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	05/21/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on review of facility policy, clinical and facility records, and staff interviews, it was determined that the facility failed to complete a thorough investigation related to incidents and accidents for three of five residents reviewed (Residents R2, R3, and R4). Findings include: Review of facility policy, Incident Reporting dated 3/12/26, revealed the purpose of this policy is to ensure that all incidents involving residents, staff, visitors, or facility operations are promptly identified, investigated, documented, and reported in accordance with federal regulations, state law, and facility standards to protect resident health, safety, and rights. All employees are responsible for immediately reporting incidents, accidents, injuries, abuse allegations, neglect, exploitation, medication errors, elopements, and other unusual occurrences involving residents or facility operations. Immediate Response - Staff discovering an incident shall: Ensure resident safety. Provide first aid or emergency care as needed. Notify the charge nurse immediately. Contact emergency services if indicated. Remove the resident from an unsafe environment when necessary. Notifications - The charge nurse or supervisor will notify the following as applicable: Attending physician, Director of Nursing (DON), Administrator, Resident representative or family, Appropriate department managers. Notification timeframes: Immediately for serious injury, abuse, or elopement, Before end of shift for all other incidents. Incident Documentation - The employee who witnessed or discovered the incident must complete an incident report before the end of the shift. The report must include: Date, time, and location, Persons involved, Objective description of the event, Resident condition at the time of discovery, Interventions taken, Witness names, Notifications completed. Investigation - The facility will initiate an investigation promptly following any incident. The investigation may include: Interviews with staff, residents, and witnesses, Medical record review, Environmental assessment, Review of staffing and equipment, Root cause analysis. Resident R3's clinical record revealed an admission date of 3/06/26, with diagnoses that included displaced intertrochanteric fracture of right femur (a type of fractured hip involving the thigh bone), encephalopathy (disease or damage that affects the brain), dementia (disease of the brain that affects behavior including mood and decision making), and Parkinson's disease (a neurological disorder that primarily affects movement and worsens overtime). Resident R3's clinical record revealed progress notes dated 4/12/26, 8:07 a.m. Called to patient room for patient yelling out in pain. Upon assessment patient is having difficulty in moving RLE [right lower extremity] with 10/10 pain with any ROM [range of motion] in that extremity. Patient states he believes it's from his previous fall earlier in the week. RN [Registered Nurse] aware. Resident R3's clinical record dated 4/12/26, 2:51 p.m. revealed Resident R3 received an x-ray of the right hip that revealed a comminuted intertrochanteric fracture (a severe type of broken bone that has shattered, splintered, or crushed into fragments) of the right hip; Physician orders to send Resident R3 to the Emergency Department were noted at this time. Resident R3's clinical record lacked evidence of a fall, investigation of a fall or pain caused by fall during the midnight shift on 4/12/26. Facility provided documentation of Nursing Assistant (NA) Employee E1's witness statement for Resident R3 fall with fracture dated 4/12/26, revealed Resident R3 was noted to be on knees on floor with torso in bed. Bed in lowest position. NA Employee E1 stated at that time, resident began yelling and favoring RLE. They (Licensed Practical Nurse [LPN] Employee E2 and NA (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee E1) did put Resident R3's legs back into bed. At one point through the night Resident R3 stated I broke my hip. Review of LPN Employee E2 witness statement for Resident R3 dated 4/14/26, revealed telephone statement with LPN Employee E2 about a fall of Resident R3 on 4/12/26, at approximately 2:30 a.m. to 3:00 a.m. and LPN Employee E2 admitted during the phone conversation that he/she didn't assess patient after being found on knees on floor at bedside. He/She also admitted ly did not inform RN Supervisor that incident occurred because he/she felt this was usual behavior for Resident R3. Facility provided documentation, Corrective Action Form, dated 4/14/26, revealed LPN Employee E2 was suspended pending completion of investigation for fall with fracture with no report/assessment by LPN Employee E2. Resident R3 was found on the floor and the employee did not follow proper procedure (assessment/report to Registered Nurse [RN]). Resident R2's clinical record revealed an admission date of 3/17/22, with diagnoses of congestive heart failure (occurs when the heart muscle becomes too weak or stiff to pump blood efficiently), protein calorie malnutrition (a severe nutritional deficiency that occurs when not enough protein and calories are consumed), macular degeneration (a disease of the eye that causes blurry vision but leaves peripheral vision) of right eye, and dysphagia (difficulty swallowing). Facility provided incident report dated 5/16/26, 3:45 p.m. revealed Resident R2 was hit in the face by another resident. Resident R2's clinical record lacked evidence of Resident R2 being hit in the face by another resident on 5/16/26. Resident R2's clinical record further lacked evidence of assessment at time of injury on 5/16/26, and timely notification of physician and family. Resident R2's clinical record dated 5/17/26, at 8:26 a.m. revealed a progress note - Alerted by unit staff that another resident has struck this resident in the face. Resident unable to explain situation. Assessed resident for any injuries. Resident has a 2 cm (centimeter) cut below right eye. Resident has some bruising around eye. Resident denies pain at this time. Once the incident occurred both residents were separated immediately. DON [Director of Nursing] was notified. Statements were collected. Family