STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395519	A. BLDG: 00 B. WING:	12/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN MEADOWS NURSING & REHABILITATION CENTER STATE LICENSE NUMBER: **137702**	**283 EAST LANCASTER AVE** **MALVERN, PA 19355**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State licensure, Civil Rights Compliance Survey and an abbreviated survey for two complaints completed on December 11, 2025, it was determined that Green Meadows Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations for the Health portion of the survey process.	F 0000		
F 0578 SS=D		F 0578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Resident 114 code status was reviewed with resident/representative and confirmed desire for DNR status. Care plan, Physician order and POLST reviewed and revised. Facility wide audit of POLST, Physician order and care plan was done to assure clinical record and POLST are consistent with residents wishes. DON/Designee educated licensed nursing staff and social services staff on importance of assuring POLST, Physician order and care plan are consistent with residents wishes. Random audits will be conducted of resident's clinical record to assure that POLST, Physician order and care plan are consistent. Audits will be done daily x 5 days, then weekly x4, then monthly x2 or until compliance is achieved. Results will be discussed in monthly QAPI meeting.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 3 Based upon clinical record review, it was determined that the facility failed to ensure appropriate advance directives regarding code status were in place for one of 33 residents reviewed. (Resident 114) Findings include: Review of Resident 114's clinical record revealed a physician's order dated October 18, 2025, stating Resident 114 was a Full Code. Review of Resident 114's current care plan revealed Resident 114 had a Full Code Status. Review of a Physician's Order for Life Sustaining Treatment (POLST) signed by Resident 114 and dated November 7, 2025, revealed Resident 114's wishes to have a Do Not Resuscitate status. Interview with the Director of Nursing on December 11, 2025, at 10:00 a.m. confirmed that Resident 114's clinical record did not concur with the POLST	F 0578		

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F 0578 SS=D	Continued from page 4 signed by Resident 114. 28 Pa. Code 201.14(a) Responsibility of Licensee Previously cited 10/9/2024 28 Pa. Code 211.12(c)(d)(3) Nursing Services Previously cited 10/9/2024, 4/30/2025	F 0578		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 5 483.20(g)(h)(i)(j) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	Resident 29 was discharged. Section H of MDS submitted within the last 14 days will be reviewed to assure clinical record and MDS coding is consistent with resident assessment of bowel and bladder. Administrator/Designee will educate clinical reimbursement staff on ensuring MDS coding is consistent with clinical record for resident assessment of bowel and bladder status. Random audits of Section H of MDS submitted will be conducted to assure clinical record and MDS coding is consistent with resident assessment of bowel and bladder. Audits will be done weekly x4, then monthly x2 or until compliance is achieved. Results will be discussed in monthly QAPI meeting.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

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F 0641 SS=D	Continued from page 6 This REQUIREMENT is not met as evidenced by:	F 0641		

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F 0641 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate assessments for one of 33 residents reviewed (Resident 29) Findings include: Review of Resident 29's admission MDS (Minimum Data Assessment - periodic assessment of resident needs) dated November 30, 2025, section H, Bladder and Bowel, indicated that the resident had an indwelling catheter (flexible tube that carries fluids into or out of the body). Further review of the clinical record no evidence that the resident had an indwelling catheter. Interview with the licensed staff E3 on December 11, 2025, at 10:45 a.m. confirmed that the resident did not have an indwelling catheter and that the MDS was coded incorrectly. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641		

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F 0641 SS=D	Continued from page 8	F 0641		
F 0692 SS=E		F 0692		

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F 0692 SS=E	Continued from page 9 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	The facility cannot retroactively correct this issue. All residents were provided fresh water cups for hydration. Facility wide audit conducted by DON/Designee to assure that residents were provided fresh water cups for hydration. DON/Designee educated nursing staff on the importance of assuring that residents were provided fresh water cups for hydration. Random room audits will be conducted to assure that residents are provided fresh water cups for hydration. Audits will be done weekly x4, then monthly x3 or until compliance is achieved. Results will be discussed at monthly QAPI.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

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F 0692 SS=E	Continued from page 10 Based on observations and staff interviews it was determined that the facility failed to provide hydration for fifteen of thirty-two rooms on the 1st floor dementia care unit. Findings Include: Observations made of resident rooms on December 8, 2025, December 9, 2025, and December 10, 2025, revealed rooms 100 through 115 had no cups of fresh water for resident's hydration or the cups were dated between November 14, 2025, and December 1, 2025. Rooms 116 through 132 were observed to have currently dated cups with fresh water. Observations made on December 8, 2025, December 9, 2025, and December 10, 2025, of rooms 113 and 114 revealed cups of water dated November 14, 2025. Observations made on December 8, 2025, December 9, 2025, and December 10, 2025, of	F 0692		

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F 0692 SS=E	Continued from page 11 room 101 revealed a cup of water dated December 1, 2025. All remaining rooms between 100 and 115 had no water cups. Interview on December 10, 2025, at 12:43 p.m., with Registered Nurse Employee E4, E4 confirmed knowledge of rooms 100 through 115 not having fresh water with properly dated cups. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 10, 2025, at 1:30 p.m., when the above information was presented, the NHA and DON denied knowledge of residents not receiving fresh hydration dailyand stated they would investigate the matter. 28 Pa. Code 211.10 (c)Resident care policies 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.12(d)(1)(5) Nursing services	F 0692		

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F 0692 SS=E	Continued from page 12	F 0692		
F 0757 SS=D		F 0757		

