required assistance with care needs, had a fall since his prior assessment, and had a diagnosis of Alzheimer's disease. A fall risk care plan for Resident 50, dated March 2, 2022, indicated that the resident was at risk for falls due to his impaired vision and had an intervention to keep his call bell in reach to encourage him to use it for assistance. Observation of Resident 50 on February 2, 2026, at 11:23 a.m. revealed that the resident was lying in his bed and his call bell was hanging across his bedside dresser to the left of the resident and behind the resident not within the resident's reach. Interview with the resident at that time indicated that he was unable to locate his call bell. Interview with Licensed Practical Nurse XX ([NAME]) on February 2, 2026, at 11:32 a.m. confirmed that Resident 50's call bell was not in reach and that he is capable of using his call bell for assistance. Observation of Resident 95 on February 2, 2026, at 11:45 a.m. revealed that the resident was sitting in her wheelchair with her overbed table in front of her and her soft touch call bell placed on her bedside dresser located behind her and not in reach. A nurse aide delivered her lunch tray at 11:57 a.m. and left the room without placing her call bell within reach. Interview with Nurse Aide XX ([NAME]) on February 2, 2026, at 12:00 p.m. confirmed that Resident 95's call bell was not in reach and should have been. Observation of Resident 97 on February 2, 2026, at 11:36 a.m. revealed that the resident was lying in bed, and his call bell was lying across his recliner chair to the left of his bed and not within reach. Interview with Licensed Practical Nurse XX ([NAME]) on February 2, 2026, at 11:44 a.m. revealed that Resident 97 currently had a urinary tract infection and was confused. She confirmed that his call bell was not in reach and stated that they check on him, but the nurse aide probably forgot to put it back in reach after a.m. care. Interview with the Nursing Home Administrator on February 2, 2026, at 3:30 p.m. confirmed that Resident 50, Resident 95 and 97's call bells should have been within reach and they were not. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for three of 40 residents reviewed (Residents 3, 9, 92). Findings include: The facility's medication administration policy, dated January 19, 2026, indicated that medications were to be administered in accordance with the physician's orders, including any required time frame. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated November 21, 2025, revealed that the resident was cognitively impaired, had pressure ulcers, and received an antibiotic intravenously. A physician's note for Resident 3, dated November 18, 2025, revealed that the resident had a wound to the left heel that continued to decline. A physician's order was received to administer 3.375 grams of Piperacillin-Tazobactam intravenously every six hours for a left heel wound infection for 14 days. Review of the resident's Medication Administration Record (MAR) for November 2025 revealed Piperacillin-Tazobactam was not administered on November 26, 2025, at 6:00 a.m. and 6:00 p.m. Interview with the Director of Nursing on February 5, 2026, at 1:07 p.m. confirmed that there was no documented evidence that Resident 3's Piperacillin-Tazobactam was administered as ordered on the above date and times. A quarterly MDS assessment for Resident 9, dated December 9, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, received insulin (medication that lowers blood sugar levels), and had diagnoses that included diabetes. Physician's orders for Resident 9, dated September 12, 2025, included an order for the resident to receive Lispro Insulin 100 unit/ml according to a sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) before meals and at bedtime. (scheduled for 5:00 a.m., 12:30 p.m., 5:30 p.m., 9:30 p.m. on Monday, Wednesday and Friday and 7:30 a.m., 12:30 p.m., 5:30 p.m., 9:30 p.m. on Tuesday, Thursday and Sunday). The sliding scale included giving 0 units of insulin for a blood sugar of 70-140 milligrams/deciliter (mg/dl), 2 units for a blood sugar of 141-180 mg/dL, 4 units for a blood sugar of 180-220 mg/dL, 6 units for a blood sugar 221-260 mg/dL, 8 units for a blood sugar of 261-300 mg/dL, 10 units for a blood sugar of 301-340 mg/dl, 12 units for a blood sugar 341 mg/dL or greater, and to notify the physician for further orders. Resident 9's Medication Administration Record (MAR) for November 2025 revealed that the residents blood sugar results were greater than 341 mg/dL at 12:30 p.m. on November 17 and 26, 2025; at 5:30 p.m. on November 1, 15 and 16, 2025; at 9:30 p.m. November 18, 2025. There was no documented evidence that the physician was notified that the resident's sliding scale blood sugar results were greater than 341 mg/dL on the dates and times mentioned. Resident 9's MAR for December 2025 revealed that the residents blood sugar results were greater than 341 mg/dL at 12:30 p.m. on December 23, 2025, and 9:30 p.m. on December 22, 2025. There was no documented