STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395899	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Orangeville, The	200 Berwick Road Orangeville, PA 17859

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for one resident (Resident A1) out of 8 residents reviewed. According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient ' s EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of clinical record revealed Resident A1 was admitted to the facility on [DATE], with diagnosis to include respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body), COPD (chronic obstructive pulmonary disease- lung disease that cause breathing difficulties), congestive heart failure (chronic condition in which the heart does not pump blood as well as it should), and diabetes. The resident was discharged to home on January 11, 2025. Review of a physician order dated December 17, 2024, noted an order for Torsemide diuretic- used to treat fluid retention/edema) 60 mg by mouth every 24 hours as needed for edema for 3 days. A review of Resident A1's clinical records revealed a physician order dated December 17, 2024, for Torsemide 60 mg (diuretic- used to treat fluid retention/edema) by mouth every 24 hours as needed for edema for three days. Further review of Resident A1's December 2024 Medication Administration Record from December 17, through December 20, 2024, revealed the following: December 17, 2024, no edema was noted on the evening or night nursing shift December 18, 2024, there was no edema noted on the day shift December 18, 2024, edema was noted on the evening and night shift December 19, 2024, edema was noted on the day, evening, and night shift December 20, 2024, edema was noted on the day, evening, and night shift. Between December 17, 2024, and December 20, 2024, nursing documentation indicated that edema was present on multiple shifts, yet the medication was never administered. Despite the presence of edema, there was no documentation of a nursing assessment describing the extent or location of the edema, nor was there any evidence that the physician was notified to clarify whether the medication should have been given. The order required administration of Torsemide every 24 hours if edema was present, but the facility failed to follow this directive. Interview with the administrator on January 23, 2025, at approximately 11:00 AM confirmed that the facility failed to ensure that Resident A1 received treatment and care in accordance with professional standards of practice and that physician orders were followed as ordered. Additionally, Resident A1 had a scheduled Pulmonary Medicine appointment on December 23, 2024, at 11:00 AM. A review of the clinical record found no evidence that transportation was arranged, and the resident did not attend the appointment. An interview with the administrator on January 23, 2025, at approximately 11:00 AM confirmed the facility failed to coordinate the necessary transportation, resulting in a missed medical appointment. The facility failed to ensure that Resident A1 received treatment and care in accordance with professional standards of practice and physician orders, potentially impacting the resident's health and well-being. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.12 (f)(i)(ii)(iii) Medical Records