STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395793	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Manor	20 Orchard Drive 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for one of three residents reviewed (Residents R1).Findings include:Review of facility policy entitled Care Plan Revisions Upon Status Change dated 4/1/25, indicated The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Review of Resident R1's clinical record revealed an admission date of 2/23/23, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), repeated falls, need for assistance with personal care, and hypertension (high blood pressure). Review of Resident R1's current care plans revealed a risk for falls care plan with an intervention for a pressure sensor pad alarm at all times while resident is in bed and to check placement and function every shift. Review of Resident R1's current physician orders revealed no order for a pressure sensor pad alarm and Resident R1's task history revealed the pressure sensor pad alarm was resolved on 4/10/25. During an interview on 12/9/25, at 9:49 a.m. the Nursing Home Administrator and the Assistant Director of Nursing confirmed that Resident R1's risk for falls care plan was not reviewed/revised to reflect current resident care and services. 28 Pa. Code 211.5(f) Medical records28 Pa. Code 211.10(c)(d) Resident care policies 28 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on review of clinical records and staff interviews, it was determined that the facility failed to have complete and accurate documentation regarding activities of daily living (ADLs) and interventions for three of three residents reviewed. (Residents R1, R2, and R3).Findings include: Review of facility policy entitled Charting and Documentation dated 4/1/25, indicated All services provided to the resident. shall be documented in the resident's medical record.Documentation in the medical record will be objective, complete, and accurate . Review of policy entitled Activities of Daily Living dated 4/1/25, indicated Care and services will be provided for the following activities of daily living: bathing, dressing, grooming. eating including meals and snacks. Review of Resident R1's clinical record revealed an admission date of 2/23/23, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), repeated falls, need for assistance with personal care, and hypertension (high blood pressure). Review of Resident R1's discontinued orders revealed an order for body pillows bilaterally under fitted sheet at edges of mattress to prevent uncontrolled rolling out of bed with a discontinue date of 11/10/25. Review of Resident R1's ADLs/task (where the nursing assistants document in the clinical record) revealed an intervention for body pillows under fitted sheet at edge of mattress to prevent rolling out of bed with documentation being completed after the discontinued date of 11/10/25, that the body pillows were in place. Further review of Resident R1's ADLs/task for the months of November 2025, and December 2025, revealed his/her showers lacked documentation that he/she received a shower on 11/21/25, 11/25/25, 11/28/25, and 12/2/25, and his/her dressing, personal hygiene, and/or eating lacked documentation on 11/1/25, 11/2/25, 11/3/25, 11/5/25, 11/9/25, 11/10/25, 11/12/25, 11/14/25, 11/15/25, 11/16/25, 11/17/25, 11/19/25,11/20/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/29/25, 12/1/25, 12/2/25, 12/3/25, 12/4/25, and 12/6/25. Review of Resident R2's clinical record revealed an admission date of 4/5/21, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), need for assistance with personal care, and hypertension (high blood pressure). Review of Resident R2's ADLs for the months of November 2025, and December 2025, revealed his/her shower information lacked documentation that he/she received a shower on 11/19/25, and his/her dressing, personal hygiene, and/or eating lacked documentation on 11/19/25, 11/20/25, 11/27/25, and 11/28/25. Review of Resident R3's clinical record revealed an admission date of 11/28/22, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), need for assistance with personal care, and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R3's ADLs for the months of November 2025, and December 2025, revealed his/her shower information lacked documentation that he/she received a shower on 11/10/25, 11/13/25, 11/17/25, and 12/4/25, and his/her dressing, personal hygiene, and/or eating lacked documentation on 11/7/25, 11/8/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/19/25, 11/22/25, 11/25/25, 11/30/25, 12/1/25, 12/2/25, 12/4/25, and 12/5/25. During an interview on 12/5/25, at 12:37 p.m. the Director of Nursing confirmed that the body pillows were being inaccurately documented as in place although the body pillows were no longer ordered as an intervention or available for Resident R1. During an interview on 12/9/25, at 9:49 a.m. the Nursing Home Administrator and the Assistant Director of Nursing confirmed that the clinical records for Residents R1, R2, and R3 lacked complete and accurate documentation for ADLs/tasks. 28 Pa. Code 211.5(f)(ix) Medical records28 Pa. Code 211.12(d)(1)(5) Nursing services