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	05/13/2026

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 0552 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, grievance form review, and staff interview, it was determined that the facility failed to timely inform and update an interested family member regarding changes in condition, ongoing assessments, and changes in treatment for one of nine residents reviewed (Resident 1).Findings include:Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with a diagnosis of spinal stenosis (narrowing between the spaces between the spines, putting pressure on the nerves causing pain in arms and legs) and kidney disease. A review of Resident 1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 20, 2026, revealed that Resident 1 is cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information a score of 13-15 indicates intact cognition). The clinical record identified the resident's daughter as an interested family member involved in the resident's care and well-being. Review of a nurse's note dated March 23, 2026, at 3:51 PM, revealed the resident was prescribed a new medication for elevated blood glucose (blood sugar) levels. Review of the clinical record failed to provide evidence that the interested family member was timely notified of the medication change. Review of a grievance form dated April 22, 2026, revealed the facility received a verbal grievance from the interested family member expressing concern that a medication affecting the resident's blood glucose levels had been prescribed without timely notification to the family. The grievance documentation indicated the facility would notify the interested family member of changes by telephone.Review of a nurse's note dated March 24, 2026, at 9:08 PM, revealed the resident's pain medication, Oxycodone, was increased from 2.5 milligrams to 5 milligrams as needed for back pain. Review of the clinical record failed to provide evidence that the interested family member was notified of the medication adjustment. Review of a nurse's note dated March 31, 2026, at 9:38 PM, revealed the resident had not voided (urinated) during the 7:00 AM to 3:00 PM shift or during the 3:00 PM to 11:00 PM shift. The note indicated that the resident's daughter was notified at 9:38 PM and that staff planned to administer 500 milliliters of fluid and reassess the resident's urinary status in six hours. Review of a nurse's note dated April 1, 2026, at 2:30 AM, revealed the resident continued not to void. A subsequent nurse's note dated April 1, 2026, at 6:06 AM, indicated staff had still not accounted for any urinary output. Review of both nurse's notes failed to provide evidence that the interested family member was updated regarding the resident's continued change in condition and ongoing assessment. Review of a diagnostic study report for a KUB (Kidney, Ureter, and Bladder) examination revealed the results were available on April 21, 2026, at 2:50 PM. Review of a nurse's note revealed the interested family member was not informed of the diagnostic study results until April 22, 2026, at 8:09 AM. During an interview on May 13, 2026, at 1:30 PM, the Nursing Home Administrator was unable to provide evidence that the facility timely informed or updated the interested family member regarding the resident's status changes, ongoing assessments, diagnostic results, or medication adjustments. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for two out of two nursing units (Units East and West). Findings include:An observation on May 13, 2026, at 10:04 AM in resident room [ROOM NUMBER] revealed grey circular discolorations, dirt accumulation, and floor stains in front of the room entrance and bathroom. An observation on May 13, 2026, at 10:06 AM in resident room [ROOM NUMBER] revealed small grey circular discolorations and floor stains in front of the room's entrance, the bathroom's entrance, and around the bathroom commode. An observation on May 13, 2026, at 10:10 AM in resident room [ROOM NUMBER] revealed a garbage can with a folded plastic liner on the bottom of the can, which was not properly inserted into the garbage to properly contain refuse. Inside the garbage can was an empty soda bottle, a cup, and several devices utilized to clean intravenous (IV) sites. An observation on May 13, 2026, at 10:10 AM in resident room [ROOM NUMBER] revealed a bedside chair with an unfolded blanket placed on the seating surface, two pillows without pillow covers, a wheelchair with leg rests, a lifting harness, and seating devices placed on the wheelchair in front of cabinetry inhibiting access. An observation of resident room [ROOM NUMBER]'s bathroom revealed a urinal on the back of the toilet and a bedpan on the floor by the commode. The flooring inside the bathroom was spotted with debris and in need of cleaning. An observation on May 13, 2026, at 10:15 AM in resident room [ROOM NUMBER] revealed the bedside table with tan liquid stains on the white bed sheets and pillowcase. A blue disposable glove and white toilet paper pieces measuring 10 inches were observed under the resident's window-side bed. A clear plastic glove was observed on the floor in front of the garbage can. Dirt and debris pieces were around the garbage can. Gray circular discolorations and stains were observed on the floor near the door-side bed. An observation on May 13, 2026, at 10:24 AM in the East Unit Kitchen revealed a tile floor with a build-up of dirt, debris, and grime underneath the dishwashing station and extending 5 feet. A white PVC pipe with sediment and dirt stains. A plunger was observed underneath the stainless steel table to the right of the dishwashing sink. An observation on May 13, 2026, at 10:40 AM in resident room [ROOM NUMBER] revealed the window-side bed with tan linen stains and discolorations. Three clear urine graduates and a blue catch basin were on the floor near the commode, strewn on top of each other. The items were directly on the floor and not identified with resident names. An observation on May 13, 2026, at 10:49 AM in resident room [ROOM NUMBER] revealed a clear urine graduate container on the bathroom floor adjacent to the commode and a pink catch basin on the floor under the bathroom sink. The urine graduate container and catch basin were not identified with resident names. An observation on May 13, 2026, at 11:30 AM in resident room [ROOM NUMBER] revealed yellow and tan stains on the door-side bed linens. During an interview on May 13, 2026, at 1:00 PM, the above findings were reviewed with the nursing home administrator (NHA). The facility failed to provide services to maintain a clean and homelike environment for residents throughout the facility. 28 Pa. Code 201.18 (e)(1)(2.1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) Nursing services.