

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER Gardens for Memory Care at Easton, The		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Washington Street Easton, PA 18042	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policy review, observation, and staff interview, it was determined that the facility failed to store food in a sanitary manner in the dietary department and on two of two nursing units. (Second floor and Third floor)</p> <p>Findings include:</p> <p>Review of the facility's policy entitled, Dietary Dress Code Policy, dated February 12, 2026, revealed that all staff were to cover all of their hair with a hair restraint when working with or around food.</p> <p>Observations during the kitchen tour on April 7, 2026, at 10:20 a.m., revealed the following:</p> <p>There was a hole in the wall above the floor next to the reach in refrigerator with a black substance. There was one flying insect in the dry storage area and one in the clean pan room next to the dish machine area. There was a bulk container of thickener that was not dated and had white dried food debris covering the length of the outside of the lid. The outside of the lid to the bulk container of flour was covered with white food debris. On the juice refrigerator, there were areas of dried food and liquid splatter along the side.</p> <p>During the lunch meal service tray line on April 8, 2026, from 11:48 a.m. to 11:58 a.m., and 12:24 p.m. to 12:32 p.m., Dietary Employee 1 and Dietary Employee 2 were observed with their mustaches and partial areas of their beards not covered.</p> <p>In an interview on April 8, 2026, at 2:45 p.m., the Director of Dietary confirmed that Dietary Employee 1 and Dietary Employee 2 should have been wearing a hair restraint to cover their facial hair during the meal tray line.</p> <p>Observation of the Second floor resident pantry on April 7, 2026, at 12:19 p.m., revealed there was black discoloring inside the microwave.</p> <p>Observation of the Third floor resident pantry on April 7, 2026, at 1:30 p.m., revealed there was a tan substance observed on the interior of the microwave.</p> <p>In an interview on April 7, 2026, at 12:19 p.m., Licensed Practical Nurse 1 confirmed that unit microwaves were for staff to use to heat up resident food only.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to maintain a safe, clean, and sanitary environment on two of two nursing units. (Second floor and Third floor) Findings include:</p> <p>During an environmental tour of the second and third floor nursing units on April 7 and 9, 2026, from 10:10 a.m. until 2:20 p.m., the following was observed:</p> <p>In the second-floor small dining room, the wooden trim on the walls was marred.</p> <p>There were two stained ceiling tiles in the corridor between rooms [ROOM NUMBERS], and 208 and 209.</p> <p>In room [ROOM NUMBER], the privacy curtain for bed two had a brown/dark gray stain, and the window curtain above the air-conditioning unit was off the rod and had a brown stain on it.</p> <p>In room [ROOM NUMBER], the towel dispenser was not working and there were dark brown spots on the wall above bed three.</p> <p>In room [ROOM NUMBER], the grab bar in the bathroom was loose.</p> <p>There was a hole in the ceiling tile in front of room [ROOM NUMBER].</p> <p>In room [ROOM NUMBER], the header of the window above the air conditioning/heating unit was cracked and caulk was hanging.</p> <p>In room [ROOM NUMBER], two towel racks were loose on the wall in the bathroom.</p> <p>The corridor wall across from room [ROOM NUMBER] was marred.</p> <p>In room [ROOM NUMBER], the walls adjacent to both sides of the closets were marred at the baseboards.</p> <p>In the [NAME] Room on the second floor, there was a black cushioned chair with a sagging seat cushion; a spring was broken and was touching the floor under the chair. A gray chair was broken causing the back of the chair to be in a reclined position so that when it was lifted to upright position it would not stay upright.</p> <p>The floor in the main corridor between rooms [ROOM NUMBERS] and inside the entrance to the third-floor residents' lounge dining room was observed to have a black substance covering it.</p> <p>Inside the entrance to rooms 307, 308, 309, and 310, the floor was observed to be covered with a black substance.</p> <p>The privacy curtain in room [ROOM NUMBER] between bed one and bed two was observed to have a large tan stain on it. (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The windows in the main dining room on the third floor had an accumulation of dirt on the surface.</p> <p>CFR 483.10(i)(2) Safe Environment Previously cited 5/1/25</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(2.1) Management.