evidence that the physician was notified that the resident's sliding scale blood sugar results were greater than 341 mg/dL on the dates and times mentioned. Resident 9's MAR for January 2026 revealed that the residents blood sugar results were greater than 341 mg/dL at 7:30 a.m. on January 6, 2026; at 12:30 p.m. on January 26, 2026, and at 9:30 p.m. on January 10, 2026. There was no documented evidence that the physician was notified that the resident's sliding scale blood sugar results were greater than 341 mg/dL on the dates and times mentioned. Interview with the Nursing Home Administrator February 5, 2026, at 11:19 a.m. confirmed that the physician should have been notified when Resident 9's sliding scale results were 341 mg/dL or greater. A quarterly MDS assessment for Resident 92, dated January 15, 2026, revealed that the resident was cognitively impaired, received insulin, and had a diagnosis of diabetes. Physician's orders for Resident 92, dated October 22, 2024, included an order for the resident to have her blood sugar checked before meals and at bedtime and for staff to administer insulin (medication used to lower blood sugar) per a sliding scale (dose is based on a person's blood sugar). Physician's orders for Resident 92, dated July 26, 2024, included an order for the resident to have a blood glucose protocol including steps for blood glucose results of 60-80 milligrams per deciliter (mg/dl), 50-59 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg/dl, less than 50 mg/dl and greater than 400 mg/dl as needed/as follows: If blood glucose 60-80 mg/dl give 120 milliliters (ml) of juice and recheck in 15 minutes. Repeat treatment if blood glucose is less than 80 mg/dl; If blood glucose is between 50-59 mg/dl, administer one Glucose Gel if able to swallow or one Glucagon injection if unable to swallow and recheck glucose in 15 minutes. Repeat treatment if glucose is between 50-59 mg/dl; If blood glucose is less than 50 mg/dl, administer two Glucose gels if able to swallow or two Glucagon injections if unable to swallow. Notify the physician if blood glucose is greater than 400 mg/dl or less than 60 mg/dl. Notify physician during normal office hours if blood glucose was less than 50 mg/dl and interventions were effective. Review of Resident 92's MAR for October 2025 through February 2026 revealed that the resident's blood sugar on October 22, 2025, at 5:30 p.m. was 76 mg/dl; on November 4, 2025, at 7:30 a.m. was 71 mg/dl; on December 12, 2025, at 7:30 a.m. was 73 mg/dl; on December 15, 2025, at 5:30 p.m. was 75 mg/dl ; on January 5, 2026, at 5:30 p.m. was 50 mg/dl ; on January 9, 2026, at 7:30 a.m. was 70 mg/dl ; on January 22, 2026, at 7:30 a.m. was 70 mg/dl; on January 25, 2026, at 7:30 a.m. was 74 mg/dl; on January 29, 2026, at 8:30 p.m. was 72 mg/dl; and on February 1, 2026, at 7:30 a.m. was 74 mg/dl. There was no documented evidence that the blood sugar protocol was followed as ordered. Interview with the Nursing Home Administrator on February 4, 2026, at 12:23 p.m. confirmed that there was no documented evidence that Resident 92's blood sugar protocol was followed as ordered on the above-mentioned dates and times. 28 Pa. Code 211.12(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. Based on review of clinical records, including an incident report, as well as observations, and staff interviews, it was determined that the facility failed to ensure that fall prevention interventions were in place as care planned for one of 40 residents reviewed (Resident 31), and that a thorough investigation was conducted to determine the safety of the shower chair for one of 40 residents reviewed (Resident 66). Findings include: The facility's policy regarding fall management, dated January 19, 2026, indicated that the purpose was to reduce the risk of falls and prevent injury. The facility would mitigate accidents by providing an environment that remains as free of hazards as possible over which the facility has control and each resident receives adequate supervision and assistive devices. The facility identifies each resident at risk for accidents and/or falls and adequately plans care and implements procedures to manage avoidable accidents. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 31, dated January 14, 2026, revealed that the resident was severely cognitively impaired, moderately impaired for vision and speech, sometimes understood and sometimes understands, lived in the memory care unit, had diagnoses that included Alzheimer's disease, dementia, anxiety, history of mental, behavioral and delusional disorders with disturbances that required assistance from two staff to transfer the resident. The resident's care plan, revised on May 22, 2025, indicated that she was at risk for falls related to poor safety awareness, confusion and a history of falls, and was to have a sensor pad/alarm/ to her bed and chair. An incident note, dated January 3, 2026, at 7:30 p.m. indicated that the resident had a witnessed fall in the memory unit common area/solarium that resulted in a hip fracture. A