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	10/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy, and clinical records, and staff interview, it was determined that the facility failed to assure a physician's order was completed to indicate the code status as Full Code (Cardiopulmonary Resuscitation-CPR/Attempt Resuscitation) or Do Not Resuscitate (DNR/Do Not Attempt Resuscitation-Allow Natural Death) for four of 19 residents reviewed (Residents R56, R58, R65, and R225). Findings include: A facility policy entitled Patient Self Determination Act / Resident Rights dated [DATE], indicated The Attending Physician will write an order for any valid Advanced Directive on the Physician Order sheet and document on the progress notes. Resident R56's clinical record revealed an admitted [DATE], with diagnoses that included dislocated left hip, chronic obstructive pulmonary disease (COPD - a condition that obstructs air flow in the lungs with symptoms of difficulty breathing, coughing, and wheezing) and neurogenic bladder (disorder where normal bladder function is disrupted due to nerve damage). Resident R56's clinical record lacked a physician's order to indicate a code status as Full Code or DNR. Further review of Resident R56's clinical record lacked evidence of an advanced directive, living will, healthcare status form, or Physician Order for Life sustaining Treatment (POLST) on the electronic health record or paper chart. During an interview on [DATE], at 12:28 p.m. the Director of Nursing (DON) and Registered Nurse (RN) Employee E1 confirmed Resident R56's clinical record lacked evidence of a physician's order addressing his/her code status and stated the facility would consider him/her a full code. Further investigation and interview with Admissions Director revealed he/she had documents located in his/her office for Resident R56 indicating he/she was a DNR. During an interview on [DATE], at 12:43 p.m. the DON and RN Employee E1 confirmed the facility failed to obtain a physician's order to honor Resident R56's DNR wishes and would have considered him/her a full code. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R58's clinical record revealed an admitted [DATE], with diagnoses that included malignant neoplasm of colon (a cancerous tumor of the large intestine), cardiac heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), weakness, and repeated falls. Resident R58's clinical record lacked a physician's order to indicate a code status as Full Code or DNR. Resident R65's clinical record revealed an admitted [DATE], with diagnoses that included fracture of left arm, acute kidney failure (a condition when the kidneys suddenly cannot filter waste from the blood), morbid obesity (a serious condition being more than 100 pounds over your recommended weight), and osteoarthritis (a type of arthritis that occurs when tissue at ends of bones wears down). Resident R65's clinical record lacked a physician's order to indicate a code status as Full Code or DNR. Resident R225's clinical record revealed an admitted [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs when the body has high blood sugar levels), dementia (a disease of the brain affecting mood, behavior, and decision making), protein-calorie malnutrition (weight loss contributed to inadequate protein and calorie intake), and cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked resulting in brain tissue death). Resident R225's clinical record lacked a physician's order to indicate a code status as Full Code or DNR. During an interview on [DATE], at 2:00 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that he/she would refer to the electronic health record where all the physician orders could be readily accessed when a resident had a change in condition and the code status would need to be referenced. LPN E2 further confirmed that R225's clinical record lacked a physician order for code status. During an interview on [DATE], at 10:30 a.m. the DON confirmed that Resident R58, Resident R65, and Resident R225's clinical records lacked a physician's order to indicate a code status as Full Code or DNR. 28 Pa. Code 201.18 (b)(1)(e)(1) Management

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to ensure that a baseline care plan was developed/implemented within the required timeframe and failed to ensure that a written copy including a summary of the resident's medications and dietary instructions was provided to residents and residents' representatives for three of five residents reviewed (Residents R56, R65, and R225). Findings include: Review of facility policy entitled, Baseline Care Plan dated 10/1/24, indicated Orchard Manor will develop and implement a baseline care plan for each Resident that includes the instructions needed to provide effective and person centered care of the Resident that meet professional standards of quality of care. The baseline care plan will be developed within 48-hours of a Resident's admission. and A copy of the baseline care plan shall be provided to the Resident and Resident representative in a language that the Resident and/or Resident representative can understand. Resident R56's clinical record revealed an admitted [DATE], with diagnoses that included dislocated left hip, chronic obstructive pulmonary disease (COPD - a condition that obstructs air flow in the lungs with symptoms of difficulty breathing, coughing, and wheezing), and neurogenic bladder (disorder where normal bladder function is disrupted due to nerve damage). Review of Resident R56's clinical record lacked evidence that a baseline care plan was developed / implemented within 48-hours of admission, and that a written summary of the baseline care plan was provided to the resident and resident representative. Resident R65's clinical record revealed an admitted [DATE], with diagnoses that included fracture of left arm, acute kidney failure (a condition when the kidneys suddenly cannot filter waste from the blood), morbid obesity (a serious condition being more than 100 pounds over your recommended weight), and osteoarthritis (a type of arthritis that occurs when tissue at ends of bones wears down). Review of Resident R65s clinical record lacked evidence that a baseline care plan was developed / implemented within 48-hours of admission, and that a written summary of the baseline care plan was provided to the resident and resident representative. Resident R225's clinical record revealed an admitted [DATE], with diagnoses that included diabetes mellitus (a chronic disease that occurs when the body has high blood sugar levels), dementia (a disease of the brain affecting mood, behavior, and decision making), protein-calorie malnutrition (weight loss contributed to inadequate protein and calorie intake), and cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked resulting in brain tissue death). Review of Resident R225's clinical record lacked evidence that a baseline care plan was developed / implemented within 48-hours of admission, and that a written summary of the baseline care plan was provided to the resident and resident representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24, at 11:40 a.m. the Registered Nurse Assessment Coordinator (RNAC) confirmed that the baseline care plans were not developed / implemented within 48 hours and there was no evidence that a written summary was provided to Residents R56, R65, and R225 and their representatives. 