STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395296	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Rehabilitation and Nursing Center	9209 Ridge Pike White Marsh, PA 19128

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based upon review of resident records, and interviews with residents and staff determined the facility failed to follow a resident's care plan consistent with the resident's rights that meets a resident's mental and psychosocial needs by failing to ensure one resident does not receive male care givers as indicated of 15 resident records reviewed (Resident R2). Findings include:Resident R2 was initially admitted to the facility June 2019 diagnosed with post traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event).Resident R2's care plan dated September 23, 2023, for ineffective coping due to past traumatic events that triggers include male care givers. Per the sister's request is not to have a male aide.Review of documentation received from the facility stated on May 1, 2025, Resident R2 made allegations of abuse when a male aide, Employee E9 was assigned to the resident.Interview with Employee R9 on October 21, 2025, at 3:00 p.m. confirmed the aide was assigned Resident R2 on May 1, 2025, and stated he was aware Resident R2 was not to receive care from male aides. Interview with Resident R2 on October 22, 2025, at 10:00 a.m., confirmed the resident did not want male aides to assist with care. 28 Pa Cre 211.109d) Resident care policies28 PA. Code 211.12(d)(1)(5) Nursing services

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with staff, reviews of facility policies and procedures, and hospital records, it was determined the facility failed to assess, monitor, and implement intervention to ensure that nutritional and hydration needs were met for one of 11 residents reviewed. (Resident R1). This failure resulted in actual harm to Resident CL1 who did not consume sufficient fluid and caloric intake resulting in abnormal blood values, requiring transfer, and admission to the hospital for the treatment of dehydration/electrolyte imbalance. (Resident CL1) Findings include:Review of facility policy titled nutrition assessment dated [DATE], revealed the facility staff were responsible for ensuring each resident maintained acceptable parameters of nutritional and hydration status. The policy indicated the facility staff were responsible for recognizing and addressing the nutritional and hydration needs of each resident. The facility staff were to provide a diet based on the resident's clinical condition when there was a nutritional indication. If the resident was unable to provide food and beverage preferences; then the necessary information will be obtained from the resident's representative. Continue review of the policy revealed that a registered dietitian would complete a nutritional assessment for each resident to determine if the resident was at risk for inadequate nutrition or hydration. The registered dietitian was responsible for assessing each resident's height, weight, food and fluid intake and collaborating this assessment with other facility staff members (nurse practitioner, nursing staff, physician, speech pathologist, social worker, psychiatrist, pharmacist) to identify risk factors for nutrition and hydration issues. The registered dietitian would be responsible for observing, assessing and monitoring the food and fluid intake of each resident. Nursing staff were to document and observe each resident daily and able to provide the registered dietitian with each resident's daily nutritional intake. The registered dietitian was responsible for developing interventions and care planning to meet each resident's medical and nutritional needs. Review of Resident CL1's comprehensive assessment (MDS-assessment of care needs) dated August 4, 2025, indicated Resident CL1 had diagnoses of Coronary Artery Disease (narrowing of the blood vessels which supply the heart with blood and oxygen), Dementia (irreversible, disease of the of the brain resulting in loss of reality), Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform) and Malnutrition. Review of Resident CL1's psychiatric evaluation dated August 13, 2025, revealed the resident thought process was illogical, tangential (thinking is fractured), and delusional with poor concentration abilities. Review for Resident CL1's September 2025 physician orders revealed an order dated May 22, 2025, for regular diet and Mighty Shake (liquid nutritional supplement) four ounce, three times a day with meals. Continued review of physician's orders revealed an order dated September 15, 2025, for Boost (nutritional supplement) eight-ounce, three times a day. Review of Resident CL1's nursing documentation dated September 19, 2025, and September 24, 2025, revealed Resident CL1 continued to refuse the nutritional supplements. Clinical record review for September 24, 2025, for Resident CL1 revealed the nurse practitioner was asked by the nursing staff to evaluate Resident CL1 due to poor oral intake. The nurse practitioner documented Resident CL1 was refusing the nutritional supplement (Boost), because the resident did not like milk. The nurse practitioner's plan was to have the registered dietitian evaluate, assess, monitor, and nutrition care plan for Resident CL1's poor by mouth intake and declining to drink the nutritional supplement. Interview conducted with the Registered Dietitian, Employee E5, at 10:30 a.m., on October 21, 2025, confirmed that the last nutritional assessment complete by a Registered Dietitian was August 5, 2025. Further interview with the Registered Dietitian, Employee E5 revealed the food and nutrition department was not notified about the dietary consult that was requested by the nurse practitioner on September 24, 2025, related to Resident CL1's poor by mouth intake and declining to consume nutritional supplement. Review of nutritional assessment dated [DATE], revealed Resident CL1 was 69 inches in height, weighed 123 pounds with an ideal body weight was 160 pounds +/- 10%. The dietary progress note indicated that Resident CL1 was at risk for malnutrition and dehydration. The nutritional care plan was for Resident CL1 was to gain 1 to 2 pounds of weight a week toward a healthy BMI (body mass index). The nutritional care plan revealed, nutritional supplementation would be provided and the resident would be monitored and encouraged to eat greater than 75% of most meals. Based on Resident CL1's weight of 123 pounds and height of 69 inches Resident CL1 had a body mass index of 18.1 which placed the resident in a category of being under weight. Based on Resident CL1's weight of 123 pounds and ideal body weight of 160 pounds +/- 10%. This resident's caloric needs were 1500 to 1950 calories a day

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents and staff, review of clinical records, facility documentation and in accordance with accepted professional standards and practices, the facility failed to maintain medical records that were accurately documented for one of 15 resident records reviewed (Resident R1).Findings include:Review of Resident R1's clinical records revealed the resident was alert and oriented and admitted to the facility on [DATE], diagnosed with atherosclerotic heart disease.Review Resident R1's nursing note dated October 13, 2025, indicated the resident said the aide pushed her while putting her in bed. The resident was noted with a large hematoma (blood leaks outside the blood vessels, usually due to injury) to her forehead and was given an icepack.Review of documentation received from the facility indicated the resident's skin was intact with no discoloration.Interview on October 22, 2025, at 4:00 p.m. unit supervisor, registered nurse, Employee E14 worked the night of the incident and assessed Resident R1 immediately afterwards. E14 confirmed the injury on the resident's forehead. 28 Pa. Code 211.12(d)(1) Nursing services