review of the fall incident report, and multiple witness statements dated, January 3, 2026, indicated that Resident 31 was restless and was assisted from her recliner to a chair at a round table in the common area/solarium. The resident pushed herself to a standing position and fell. The resident did not have the sensor pad/alarm on the chair she was sitting in, per her care plan, at the time of her fall. Interview with the Nursing Home Administrator on February 5, 2026, at 1:10 p.m. indicated that she questioned that the absence of the chair alarm would have prevented the fall. This surveyor confirmed that Resident 31 did not have her care planned fall intervention, the sensor pad/alarm placed on the chair she was sitting in. The facility's policy for Durable Medical Equipment (DME) dated December 31, 2025 revealed that the facility will ensure that all DME used by residents is clinically appropriate, properly ordered, safely maintained, and used in a manner that promotes resident safety and quality of care. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 66, dated December 24, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care, assistance of one staff for bathing/showers and had a diagnosis of morbid obesity. An incident report for Resident 66, dated January 18, 2026, at 4:20 p.m. revealed that the resident was seated in a shower chair in the shower room. While the resident was sitting in the shower chair one of the supportive connections of the PVC (a rigid, durable and corrosion-resistant thermoplastic) pipe cracked weakening the strength of the chair. Resident 66 did not fall through the chair. A nursing assessment was completed at the time of the incident that revealed no injuries. He was transferred to his wheelchair and taken back to his room. The shower chair was removed from service by the director of maintenance. Interview with the Director of Maintenance and the Nursing Home Administrator February 3, 2026, at 1:35 p.m. revealed that the chair was taken out of service immediately and it was disposed of. The Maintenance Director stated that the shower chairs are inspected monthly and if there are any concerns with the chairs it is immediately corrected and documented as to what the corrective action was. Review of four months of the inspections revealed that the chair was last inspected December 24, 2025 and there were no (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported concerns with the shower chair. The inspection documentation listed each shower chair by number and not a specific model number or weight limit. Observation in the second floor shower room February 4, 2026, at 9:36 a.m. revealed 2 shower chairs that were labeled with the model number and the weight limit. Interview with the Maintenance Director at that time revealed that the chairs observed in the shower room were in service and being used by staff for resident care. Interview with the Nursing Home Administrator February 4, 2026, at 2:47 p.m. revealed the she did not have documentation of the model number or the weight limit of the shower chair that was used for Resident 66 on January 18, 2026. Interview with the Nursing Home Administrator February 5, 2026, at 11:23 a.m. confirmed that the investigation that was completed concerning the incident on January 18, 2026 did not determine the safety of the shower chair that was used for Resident 66 and it should have. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that interventions were in place to prevent urinary tract infections for one of 40 residents reviewed (Resident 3) who had an indwelling urinary catheter. Findings include: The facility policy for urinary catheters, dated January 19, 2026, revealed that clean technique was to be used when handling the catheter, tubing or drainage bag. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated November 21, 2025, revealed that the resident was cognitively impaired, dependent on staff for daily care needs, was frequently incontinent of urine, had pressure ulcers, and had diagnoses that included dementia. Physician's orders for Resident 3, dated December 24, 2025, included an order for the resident to have an indwelling urinary catheter (a flexible tube inserted and held in the bladder to drain urine) for wound healing. Observations of Resident 3 on February 5, 2026, at 9:34 a.m. revealed that she was in bed and her catheter drainage tubing was in direct contact with the floor. Interview with Licensed Practical Nurse 1 on February 5, 2026, at 9:38 a.m. confirmed that the catheter tubing was on the floor and should not have been. 28 Pa. Code 211.12(d)(5) Nursing Services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Meadow View Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that long-term intravenous catheters were flushed per physician's order and facility policy for one of 40 residents reviewed (Resident 120). Findings include: The facility's policy regarding the flushing of peripheral (PICC) and midline intravenous catheters (a catheter that is placed in a peripheral vein for long-term administration of fluids and/or medication), dated January 19, 2026, indicated that the peripheral or midline catheter was to be flushed with 10 cubic centimeters (cc's) of normal saline (sterile salt and water solution) every shift and after each use with 5-10 cc's of normal saline and 5 cc's of Heparin (blood thinner), if physician's orders indicated. