

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Gardens at Millville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, staff interviews, and review of the facility's meal service schedule, it was determined the facility failed to consistently maintain sufficient staffing in the dietary department to effectively and efficiently carry out the functions of the food and nutrition service department. This failure resulted in delayed meal service for all the residents in the B wing unit, C wing unit, D wing unit, and the main dining room. Findings include: A review of grievances revealed a grievance filed at the facility dated May 21, 2026, which indicated on May 21, 2026, Resident CR1 reported their dinner was delivered late around 7:00 PM and stated this had been occurring regularly. Interviews with nursing staff conducted on June 9, 2026, at 8:35 AM, revealed staff reported the meal carts were consistently delivered late to the nursing units. Staff requested anonymity. A document titled Meal Delivery Times revealed the breakfast trays were expected to arrive on the B-wing unit at 7:55 AM and the main dining room at 8:00 AM. Observation of breakfast meal service on June 9, 2026, revealed delayed meal delivery. At 8:57 AM, the B Wing breakfast cart left the kitchen and arrived on the unit at 8:58 AM, 63 minutes later than the scheduled arrival time. Unit staff began passing trays at 9:00 AM, and the final resident tray was delivered at 9:15 AM. An observation conducted on June 9, 2026, at 9:07 AM the breakfast cart arrived in the main dining room, 67 minutes later than the scheduled arrival time. Staff began serving trays immediately, and the final resident tray was delivered at 9:28 AM. Observation of the dietary department on June 9, 2026, at 11:00 AM revealed three staff members were working in the kitchen, including one dietary manager, one cook, and one dietary aide. During an interview conducted at that time, the dietary manager reported the kitchen was significantly short staffed. The dietary manager stated only the dietary manager and the cook were originally scheduled to prepare and serve breakfast and lunch on June 9, 2026. The dietary aide reported to work on a scheduled day off to assist with meal service. The dietary manager further reported that the facility had recently hired four dietary employees, but none had started employment. A document titled Meal Delivery Times revealed lunch trays were scheduled to arrive on D Wing at 12:05 PM, C Wing at 12:20 PM, B Wing at 12:55 PM, and the main dining room at 1:00 PM. Observation of lunch meal service on June 9, 2026, revealed continued delays in meal delivery. At 12:55 PM, the D Wing lunch cart left the kitchen and arrived on the unit at 12:57 PM, 52 minutes later than the scheduled arrival time. Unit staff began passing trays immediately, and the final resident tray was delivered at 1:04 PM. At 1:12 PM, the C Wing lunch cart arrived on the unit, 52 minutes later than the scheduled arrival time. At 1:56 PM, the B Wing lunch cart arrived on the unit, 61 minutes later than the scheduled arrival time. Unit staff began passing trays at 1:58 PM, and the final resident tray was delivered at 2:05 PM. Observation of the main dining room at 2:05 PM revealed lunch service began 65 minutes later than the scheduled serving time. During an interview on June 9, 2026, at 1:45 PM, the Nursing Home Administrator (NHA) reported the dietary department had experienced staffing turnover. The NHA stated the facility had recently hired additional dietary employees; however, they had not yet started employment. The NHA acknowledged ongoing concerns related to dietary staffing levels. The facility failed to maintain sufficient dietary staff to prepare and serve meals in a timely manner for its census of 99 residents. As evidenced by direct observation, breakfast and lunch meal service was delayed on multiple nursing (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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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	units and in the main dining room due to insufficient dietary staffing. 28 Pa. Code 201.14(a)(b) Responsibility of licensee.28 Pa. Code 201.18 (b)(1) Management.		

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of select facility policy, observation, and staff interview, it was determined the facility failed to store, label, date, and maintain food in a sanitary manner to prevent contamination and the potential for microbial growth, placing residents at risk for food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of the facility policy titled General Food Preparation and Handling last reviewed by the facility on November 6, 2025, revealed that food items are to be prepared to conserve maximum nutritive value, enhance flavor, and remain free of injurious organisms and substances. The policy further states that foods are to be received, checked, and stored appropriately upon delivery; food deliveries will be placed on a flatbed cart or utility cart to prevent food from being delivered on the floor; and leftovers (any food that was prepared for service but was not all served) are to be covered, labeled, dated, refrigerated immediately following meal service, and discarded after three days. The initial tour of the dietary department was conducted with the Dietary Manager, on June 9, 2026, at 11:00 AM revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: Observation of the reach-in refrigerator revealed a steam table pan containing gravy, a pan containing cooked eggs, a pan containing sausage patties, and a pan containing oatmeal. None of the pans were labeled with the contents, preparation date, or discard date. Standing water was observed on the bottom of the refrigerator. Observation of the walk-in refrigerator revealed two pans of leftover baked ziti dated May 29, 2026. A pan of leftover French toast dated June 6, 2026, was covered with aluminum foil but was not labeled with the contents. The pan was stored on a shelf directly beneath a refrigeration fan unit. Water was observed dripping from the fan unit onto the aluminum foil covering the food. Additional water was observed dripping onto lower shelves and wetting food containers stored beneath the unit. Further observation of the walk-in refrigerator revealed a container holding four raw green peppers and one onion that appeared withered and were not dated. A pan of egg salad was labeled with a preparation date of June 2, 2026, and a use-by date of June 14, 2026. During an interview at the time of the observation, the Dietary Manager stated that egg salad could be retained for up to two weeks. However, food safety guidelines indicated that prepared salads containing eggs should generally be discarded within 3-5 days when refrigerated. Further observation of the walk-in refrigerator revealed 6 cases of stacked assorted food items stored directly in direct contact with the floor. Observation of the walk-in freezer revealed one case of strawberry ice cream stored directly on the floor. Observation of the dry storage room revealed 11 cases of assorted food items stored directly on the floor. Food safety standards require food to be stored at least 6 inches off the floor to protect against contamination. During an interview on June 9, 2026, at 11:15 AM, the Dietary Manager confirmed that food and beverages are expected to be properly labeled, dated, stored, and maintained in accordance with facility policy and food safety standards. The facility failed to ensure that food was labeled, dated, protected from contamination, stored off the floor, and discarded within established safe timeframes, in accordance with facility policy and federal food safety standards. Refer F80228 Pa. Code 201.18 (e)(2.1) Management. 28 Pa. Code 211.10 (c) Resident Care Policies.		