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy review, observation, and staff interview, it was determined that the facility failed to administer medications in a manner that prevented the spread of infection for two of 22 sampled residents. (Residents 24 and 81) Additionally, the facility failed to properly handle soiled linen and failed to keep clean linen from becoming contaminated to prevent the spread of infection. Findings include: Review of the facility policy entitled Administering Oral Medications, last reviewed February 12, 2026, revealed that employees were not to touch the medication with their hands. Review of the facility policy entitled, Departmental (Environmental Services) - Laundry and Linen, last reviewed February 12, 2026, revealed that employees sorting or washing linen were to wear a gown and gloves and clean linen was to remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination. Observation on April 8, 2026, between 8:25 a.m. and 8:58 a.m., revealed Licensed Practical Nurse (LPN) 2 administered oral medications to Residents 24 and 81. LPN 2 poured two tablets of a medication used to treat pain and fever, acetaminophen 325 milligrams (mg), from a bottle and into her ungloved hand before placing them into a pill cup and administering them to the residents. LPN 2 poured one tablet of a medication used to treat constipation (senna 8.6 mg) into her ungloved hand before placing it into a pill cup and administering it to Resident 24. Observation on April 8, 2026, at 1:30 p.m., revealed Environmental Services (EVS) Supervisor 1 put soiled linen into the clothes washer wearing gloves and no gown. Observation on April 10, 2026, at 12:25 p.m., revealed EVS Supervisor 1 opened a clothes dryer while the dryer was running and three washcloths fell out of the dryer and onto the floor. EVS Supervisor 1 then picked up the three washcloths from the floor and put them back into the dryer. In an interview on April 8, 2026, at 10:34 a.m., the Director of Nursing (DON) confirmed that LPN 1 should not have touched the pills with bare hands. In an interview on April 10, 2026, at 1:25 p.m., the Nursing Home Administrator confirmed that EVS Supervisor 1 should have worn a gown while handling soiled linen and the washcloths should have been treated as dirty and placed in a soiled linen bin. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide assistance with dining in a manner that promoted and maintained dignity for one of 22 sampled. (Resident 12) Findings include: Clinical record review revealed that Resident 12 had diagnoses that included dementia, and protein-calorie malnutrition, and had impaired vision. Review of the Minimum Data Set assessment, dated March 13, 2026, revealed that the resident had cognitive impairment and required assistance from staff with eating. Review of Resident 12's care plan revealed that the resident had self-care deficits and was at increased risk for nutrition problems related to dementia and included interventions for staff to encourage fluid and food consumption, provide cueing for eating, and reorient as needed. On April 7, 2026, from 12:45 p.m. through 1:25 p.m., Resident 12 was observed in the dining room with other residents and a lunch tray that included a covered drink, a banana, and a ham and cheese sandwich on a plate. The resident was observed having difficulty with picking up the food; he leaned over his tray and ate the sandwich directly off the plate without using his hands. The resident attempted to obtain his drinks which were out of his reach and picked up the opened banana but did not peel it further or attempt to eat it. Staff did not offer to assist the resident until 1:25 p.m., 40 minutes after he received his lunch tray. In an interview on April 10, 2026, at 9:22 a.m., the Assistant Director of Nursing confirmed that staff should have assisted Resident 12, including cueing and better set-up for access to his meal. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement physicians' orders for two of 22 sampled residents. (Residents 49 and 76) Findings include:</p> <p>Clinical record review revealed that Resident 49 had diagnoses that included peripheral vascular disease (a progressive circulation disorder involving damage or blockage in blood vessels often affecting legs and feet). A physician's order dated March 5, 2026, directed staff to apply specialized compression garments designed to improve circulation and reduce blood clot risks (TED stockings) in the morning and to remove them at bedtime.</p> <p>On April 7, 2026, at 1:00 p.m. Resident 49 was observed lying in bed, and the TED stockings were not in place. On April 9, 2026, at 11:05 a.m., 12:30 p.m., and 1:27 p.m., Resident 49 was observed ambulating on the nursing unit, and the TED stocking were not in place.</p> <p>In an interview on April 10, 2026, at 9:40 a.m., the Director of Nursing confirmed there was no evidence that the physician's order was followed or that the treatment was refused by Resident 49.</p> <p>Clinical record review revealed that Resident 76 had diagnoses that included hypertension (high blood pressure). A physician's order dated January 1, 2026, directed staff to administer a blood pressure medication (carvedilol) two times a day. The physician ordered that 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 less than 110 millimeters of mercury (mm/Hg) or when the heart rate (HR, the number of heart beats per minute) was less than 55. Review of Resident 76's Medication Administration Records for March 2026 and April 2026, revealed that staff administered carvedilol four times in March and one time in April when Resident 76's SBP was less than 110 mm/Hg. Further review revealed that staff administered carvedilol one time in March and three times in April when Resident 76's HR was less than 55 beats per minutes.