STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395729	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Easton, The	498 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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48108 Based on observation, it was determined that the facility failed to maintain residents' environment and equipment in a safe, clean, comfortable, and homelike manner on two of three nursing units. (First and Second Floor nursing units) Findings include: Observations on May 13, 2025, from 9:30 a.m. through 2:00 p.m., and May 14, 2025, from 8:45 a.m. through 3:00 p.m., revealed the following environmental issues: In room [ROOM NUMBER] (bed 1) there was paint peeling behind the resident's headboard. In room [ROOM NUMBER] (bed 1) the privacy curtain was torn. In the First Floor community shower room there was a black substance in the far left shower stall, in the middle shower stall, there were chipped tiles in the floor and a missing shower head and faucet, the bottom of the handle on the bathtub had a dark substance on it, and the toilet area had chipped paint on the right side of the wall and a brown substance behind the toilet. Resident 62's wheelchair had a broken and torn left arm rest, the back of the wheelchair was torn, and had loose axles. In the Second Floor dining room, there was dust was in the corners of the room, peeling tape around the two air conditioning units and on the window sills, the curtain on the middle window had a brown stain, and the dining room hand sanitizer dispenser was empty. The heater in the hallway outside of room [ROOM NUMBER] was covered with a black substance and the wall behind it was cracked. The handrails between the dining room and room [ROOM NUMBER], and between rooms 202 to 205, rooms 207 to 209, rooms 216 to 219, rooms 220 to 222, and between rooms [ROOM NUMBERS] had cracked paint and were loose. The bottom of the window curtains in resident rooms 223 (bed 3) and 226 (bed 1), were stained, and the windows were cloudy with a black residue in corners. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessments were completed to accurately reflect the residents' current status for two of 32 sampled residents. (Residents 27, 93) Findings include: Clinical record review revealed that Resident 27 had diagnoses that included diabetes mellitus and pulmonary embolism. A physician's order dated April 9, 2025, directed staff to administer an anti-coagulant medication (dabigatran). Review of the MDS assessment dated [DATE], revealed that the resident was on an anti-platelet medication in the last seven days, not an anti-coagulant medication. The MDS inaccurately reflected the use of an anti-platelet medication, as the dabigatran was an anti-coagulant medication. Clinical record review revealed that Resident 93 had diagnoses that included end stage renal disease and chronic congestive heart failure. Review of the nurse practitioner's progress notes dated February 27, 2025, and March 4, 2025, revealed that Resident 93 was on chronic oxygen via nasal cannula. Review of the oxygen saturation summary dated November 18, 2024, through May 7, 2025, revealed that Resident 93 was on oxygen via nasal cannula. Observations on May 13, 2025, at 11:16 a.m. and again on May 14, 2025, at 12:09 p.m., revealed Resident 93 sitting up in bed with oxygen via nasal cannula. Review of the MDS assessment dated [DATE], did not identify the resident was receiving oxygen therapy. In an interview on May 15, 2025, at 2:05 p.m., the Director of Nursing confirmed that Resident 27's and 93's MDS assessments were inaccurate and did not reflect the residents' current status.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45840 Based on facility policy review, clinical record review, observation, and resident and staff interview it was determined that the facility failed to obtain a physician's order for oxygen and provide appropriate care for respiratory equipment for one of 32 sampled residents. (Resident 93) Findings include: Review of the facility policy entitled, Equipment Changing, last reviewed January 8, 2025, revealed that all respiratory therapy equipment should be changed on a weekly basis and as needed when the equipment came in contact with the ground. Clinical record review revealed that Resident 93 had diagnoses that included end stage renal disease and chronic congestive heart failure. Observations on May 13, 2025, at 11:16 a.m. and again on May 14, 2025, at 12:09 p.m., revealed Resident 93 was sitting up in bed with oxygen being administered using a nasal cannula. In an interview at that time, Resident 93 stated that he always wears oxygen except for when going outside to smoke. Review of the nurse practitioner's progress notes dated February 27, 2025, and March 4, 2025, revealed that Resident 93 was on oxygen at all times. Review of the oxygen saturation summary dated November 18, 2024, through May 7, 2025, revealed that Resident 93 was using oxygen via nasal cannula. Review of the May 2025 physician's orders revealed no order for oxygen therapy via nasal cannula. There was also no documented evidence that staff changed the oxygen tubing weekly according to facility policy. In an interview on May 15, 2025, at 1:45 p.m., the Director of Nursing confirmed that the resident should have had a physician's order for the oxygen and that tubing should be changed weekly. 28 Pa. Code 211.12(d)(1)(2)(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. 48108 Based on a review of facility policy, staff interview, and observation, it was determined that the facility failed to properly store medications on one of three nursing units. (Second Floor nursing unit) Findings include: Review of the facility policy entitled, Medication Storage and Labeling, last reviewed January 8, 2025, revealed that medications requiring refrigeration were to be stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications were to be stored separately from food and were to be labeled accordingly. In an interview on May 14, 2025, at 10:19 a.m., the Administrator stated that the acceptable temperature for a medication refrigerator was to be between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Observation of the Second Floor medication refrigerator on May 14, 2025, at 9:00 a.m., revealed a temperature of 60 degrees Fahrenheit. At 10:02 a.m., the temperature was 58 degrees Fahrenheit. At 12:22 p.m., the temperature was 59 degrees Fahrenheit. At 1:26 p.m., the Maintenance Director confirmed the refrigerator temperature was 54 degrees Fahrenheit. At each observation, there were two opened medications that required refrigeration, Cefepime and Konvomep. Per manufacturer guidelines, these medications were to be stored at a temperature between 36 degrees Fahrenheit and 46 degrees Fahrenheit. In an interview on May 14, 2025, at 3:01 p.m., the Administrator confirmed the temperatures of the Second Floor medication refrigerator were above acceptable temperatures. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45125 Based on policy review, observation, and staff interview, it was determined that the facility failed to properly store food and maintain sanitary conditions in the dietary department. Findings include: Review of the facility's policy entitled, Employee Sanitary Practices, dated January 8, 2025, revealed that all staff were to cover all of their hair with a hair restraint. Observations during the tour of the dietary department on May 13, 2025, at 10:22 a.m., revealed the following: There was a blender lid on the floor next to the pot rack. There were four large containers of dry cereal that had a layer of sticky food debris on the outside of the lid and bottom of each container. In the walk-in freezer, there was ice build up and condensation on the three fan vents on the wall. On the floor below the fans, there were multiple spots of ice and condensation. On the two shelves below the fans, there was a box of sherbet and peas that were covered with ice. Next to this, on another shelf, there were two opened boxes of pretzels that were covered with ice. There was a large ice formation on each of two shelves below the fans. Observation during of the lunch meal service tray line on May 14, 2025, from 12:15 p.m. to 12:30 p.m., revealed Dietary Employee (DE) 1 was observed with a mustache that was not covered. In an interview on May 14, 2025, at 12:55 p.m., the Food Service Director confirmed that DE 1 should have been wearing a hair restraint to cover the mustache during the meal tray line. CFR 483.60(i) Food Safety Requirement Previously cited 4/18/24 28 Pa. Code 201.14(a) Responsibility of licensee.