28 Pa. Code 201.24 (e)(4) Admissions Policy 28 Pa. Code 211.10(c) Resident care policies

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide appropriate care regarding a urinary catheter (a tube inserted into the bladder to drain urine into a bag) for one of two residents reviewed for catheters (Resident R56). Findings include: Review of facility policy entitled Indwelling Catheter Use and Removal dated 10/1/24, indicated Catheter bag should be in a cover. Resident R56's clinical record revealed an admitted [DATE], with diagnoses that included dislocated left hip, chronic obstructive pulmonary disease (COPD - a condition that obstructs air flow in the lungs with symptoms of difficulty breathing, coughing, and wheezing) and neurogenic bladder (disorder where normal bladder function is disrupted due to nerve damage). Resident R56's clinical record revealed a physician's order dated 9/13/24, that indicated to Check urinary drainage bag to ensure it is covered Observations on 10/28/24, at 3:30 p.m. and 10/29/24, at 12:50 p.m. revealed that Resident R56 was laying in his/her bed and the urinary drainage bag was hanging from their bed and was visible from the hallway and lacking a privacy cover. During an interview on 10/29/24, at 1:36 p.m. the Director of Nursing confirmed that the catheter drainage bag should be covered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen for one of four residents reviewed for respiratory services according to physician's orders (Resident R19). Findings include: Review of facility policy entitled Oxygen Therapy via Concentrator or Portable dated 10/1/24, indicated To administer oxygen for the treatment of certain disease or conditions per physician's orders And Nurse responsibility for oxygen therapy includes but isn't limited to checking physician order and set control to the prescribed liters per minute. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that obstructs air flow in the lungs with symptoms of difficulty breathing, coughing, and wheezing), congestive heart failure (CHF - condition where the heart muscle don't pump blood as well causing difficulty breathing and fluid retention), and high blood pressure. Resident R19's clinical record revealed a physician's order dated 9/12/23, for oxygen at three liter per minute (3L/min) via nasal cannula (N/C - a tube that delivers oxygen to your nose through soft prongs) continuous every shift for shortness of breath. Observation of Resident R19's oxygen flow meter (a medical device used for oxygen flow measurement) on 10/28/24, at 4:06 p.m. revealed the oxygen flow measurement was at 5L/min via N/C. At the time of observation Resident R19 stated he/she was not to have their oxygen concentrator set at 5L/min. During an interview at the time of observation Licensed Practical Nurse Employee E3 confirmed the oxygen administration level was set at 5L/min via N/C and did not follow the physician's orders. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of clinical records and facility policy, observations, and staff interview, it was determined that the facility failed to use appropriate infection control practices for disinfection and storage of bedpans and wash basins for two of 19 residents reviewed (Residents R29 and R58). Findings include: Review of a facility policy entitled, Disinfection of Bedpans and Urinals, dated 10/01/24, revealed purpose to provide guidelines for disinfection of bedpans and urinals to put on gloves, cover bedpan or urinal before taking it to the bathroom or to the dirty utility room, empty contents (urine & feces) into toilet or hopper, flush the toilet or hopper, rinse bedpan or urinal with cool water to remove feces and urine, pour small amount of disinfectant solution (enough to thoroughly wet all surfaces) on and into bedpan or urinal or spray disinfectant liberally to thoroughly wet the surfaces. (May use a disinfectant cloth instead), wash hands, cover and return bedpan or urinal to resident's cabinet, wash hands. Nursing considerations: disposable bedpans and urinals are for single resident use only. [NAME] with the resident's name and discard upon discharge. Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included injury of head, concussion (a brain injury caused by a blow to the head or shaking of the head and body), fracture of facial bones, and a maxillary fracture (a facial injury to the upper jawbone). Resident R58's clinical record revealed an admitted [DATE], with diagnoses that included malignant neoplasm of colon (a cancerous tumor of the large intestine), cardiac heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), weakness, and repeated falls. Observations on 10/29/24, at 10:30 a.m. and 12:30 p.m. revealed an unlabeled bedpan on the floor of Resident R29 and Resident R58's shared bathroom. Further observations on 10/30/24, at 12:00 p.m. and 1:30 p.m. revealed a bedpan, with a wash basin laying upside down on top of the bedpan, in the residents' shared bathroom. The wash basin was labeled with Resident R29's name. The Registered Nurse Infection Control (RN IC) employee confirmed on 10/30/24, at 1:30 p.m. that the unlabeled bedpan was observed on the floor of Resident R29 and R58's shared bathroom with a wash basin resting on top of the bedpan. The RN IC further confirmed that the bedpan should be labeled with an individual resident's name, sanitized, and stored in a clean bag immediately after use in the individual resident's bedside stand, and the wash basin should also be clean and stored after individual resident use and not laying on the floor. 28 Pa. Code 211.12 (d)(1)(5) Nursing services