</p> <p>In an interview on April 10, 2026, at 11:00 a.m., the Director of Nursing confirmed that the medications were administered outside physician ordered parameters for Resident 76.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the necessary device to prevent an incident or accident for one of 22 sampled residents. (Resident 90) Findings include: Clinical record review revealed that Resident 90 had diagnoses that included dementia with mood disturbance and had a history of falling. A review of the Minimum Data Set assessment (a periodic evaluation of resident care needs) dated March 23, 2026, revealed the resident had memory impairment. A review of Resident 90's care plan revealed that the resident had behaviors that included being territorial of her space and being combative. A nurse noted on July 11, 2025, that Resident 90 was observed lying on the floor by her bed holding on to the ankle of another resident who had walked into her room. The new intervention following the incident on July 11, 2026, was for staff to hang a stop sign across the doorway of her room to deter wandering residents from entering. Observations on April 8, 2026, between 11:17 a.m. and 3:15 p.m., and on April 9, 2026, between 10:50 a.m. and 1:17 p.m. revealed the stop sign was not present at Resident 90's doorway. In an interview on April 10, 2026, at 9:20 a.m. the Assistant Director of Nursing confirmed that a stop sign should have been present on Resident 90's room doorway. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) for one of two nursing units observed during medication administration. (Second floor) Findings include: Observations of medication administration on April 8, 2026, from 8:40 a.m. to 8:58 a.m., revealed 29 medication opportunities with three medication errors that resulted in a medication administration error rate of 10.34%. Review of the policy entitled Crushing Medications, last reviewed on February 12, 2026, revealed that medications were to be crushed only when it was appropriate and safe to do so, consistent with physicians' orders and that nursing staff or the consultant pharmacist was to notify any attending physician who gave an order to crush a drug that the manufacturer stated should not be crushed, such as enteric coated medications. Review of the facility list of medications not to be crushed revealed that a Depakote tablet was not to be crushed due to the enteric coated formulation (a form designed to pass through the acidic stomach intact and dissolved in the smaller intestines). Clinical record review revealed that Resident 24 had diagnoses that included dementia with behavioral disturbance and psychotic disorder. A review of the physician's orders dated November 14, 2023, revealed that staff was to administer a medication used to treat bipolar disorder (Depakote sprinkles oral capsule delayed release), and two medications used to treat constipation, a combination medication (senna-docusate oral tablet 8.6 milligrams(mg)-50 mg), and 17 grams of a powder that was to be measured in a calibrated cup (polyethylene glycol powder). Observation of the medication pass on April 8, 2026, between 8:35 a.m. and 8:58 am, revealed that Licensed Practical Nurse (LPN) 2 crushed and administered a Depakote delayed release enteric coated tablet, administered a senna 8.6 mg tablet, which should have been senna 8.6 mg-docusate sodium 50 mg, and used a plastic spoon to put polyethylene glycol powder into a plastic drinking cup and mixed it with water. The polyethylene glycol powder was not appropriately measured for accuracy using the calibrated cup. In an interview on April 8, 2026, at 12:20 p.m., the Director of Nursing confirmed that the three medication administration errors occurred. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, it was determined that the facility failed to dispose of trash and refuse properly. Findings include:</p> <p>Observation of the dumpster area on April 7, 2026, at 11:00 a.m., revealed the area adjacent to the dumpster had multiple pieces of plastic and paper debris, including used face masks, used gloves, plastic spoons, and condiment packets. Further observation on the same date, from 1:25 p.m. to 1:30 p.m., revealed that Dietary Employee 3 was pushing and then pulling a garbage can on wheels full of garbage across the parking lot to the dumpster and opening the dumpster lid. Six pieces of loose, large, plastic were observed blowing out of the can in a direction towards the back of the dumpster. Dietary Employee 3 was observed to pick up one of the six pieces of garbage that had blown from the garbage can, emptied the garbage can into the dumpster, and left the area while the other five pieces of garbage remained on the ground and the dumpster remained open.</p> <p>28 Pa Code 201.18(b)(3) Management.</p>