were notified. Third eye (medical provider company) was notified. Resident R4's clinical record revealed an admission date of 9/25/25, with diagnoses that included vascular dementia (a decline in thinking and memory skills caused by reduced blood flow to the brain), high blood pressure, hyperlipidemia (high levels of fats in the blood), and lymphedema (a chronic condition causing swelling, usually in the arms and legs). Resident R4's clinical record lacked evidence of him/her participating in an incident involving striking another resident in the face on 5/16/26, including timely notification of physician and family. Interview with the DON on 5/18/26, at 3:15 p.m. confirmed that Resident R4 was the resident involved in the act of striking Resident R3 in the face. The DON further confirmed that Resident R2 and R4's clinical records lacked evidence of a timely and complete investigation at the time of the incident, and that Resident R2 was not assessed timely thereafter for injury from being stuck in the face by Resident R4. Interview on 5/18/26, at 4:15 p.m. with the Nursing Home Administrator (NHA) confirmed that Resident R3's clinical record lacked evidence of a timely and complete investigation at time of fall with fracture during the midnight shift of 4/12/26, and that Resident R3 was not assessed timely thereafter for a hip fracture, along with physician and family notification until the dayshift hours of 4/12/26. The NHA further confirmed it is the responsibility of the facility to ensure all incidents, including falls, are investigated and documented thoroughly, and notifications of physician and family are completed in a timely manner. 28 Pa. Code 201.14(a)(c) Responsibility of licensee 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to follow physician orders for one of one closed records reviewed (Resident CR1). This deficiency is cited as past non-compliance. Findings include: Facility policy entitled, Medication Administration dated 3/12/26, revealed the policy establishes the standards and procedures for the safe and accurate administration of medications to residents of the facility. The Five Rights of Medication Administration - Prior to administering any medication, the licensed nurse must verify all of the following: Right Resident - Verify the resident's identity using at least two identifiers (name and date of birth or room number) and confirm against the Medication Administration Record (MAR). Right Medication - Confirm the medication name matches the current physician order and the MAR. Right Dose - Verify the dose is consistent with the current order and within safe parameters. Right Route - Confirm the route of administration matches the order (oral, topical, injectable, etc). Right Time - Administer the medication within the facility's acceptable time window of the scheduled administration time. Resident's CR1's clinical record revealed an admission date of 4/28/26, with diagnoses that -included Atrial fibrillation (Afib - when the heart's upper chambers beat rapidly and irregular disrupting the flow of blood), chronic pulmonary obstructive disease (COPD - a group of lung disease that causes breathing difficulties), history of falls, and iron deficiency anemia (a blood condition when the body lacks iron which causes the red blood cells to not be able to carry oxygen efficiently throughout a person's body). Resident CR1's clinical record revealed a progress note dated 4/29/26, 10:50 a.m. that revealed Licensed Practical Nurse (LPN) Employee E3 reported that Resident CR1 had received the wrong medications this morning and that Resident CR1 received his roommate's medications. Resident CR1's clinical record revealed a progress note dated 4/29/26, Late entry: Nurse entered Resident CR1's room to assess Resident CR1 after notification of medication errors. Spouse of Resident CR1 was in room. Assessment recorded and vital signs within normal limits. Resident did not seem to understand what occurred when asked how he/she was feeling. Spouse of Resident CR1 stated that he/she didn't know why Resident CR1 received a shot. The nurse explained that his/her spouse received roommate's medications in error. Resident CR1's clinical record revealed a physician order dated 4/29/26, Send to ER (emergency room) secondary to receiving 30 unit of Lantus [a type of long acting insulin to control blood sugar in a person who is diabetic which involves a condition where the body cannot produce enough insulin or use it properly] and wrong medications to monitor for hypoglycemic [low blood sugar] and adverse events. Resident CR1 did not show any signs and symptoms of hypoglycemia or ill effects of the inaccurate administration of medications. During an interview on 5/18/26, at 1:50 p.m. the Nursing Home Administrator (NHA) confirmed Resident CR1 received his/her roommate's medications in error on 4/29/26, and the facility failed to ensure Resident CR1's physician orders were safely and accurately followed. The deficiency is cited as past non-compliance. On 5/18/26, the facility submitted a plan to include: The LPN Employee E3 was removed from the schedule and would not be returning. Resident CR1 was assessed by the Director of Nursing (DON) on 4/29/26, physician and spouse notification was completed. Resident CR1 was transferred to the hospital for further evaluation and treatment related to the wrong medication administered. Resident CR1's roommate was interviewed and administered his/her correct medications according to the physician orders. Alert and oriented residents who resided on the similar unit that LPN Employee E3 was responsible for medication administrations were interviewed to ensure each resident received their correct medications according to their physician orders. Residents who were not alert and oriented were assessed by the Director of Nursing (DON) and/or his/her designee for any abnormalities or adverse effects of medication administration. A review of all residents' Medication Administration Records (MARs) on the unit that LPN Employee E3 was responsible for was completed to ensure each resident received their medications according to the physician's orders by the DON and/or his/her designee. A review (continued on next page)

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