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 120, dated December 11, 2025, indicated that the resident was cognitively intact, was understood and able to understand others, required assistance with care needs, received an intravenous medication, and had a diagnosis of cancer. A nursing note, dated December 5, 2025, revealed the resident was admitted to the facility and had a PICC line to his left upper arm. Physician's orders for Resident 120, dated December 5, 2025, included an order for the resident to have each port of his PICC line flushed with 10 cc's of normal saline every shift. Review of the Medication Administration Record (MAR) for Resident 120 for December 2025 and January 2026 revealed that there was no documented evidence that both ports of the resident's PICC line were flushed every shift on December 7, 9, 14, 16, 18, 21, 24, and 30, 2025, and January 6, 12, 14, 17, 18, 19, 21-25, and 29, 2026. Interview with the Nursing Home Administrator on February 5, 2026, at 12:44 p.m. confirmed that there was no documented evidence that Resident 120's PICC line was flushed every shift as ordered by the physician and per facility policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

Department of Health & Human Services
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NAME OF PROVIDER OR SUPPLIER Meadow View Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that there was a physician's order for oxygen therapy for two of 40 residents reviewed (Residents 2, 24). Findings include: The facility's policy for oxygen use, dated January 19, 2026, revealed that residents who required oxygen would have a physician's order which included the oxygen flow rate, how the oxygen would be administered (i.e. nasal cannula or mask), if humidified air was required, and how often the oxygen tubing should be changed. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 9, 2025, revealed that the resident was cognitively intact, used oxygen, and had diagnoses that included pulmonary embolism (blood clot that goes to lungs). Nursing notes, dated November 7 at 10:46 a.m., November 10 at 11:14 a.m., November 12 at 10:35 p.m., November 15 at 11:02 a.m., and November 16, 2025, at 10:17 a.m., revealed the resident was using 3 liters per minute (lpm) of oxygen via nasal cannula (tube that delivers oxygen through the nose). There was no documented evidence that a physician's order was obtained for Resident 2 to use oxygen during this time. Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for November 2025 revealed that there was no documented evidence that Resident 2 used oxygen. An admission MDS assessment for Resident 24, dated January 18, 2026, revealed that the resident was cognitively impaired, dependent on staff for daily care tasks, and had diagnoses that included heart disease. A care plan, dated January 4, 2026, indicated that Resident 24's oxygen was to be administered as ordered. A nursing note for Resident 24, dated January 12, 2026, at 11:38 p.m. revealed the resident returned from the hospital and was using 2 lpm of oxygen. Nursing notes dated January 13 at 11:23 a.m., January 14 at 6:36 p.m., January 15 at 8:47 a.m., January 17 at 12:26 p.m., and January 18, 2026 at 11:43 a.m., revealed the resident was using 2 lpm of oxygen via nasal cannula. There was no documented evidence that a physician's order was obtained for Resident 24 to use oxygen during this time. Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for January 2026 revealed that there was no documented evidence that Resident 24 used oxygen during this time. Interview with the Nursing Home Administrator on February 4, 2026, at 1:40 p.m. confirmed that there was no physician's order for Resident 2 and 24's use of oxygen. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of facility policies and personnel files, as well as staff interviews, it was determined that the facility failed to complete a performance review of every nurse aide at least once every 12 months for one of three nurse aides reviewed (Nurse Aide 2). Findings include: The facility's policy regarding performance evaluations, dated January 19, 2026, indicated that performance evaluations were to be completed for all employees annually. A review of the annual performance evaluation for Nurse Aide 2 revealed the evaluation was completed on September 21, 2024. As of February 5, 2026, there was no documented evidence that an annual performance evaluation had been completed since September 21, 2024. Interview with the Nursing Home Administrator on February 5, 2026, at 12:36 p.m. confirmed that the annual performance evaluation was not completed as required for Nurse Aide 2.28 Pa. Code 201.18(e)(1) Management.		