STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395872	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Millville, The	48 Haven Lane Millville, PA 17846

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, facility investigative documentation, and staff and resident interviews, it was determined the facility failed to ensure necessary assistance with activities of daily living and supervision were provided to prevent an accident that resulted in a major head injury resulting in harm for one of ten sampled residents (Resident 1).Findings include: A review of facility policy entitled Fall Management System last reviewed [DATE] revealed, it is the facility policy to provide appropriate evaluations and interventions to prevent falls and minimize complications if a fall occurs. Closed clinical record review for Resident CR1 revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (a progressive disorder causing memory loss and impaired judgment), muscle weakness (loss of muscle strength), hypertension (high blood pressure), and a history of falling (previous episodes of losing balance). An admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated [DATE], indicated the resident was moderately cognitively intact with a BIMS (brief interview to assess cognitive status) score of 13 (13 to 15 represents cognitively intact) and required the assistance of staff for activities of daily living (ADL'S, basic selfcare tasks such as dressing, bathing, toileting, and ambulation). A physical therapy discharge note dated [DATE], included a functional skilled assessment to include the resident's level of ambulation and documented that the resident ambulated 10 feet following staff setup with a roller walker (a two wheeled walking device used for balance and mobility). The note described gait training (instruction to improve walking safety and coordination) with the roller walker to normalize gait pattern. A review of the resident's care plan for ADL selfcare performance, revised [DATE], documented the resident as independent for transfers and ambulation with the roller walker. A review of facility investigative documentation and nursing progress notes dated [DATE], at 11:45 AM revealed Resident CR1 was found on the floor of the locked dementia dining/activity room next to a recliner chair. The resident's wheelchair was located behind her. Employee 3 (LPN, licensed practical nurse) assessed the resident and documented no apparent injury. The resident was placed back into the recliner chair. The report indicated she had slipper socks on. There was no evidence that the roller walker was present in the room at the time of the incident. Documentation reflected that the resident stated, I was getting up and my legs got tangled. I tried to walk by pushing the wheelchair and I fell on my butt. A therapy referral was initiated, and the resident was educated to use the roller walker when ambulating or transferring. A new physician's order dated [DATE], directed staff assistance of two persons with the roller walker for all transfers and ambulation. The resident's care plan and electronic Kardex were updated to reflect the change in ambulation/transfer status to assistance of two staff with the roller walker. A witness statement dated [DATE], from Employee 1 (Activity Aide) documented that she did not witness Resident CR1's fall but found the resident sitting on the floor. During an interview on [DATE], at 1:00 PM, Employee 1 stated she was assisting other residents in the activity room and did not recall whether Resident CR1 had her walker in the room, stating probably not because the resident was seated in the recliner. A review of facility investigative documentation and nursing notes dated [DATE], at 8:05 AM revealed the resident was being assisted by Employee 2 (Nurse Aide) from her bed to a standing position when she leaned forward and fell into the wall. The Registered Nurse (RN) Supervisor was notified. The resident was found face down between the bed and wall with her right arm under her body and a laceration (deep cut) noted to the right temple area (side of the head) with blood surrounding the head and face. Documentation indicated the resident was unresponsive for three minutes before responding to verbal stimuli. Resident CR1 indicated she had pain in her right arm and was noted to have a hematoma (blood underneath the skin) to her right wrist emergency medical services were called, and the resident was transported to the hospital. Education was provided at that time to Employee 2 (Nurse Aide) regarding using proper assistive devices when transferring a resident. A written witness statement dated [DATE] (no time indicated) revealed Employee 2 (Nurse Aide) stated Resident CR1 Sat up on the side of the bed. She was going to the bathroom. I was with her when she stood up. She pulled on the right side of her night gown. She leaned forward, fell face first on the floor, hitting her head on the wall. I got Employee 3 (LPN) right away. During an interview on [DATE], at 2:00 PM Employee 2 (Nurse Aide) stated she was performing morning care for Resident CR1 on the morning of [DATE]. She explained that she assisted the resident to a seated position on the edge of the bed and stood her up by herself. Employee 2 stated the resident began to pull on