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F 0757 SS=D	Continued from page 13 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	Resident 35's clinical record was revised to show evidence of monitoring of side effects of the anti-depressant medication and its effectiveness. DON/Designee conducted a facility wide audit of current residents on antidepressant medications to ensure monitoring of side effects and its effectiveness are in place. DON/Designee educated nursing staff on the importance of monitoring side effects and its effectiveness for residents on antidepressant medications. DON/Designee will randomly audit residents with antidepressant medication to ensure effectiveness and side effects are monitored. Audits will be done weekly x4 then monthly x2 or until compliance is achieved. Results will be discussed at monthly QAPI.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

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F 0757 SS=D	Continued from page 14 Based upon clinical record review, it was determined that the facility failed to ensure appropriate monitoring for side effects and effectiveness were completed for the use of an anti-depressant medication for one of 33 records reviewed (Resident 35). Findings include: Review of Resident 35's diagnosis list revealed a diagnosis of major depressive disorder. Review of Resident 35's physician's orders dated November 27, 2025, revealed an order for Mirtazapine (antidepressant) to be administered for treatment of Resident 35's depression. Further review of Resident 35's clinical record failed to reveal evidence of monitoring for side effects of the anti-depressant medication and failed to reveal documented evidence of the effectiveness of the anti-depressant medication.	F 0757		

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F 0757 SS=D	Continued from page 15 Interview with the Director of Nursing on December 11, 2025, at 11:00 a.m. confirmed that no monitoring for side effects of the anti-depressant medication was conducted and further that no monitoring of the effectiveness of the medication was conducted. 28 Pa. Code 211.12(c)(d)(3) Nursing Services Previously cited 10/9/2024, 4/30/2025	F 0757		
F 0810 SS=D		F 0810		

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GREEN MEADOWS NURSING & REHABILITATION CENTER STATE LICENSE NUMBER: **137702**	**283 EAST LANCASTER AVE MALVERN, PA 19355**

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F 0810 SS=D	Continued from page 16 483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by:	F 0810	The facility cannot retroactively correct this issue. Resident 7 was given a Kennedy cup for all meals. DON/Designee conducted a facility wide audit of residents who has orders for adaptive equipment to ensure appropriate adaptive equipment was in place during meals. DON/Designee educated Nursing/Dietary staff on the importance of assuring that assistive devices ordered are in place during meals. DON/Designee will conduct meal observations weekly x 4 then monthly x3 or until compliance is achieved to verify adaptive equipment ordered is present during meals. Results will be discussed at monthly QAPI.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395519	A. BLDG: 00 B. WING:	12/11/2025

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F 0810 SS=D	Continued from page 17 Based on observations, interviews and record reviews it was determined that the facility failed to provide an assistive device for one of seven residents investigated, (Resident 7). Findings Include: Review of Resident 7's physician orders revealed an order for regular diet, regular texture, thin consistency Kennedy Cup (a spill-proof drinking cup with a secure lid and J-shaped handle) built up fork and spoon dated May 21, 2025. Review of Resident 7's care plan revealed a care plan for nutritional problem orpotential nutritional problem related to need for assist with meals, intellectual disability, and weight stable. Review of Resident 7's face sheet revealed medical diagnoses that include Encephalopathy (a group of conditions that cause brain dysfunction). Observations made of Resident 7 on December 8,	F 0810		

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F 0810 SS=D	Continued from page 18 2025, December 9, 2025, and December 10, 2025, during lunch service revealed the resident drinking from a regular cup with a straw. Interview on December 10, 2025, at 12:43 p.m., with Unit Manager Registered Nurse Employee E4, E4 confirmed knowledge of resident not drinking from a Kennedy cup as per physician order. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 10, 2025, at 12:48 p.m., when the above information was presented, the NHA and DON denied knowledge of the resident not utilizing a Kennedy cup. Interview conducted on December 11, 2025, at 10:58 a.m., with the DON who stated that a new order of Kenndy cups had been received and were now available for Resident 7's use. 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10 (d) Resident care policies	F 0810		

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F 0810 SS=D	Continued from page 19 28 Pa Code 211.12(d)(1)(5) Nursing services	F 0810		
F 0910 SS=E		F 0910		

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F 0910 SS=E	Continued from page 20 483.90(e) Resident Room §483.90(e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by:	F 0910	Soiled curtains were immediately replaced with clean privacy curtains and privacy curtains were hung in rooms that were missing privacy curtains. Facility wide audit conducted by NHA/Designee to ensure resident rooms have privacy curtains and are free from soilage. NHA/ Designee provided education to housekeeping and maintenance staff on assuring that resident rooms have privacy curtains in place and free from soilage. NHA /Designee will audit random rooms to ensure privacy curtains are present and free from soilage. Audits will be done weekly x4 then monthly x2 or until compliance is achieved. Results will be discussed at monthly QAPI.	Completion Date: **01/26/2026** Status: **APPROVED** Date: **12/29/2025**

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F 0910 SS=E	Continued from page 21 Based on observations and staff interviews it was determined that the facility failed to provide privacy curtains for three of thirty-two resident rooms and failed to provide clean privacy curtains for eighteen of thirty-two resident rooms located on the 1st floor dementia care unit. Findings Include: Observations made on December 8, 2025, December 9, 2025, and December 10, 2025, of resident rooms on the 1st floor dementia care unit revealed 3 rooms with missing privacy curtains. Observations made on December 8, 2025, December 9, 2025, and December 10, 2025, of resident rooms on the 1st floor dementia care unit revealed 18 rooms with privacy curtains that were soiled or had brown stains on them. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 11, 2025, at 10:58 a.m.,	F 0910		

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F 0910 SS=E	Continued from page 22 when the above information was presented, the NHA stated the facility was in the process of remodeling the 1st floor and new privacy curtains have already been ordered for all rooms. 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10 (d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services	F 0910		

Certified End Page

GREEN MEADOWS NURSING & REHABILITATION CENTER

STATE LICENSE NUMBER: 137702

SURVEY EXIT DATE: 12/11/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY