

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Respond appropriately to all alleged violations.  (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an elopement for one of two residents reviewed (Resident R1). Findings include: Review of facility policy entitled Accidents and Incidents - Investigating and Reporting dated 4/1/25, revealed all accidents or incidents involving residents, employees, visitors, vendors etc , occurring on our premises shall be investigated and reported to the Administrator. Resident R1's clinical record revealed an admission date of 3/28/2025, with diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities), Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and high blood pressure. During an onsite investigation on 12/15/25, it was identified that Resident R1 had eloped from the dementia unit of the facility on 12/09/25. Review of Resident R1's clinical record lacked any documentation on 12/9/2025, regarding the elopement until after the investigation on 12/15/25. Review of Resident R1's clinical record, incident documentation, and staff interviews revealed a lack of evidence that an investigation was started or completed. Further review of the clinical record lacked evidence of interviews from staff present at the time of the incident or handwritten statements from staff. Interview with Nursing Assistant (NA) Employee E1 on 12/15/25 at 11:30 a.m. revealed that he/she was working on SSW 12/9/25. At approximately 10:30 a.m. the door alarms sounded and he/she walked to the nursing station to check to see where the alarm triggered. He/she stated it was the solarium doors in Sunshine Way. NA Employee E1 went to check the doors in the dining area and found the doors locked without any visible tracks in the snow outside the door. NA Employee E1 then went to the kitchen door in SSW and found the doors locked without any tracks visible in the snow outside the door, then proceeded down the hall to the solarium where the RN supervisor, a LPN, and a NA were already looking out and saw Resident R1 walking in the parking lot. The RN supervisor unlocked the solarium doors and NA Employee E1 ran through the back parking lot and was able to talk the resident into walking back to the unit. He/she stated the resident was wearing a gray hoodie with the hood up, jeans, tennis shoes and socks. The resident told staff he was cold but denied any injuries. NA Employee E1 stated he/she was not asked to complete an incident report. Review of video footage on 12/16/25 supplied by the facility of the rear camera that captures the sidewalk for SSW solarium doors, the employee entrance, and rear employee parking lot revealed that on 12/9/25 at 10:29 a.m. Resident R1 was seen walking alone on partially snow-covered sidewalk from the direction of the solarium doors toward the rear employee parking lot. Resident R1 was wearing a hoodie, jeans, and shoes. As Resident R1 was walking, he/she put the hood of his/her hoodie up. At 10:30 a.m., a facility staff member was seen walking from his/her car to the rear employee entrance and Resident R1 was within view of this employee near the facility dumpsters. Video footage at 10:30 a.m. revealed an employee walking from a fenced area at the back of the facility between the solarium sidewalk and the employee entrance and proceeds to walk to the employee entrance area and enter the building. Video footage at 10:31 a.m. revealed three facility staff running from the direction of the SSW solarium doors towards Resident R1 who was walking in the far front corner of the rear employee parking lot. Video footage at 10:33 a.m. revealed a facility staff member in a red hoodie seen walking from the employee parking lot to the employee entrance and Resident R1 and the three staff seen passing in front of the employee in the red hoodie walking back toward the SSW solarium doors. Video footage at 10:33 a.m. revealed Resident R1 and three facility employees approaching the area of the solarium doors. During a follow-up interview on 12/16/25, at approximately 12:19 p.m. the NHA confirmed that he/she was aware of Resident R1's elopement from the facility on 12/9/25 and failed to conduct an investigation of the elopement. 28 Pa. Code 201.18 (e)(1)(2) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of clinical records, facility policy and documentation, and staff and resident interviews, it was determined that the facility failed to implement sufficient monitoring interventions and supervision to prevent elopement (unauthorized leave from the facility). This failure placed residents at the facility in an Immediate Jeopardy situation for one of two residents reviewed who eloped from the facility (Resident R1). Findings include: Review of facility policy entitled, Safety and Supervision of Residents dated 4/1/25, indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our facility-oriented approach to safety address risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring and reporting process; Quality Assurance and Performance Improvement (QAPI) reviews of safety and incident/accident date; and a facility-wide commitment to safety at all levels of the organization. Review of facility policy entitled, Wandering and Elopements dated 4/1/25, indicated When the resident returns to the facility, the director of nursing or charge nurse shall: examine the resident for injuries; contact the attending physician and report findings and conditions of the resident; notify the resident's legal representative; complete and file an incident report; document relevant information in the resident's medical record. Resident R1's clinical record revealed an admission date of 3/28/2025, with diagnoses that included Dementia (loss of memory, language, problem-solving, and other thinking abilities), Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and high blood pressure. A Minimum Data Set (MDS-a periodic assessment of resident care needs) Section C Cognitive Patterns dated 10/30/2025, identified Resident R1 with a Brief Interview for Mental Status (BIMS-a type of test to determine one's level of cognition) score of 11 and moderately impaired. Review of Resident R1's MDS Section E Behaviors dated 10/30/2025, revealed under section E0900 wandering presence and frequency- Has the resident wandered? with response of 2-Behavior of this type occurred 4-6 days. Review of an Elopement Risk Assessment completed on 4/15/25, indicated Resident R1 had an elopement score of 11. High Risk to Wander. During an onsite investigation on 12/15/25, it was identified that Resident R1 had eloped from the dementia unit of the facility on 12/09/25. Review of Resident R1's clinical record lacked any documentation on 12/9/2025, regarding the elopement until the investigation on 12/16/25. Review of Resident R1's care plans revealed no updates to care plans regarding elopement risk from the date of the elopement on 12/9/25, to investigation on 12/15/25. During an initial interview on 12/15/25, at approximately 9:00 a.m. the Director of Nursing (DON) revealed that he/she was unaware of any elopements or close calls since April 2025, which the facility investigated and reported as required. DON stated that he/she was on vacation last week and just returned this morning. DON stated that the Nursing Home Administration is scheduled to return from vacation tomorrow. Interview with Maintenance Supervisor on 12/15/25 at 11:00 a. m. revealed that he/she heard that there was an elopement last week on the locked unit, Sunshine Way (SSW), but didn't know any details and was not asked to check any door locks in the facility last week or this week. He/she stated all doors and door alarms are checked monthly and were last inspected on 12/1/25. During interviews on 12/15/25, Nursing Assistant (NA) Employee E3 and E4, Licensed Practical Nurse (LPN) Employees E5, E6, E 8, and E11, and Housekeeping Employees E7, and E9 revealed he/she were unaware of an elopement or elopement drill at the facility last week. Interview with NA Employee E1 on 12/15/25 at 11:30 a.m. revealed that he/she was working on SSW 12/9/25. At approximately 10:30 a.m. the door alarms sounded and he/she walked to the nursing station to check to see where the alarm triggered. He/she stated it was the solarium doors in Sunshine Way. NA Employee E1 went to check the doors in the dining area and found the doors locked without any visible tracks in the snow outside the door. NA Employee E1 then went to the kitchen door in SSW and found the doors locked without any tracks visible in the snow outside the door, then proceeded down the hall to the solarium where the RN supervisor, an LPN, and a NA were already looking out and saw Resident R1 walking in the parking lot that was located up a sidewalk and a distance from the exit door of SSW. The RN supervisor unlocked the solarium doors and NA Employee E1 ran through the back parking lot and was able to talk the resident into walking back to the unit. He/she stated the resident was wearing a gray hoodie with the hood up, jeans, tennis shoes and socks. The resident told staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Orchard Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of facility records and job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) failed to effectively manage the facility to make certain that proper supervision and elopement prevention were effectively implemented in the facility. Findings include: Review of the job description for the NHA revealed The administrator is charged with the general administration of the facility; Manage subordinate supervisors who supervise all employees in all departments; Responsible for the overall direction, coordination, and evaluation of these units; and directly or through delegation, carries out supervisory responsibilities in accordance with the facility's policies and applicable laws. Based on the findings in this report that identified the facility failed to consistently supervise and maintain all safety interventions to prevent elopement for their residents, the NHA failed to fulfill their essential job duties to ensure that the Federal and State guidelines and Regulations were followed. Refer to F689 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies</p>		