

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: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 435 North Broad Street Grove City, PA 16127	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of four residents reviewed for hospitalizations (Residents R1, R12, and R57). Findings include: A facility policy entitled Bed-Holds and Returns dated 1/22/25, indicated that prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Facility policy entitled Transfer / Discharge Documentation dated 1/22/25, indicated that when a resident is transferred or discharged, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. The policy further stated that should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: basis for the transfer; contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advanced directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information including any documentation to ensure a safe and effective transition of care. Resident R1's clinical record revealed an admission date of 7/19/24, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and high blood pressure. Resident R1's clinical record revealed a progress note dated 6/9/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R1's clinical record also lacked evidence indicating that Resident R1 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Resident R12's clinical record revealed an admission date of 6/4/21, with diagnoses that included chronic obstructive pulmonary disease (COPD &ndash; a condition that prevents airflow to the lungs resulting in difficulty breathing), gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and high blood pressure. (continued on next page)		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R12's clinical record revealed a progress note dated 7/21/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R57's clinical record revealed an admission date of 4/16/21, with diagnoses that included diabetes, high blood pressure, and dementia (loss of cognitive functioning affecting a person's memory and behaviors). Resident R57's clinical record revealed a progress note dated 12/7/24, indicating a transfer to the hospital. The clinical record lacked evidence that Resident R57 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Further review revealed a progress note dated 4/18/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R57's clinical record also lacked evidence indicating that Resident R57 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. During an interview on 9/18/25, at 9:42 a.m. the Director of Nursing confirmed that Residents R1, R12, and R57's clinical records lacked evidence that necessary clinical information was communicated to the receiving health care provider and that Residents R1 and R57's clinical records lacked evidence that the resident and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights		

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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 on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 16 residents reviewed (Resident R22). Findings include: A facility policy entitled Comprehensive Person-Centered Care Planning dated 1/22/25, indicated that a comprehensive care plan will include focus, issues, problems and needs (social, emotional, psychological, physical, behavioral, rehabilitation, cultural, spiritual, nutritional, leisure, prevention in decline in condition, and etc.) identified through resident involvement, observation, coordination of discipline observations and assessments. Resident R22's clinical record revealed an admission date of 5/17/25, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and bladder cancer. Resident R22's clinical record progress notes revealed that on 5/28/25, a smoking assessment was completed. At that time, Resident R22 was offered a nicotine patch, which he/she declined and stated he/she wanted to continue to smoke. Resident R22 was observed on 9/17/25, at 3:00 p.m. smoking at designated area outside the facility. Resident R22's clinical record lacked evidence that a care plan had been developed to address his/her smoking. During an interview on 9/17/25, at 1:15 p.m. the Director of Nursing confirmed that a care plan had not been developed to address Resident R22's smoking. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for one of two medication carts reviewed (Cart A) and one of one medication rooms reviewed. Findings include: Review of a facility policy entitled Medication Storage and Handling dated [DATE], indicated that medications will be monitored by the Unit Nurse, Charge Nurse, and Consultant Pharmacist to assure that they are not Expired, Contaminated, or Unusable. Review of a facility policy entitled Medication Storage and Handling dated [DATE], indicated that all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Review of manufacturer's guidelines revealed that an open pen of Lantus/Basaglar Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Observation of drug storage on [DATE], at 11:45 a.m. of medication Cart A revealed an open Lantus Insulin pen with an open date of [DATE], and discard date of [DATE], which was beyond the 28 days after opening. During an interview at the time of observation, Licensed Practical Nurse (LPN) Employee E1 confirmed that the open date on the Lantus Insulin pen was beyond 28 days and should have been discarded. Manufacturer's recommendations for Aplisol (solution used for tuberculosis testing upon admission and for employment), indicated that vials in use for more than 30 days should be discarded due to possible oxidation and degeneration which may affect potency. Observation of drug storage on [DATE], at approximately 11:55 a.m. in the medication storage room refrigerator revealed one open vial of Aplisol with no date indicating when the vial was opened. During an interview at the time of observation, LPN Employee E1 confirmed that the open Aplisol vial lacked an opened date, and staff were unable to determine the discard date. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services		