STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395077	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Spring Nursing and Rehabilitation Center	1113 North Easton Road Willow Grove, PA 19090

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 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. 45125 Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to verify professional license and complete a criminal background check prior to the start of employment for one of five newly hired employees. (E5) Findings include: A review of the facility policy entitled, Background Screening Investigations, dated October 23, 2023, revealed that the facility was to conduct screening for all potential hires. This included license/registration verification and a criminal background check. Employee 5 (E5) had been working in the facility as a Registered Nurse since August 16, 2024, and an inquiry to the state licensure board and a criminal background check were not completed until October 16, 2024. In an interview on October 18, 2024, at 9:45 a.m., the Administrator confirmed there was no documented evidence that the license verification and criminal background check were done prior to start of employment per facility policy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.19(3) Personnel policies and procedures.

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 14599 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s), including the reasons for the moves and Ombudsman information, in writing upon transfer from the facility for five of five sampled residents who were transferred to the hospital. (Residents 41, 48, 50, 81, 117) Findings include: Clinical record review revealed that Resident 41 was transferred to the hospital on August 2 and 16, 2024, after changes in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfers to the hospital. Clinical record review revealed that Resident 48 was transferred to the hospital on June 25, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 50 was transferred to the hospital on October 5, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 81 was transferred to the hospital on September 15, 2024, after a change in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfer to the hospital. Clinical record review revealed that Resident 117 was transferred to the hospital on February 21, February 26, April 1, and May 24, 2024, after changes in condition. There was no documentation to support that the resident or the resident's responsible party or legal representative was provided written information regarding the transfers to the hospital. In an interview on October 18, 2024, at 9:51 a.m., the Administrator confirmed that the residents or resident representatives were not given written notices regarding their transfers.

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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 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. 45125 Based on clinical record review and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for one of 26 sampled residents. (Resident 65) Findings include: Clinical record review revealed that Resident 65 had diagnoses that included hypotension (low blood pressure). A physician's order dated February 9, 2022, directed staff to administer a medication (midodrine) three times a day for hypotension. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 120 millimeters of mercury (mm Hg). Review of Resident 65's medication administration records revealed that staff administered the medication 17 times in September and six times in October 2024, when the resident's SBP was greater than 120 mm Hg. In an interview on October 18, 2024, at 9:39 a.m., the Director of Nursing confirmed that the medications were administered outside established parameters for Resident 65. CFR 483.25 Quality of Care Previously cited 11/16/23 28 Pa. Code 211.12(d)(1)(5) Nursing services.