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of controlled drug records and select facility policy and staff interview, it was determined the facility failed to implement pharmacy procedures for reconciling controlled drugs and records accounting for their administration for two of 10 residents sampled (Resident 2 and 3). Findings include: A review of the facility's Medication Administration policy reviewed November 2024 revealed that medications are prepared only by licensed nursing staff, medical staff, pharmacy or other personnel authorized by state laws and regulations to prepare medications. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. Administration of the medication is documented immediately after it is given.Clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses of dementia (a progressive disorder causing memory loss and impaired judgment), anxiety and mood disorder. A quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated September 4, 2025, indicated the resident was severely cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 3 a score of 0-7 indicates severe cognitively impairment), required assistance for activities of daily living and received antianxiety medication. A physician's order dated September 8, 2025, directed administration of Ativan 0.5 mg (an anti-anxiety medication) by mouth every 6 hours as needed (PRN) for anxiety. The resident's September 2025 individual resident-controlled substance record (a prescription drug that is regulated by federal and state laws because it has the potential for abuse dependence or addiction) accounting for Resident 2's supply of the controlled drug, and nursing staff's removal of doses for administration of Ativan 0.5 mg revealed that nursing staff signed out doses of the controlled medication for administration to the resident on the following dates and times: September 12, 2025, at 2:00 PMSeptember 15, 2025, at 3:00 PMSeptember 16, 2025, at 2:30 PMSeptember 18, 2025, at 4:00 PMSeptember 20, 2025, at 8:00AMSeptember 21, 2025, at 8:00 AMSeptember 24, 2025, at 9:00 AMSeptember 25, 2025, at 1:00 PMSeptember 26, 2025, at 10:00 AMReview of the corresponding September 2025 MAR (medication administration record) did not contain documentation showing those medications were administered as ordered. Clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses of dementia and anxiety. An annual MDS dated [DATE], revealed that Resident 3 was severely, cognitively impaired with a BIMS score of 3 and required assistance for activities of daily living and received antianxiety and pain medication. The resident had a physician order dated May 10, 2025, for Ativan 0.5 mg (an antianxiety medication) one tablet by mouth every 6 hours as needed for anxiety/restlessness. The resident's August 2025 individual resident-controlled substance record accounting for Resident 3's supply of the controlled drug, and nursing staff's removal of doses for administration of Ativan 0.5 mg revealed that nursing staff signed out doses of the controlled medication for administration to the resident on the following dates and times: August 1, 2025, at 12:00 PMAugust 3, 2025, at 3:00 PMAugust 9, 2025, at 2:30 PMAugust 15, 2025, at 9:00 AMAugust 18, 2025, at 8:00 AMAugust 19, 2025, at 10:00 PMAugust 25, 2025, at 10:00 PMAugust 27, 2025, at 1:00 PM A review of the corresponding August 2025 MAR, the above noted doses were not signed out on the medication administration record (MAR) showing those medications were administered to the resident as ordered. The resident's September 2025 individual resident-controlled substance record accounting for Resident 3's supply of the controlled drug, and nursing staff's removal of doses for administration of Ativan 0.5 mg revealed that nursing staff signed out doses of the controlled medication for administration to the resident on the following dates and times: September 1, 2025, at 1:00 PMSeptember 2, 2025, at 12:00 PMSeptember 3, 2025, at 12:00 AMSeptember 8, 2025, at 8:30 PMSeptember 10, 2025, at 1:00 PMSeptember 12, 2025, at 10:41 AMSeptember 15, 2025, at 8:00AMSeptember 20, 2025, at 1:00 PMSeptember 22, 2025, at 9:00 PMSeptember 23, 2025, at 11:00 PMSeptember 24, 2025, at 8:00 AMSeptember 24, 2025, at 6:00 PMSeptember 26, 2025, at 7:45 AMSeptember 27, 2025, at 3:20 PMSeptember 28, 2025, at 7:00 PMSeptember 30, 2025, at 11:45 PMA review of a September 2025 MAR, the above noted doses were not signed out on the medication administration record (MAR) showing those medications were administered to the resident as ordered. The residents' October 2025 individual resident-controlled substance record accounting for Resident 3's supply of the controlled drug, and nursing staff's removal of doses for administration of Ativan 0.5 mg revealed that nursing staff signed out doses of the controlled drug for administration to the resident on the following dates