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	12/06/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by one resident out of the 19 residents sampled (Resident 42) and experiences reported by four out of the five residents during a resident group interview (Residents 4, 15, 36, and 52). Findings include: A clinical record review revealed Resident 42 was admitted to the facility on [DATE], with diagnoses that include chronic kidney disease (gradual loss of kidney function) and fibromyalgia (a chronic disorder that causes pain and tenderness throughout the body, as well as fatigue and trouble sleeping). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 20, 2024, revealed that Resident 42 is cognitively intact with a BIMS score of 14 (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 cognition is intact). During an interview on December 3, 2024, at 1:01 PM, Resident 42 indicated she regularly waits 45 minutes to an hour for care after ringing her call bell for assistance. She explained that she needs staff assistance and is upset that it takes so long to get help. Resident 42 indicated the longest wait times for care are on the second shift. She explained that often when the staff respond, they are stressed and not pleasant. Resident 42 indicated the facility is low on nurse staffing a few times a week, and it leads to negative care experiences. During a group interview with alert and oriented residents on December 4, 2024, at 10:00 AM, four out of the five residents (Residents 4, 15, 36, and 52) interviewed indicated they have concerns about the long wait times to receive care from staff after ringing their call bells for assistance. Residents 4, 15, 36, and 52 explained that they are frustrated and upset because they rely on staff for care. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the group interview, Resident 4 explained that when staffing is low, she waits over 20 minutes for staff to respond to her call bell for assistance. She indicated the facility is low on staffing at least twice a week. During the group interview, Resident 15 indicated that he waits the longest for care in the mornings but reported that long wait times for care occur on all shifts. He explained that he is upset and frustrated because last night he had to wait over an hour for staff to respond to his call bell after he rang for assistance Resident 15 indicated he soiled himself waiting for assistance to get to the restroom. He explained it wasn't the first time, and the experiences are very embarrassing. During the group interview, Resident 36 indicated he waits over an hour for care. He explained that the longest wait times occur in the afternoon around lunch time. Resident 36 indicated he is frustrated and had a similar experience of soiling himself waiting for care. He explained that he feels upset and frustrated with the long wait times for staff assistance to provide him care. During the group interview, Resident 52 indicated he waits over an hour for care. He explained the wait times vary depending on the amount of staff working. Resident 52 indicated when there is only one nurse aide assigned to his hall, he knows the residents are going to experience long wait times for care. He explained he felt the facility does not have enough nurse aide staff multiple times a week. During an interview on November 6, 2024, at approximately 10:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified that all residents at the facility should be treated with dignity and respect and provided care in a manner that promotes each resident's quality of life. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.

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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** 48276 Based on observations and resident and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for two out of three nursing units (100 and 200 Halls). Findings include: An observation on December 3, 2024, at 10:42 AM revealed room [ROOM NUMBER]'s bathroom with brown stains on the floor to the left of the toilet. The inner bathroom doorframe was also observed with similar brown stains. An observation on December 3, 2024, at 1:09 PM revealed room [ROOM NUMBER] contained a window air conditioning unit with a large build-up of dust and fuzz on the intake vent. Several black, round-shaped substances build-ups were observed on the airflow fins. An observation on December 3, 2024, at 1:38 PM revealed room [ROOM NUMBER] the bed located by the window had a white sheet with tan stains. Garbage and paper debris were observed on the floor on both sides of the bed. An observation on December 4, 2024, at 9:30 AM revealed the floor trim board had multiple stained and discolored areas in the 200 hallway. The gray wall fabric was observed with stains and discolorations. During an interview on December 6, 2024, at 10:00 AM, the Nursing Home Administrator (NHA) confirmed the facility is responsible for providing services to maintain a clean and homelike environment for all residents. 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of two residents out of 19 sampled (Residents 53 and 70). Findings included: A review of Resident 53's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease. A current physician order initially dated December 3, 2021, noted an order for Apixaban (an anticoagulant medication also known as a blood thinner) 5 mg by mouth twice daily for history of thrombosis (formation of a blood clot inside a blood vessel) and embolism (traveling blood clot). Review of Resident 53's October 2024 and November 2024 Medication Administration Records revealed Apixaban 5 mg was administered twice daily as ordered by the physician. A review of Resident 53's quarterly MDS assessment dated [DATE], Section N 0415 indicated the resident did not receive an anticoagulant (blood thinner) medication during the 7-day look-back period. An interview with the RNAC (registered nurse assessment coordinator) on December 6, 2024, at approximately 11:30 AM confirmed Resident 53's MDS was not accurate. A review of Resident 70's clinical record revealed the resident was admitted to the facility on [DATE] and discharged from the facility on September 16, 2024. A review of Resident 70's Discharge MDS assessment dated June September 16, 2024, revealed in Section A 2105 Discharge Status that Resident 70 was discharged to a short term general hospital. A review of a discharge note dated September 17, 2024, at 8:53 AM revealed the resident was discharged home on September 16, 2024, accompanied by her spouse. An interview with the Nursing Home Administrator on December 6, 2024, at approximately 1:30 PM, confirmed the aforementioned MDS Assessment was inaccurate. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility investigative reports, and staff interviews, it was determined the facility failed to implement effective safety measures to prevent an injury during transfer for one out of the 19 sampled residents (Resident 43). Findings include: A clinical record review revealed Resident 43 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and osteoporosis (a bone disease that develops when bone mineral density and bone mass decrease, or when the structure and strength of bone change). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 20, 2024, revealed that Resident 43 is severely cognitively impaired with a BIMS score of 03 (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 01-07 indicates cognition is severely impaired). A care plan indicating Resident 43 has a self-care deficiency requiring extensive-to-total assistance with mobility and transfers related to dementia and osteoporosis was initiated on March 29, 2024. Interventions implemented include assisting the resident with tasks as needed and transfers with the assistance of two staff members. A facility skin tear investigation report dated September 9, 2024, at 9:50 AM revealed Resident 43 sustained a right shin (right lower extremity) laceration measuring 5.5 cm x 4.5 cm and had right shin ecchymosis measuring 1.0 cm x 0.8 cm during a transfer from her bed to a wheelchair using a sit-to-stand lift. The investigation report indicated that the injury was new and bleeding. The resident's skin is described as fragile (poor skin integrity, as manifested by splitting of the dermis following relatively minor trauma, especially over pressure points). A witness statement dated September 9, 2024, provided by Employee 1, Nurse Aide (NA), revealed she was using the sit-to-stand lift to transfer Resident 43 from her bed to a chair. Employee 1, NA, indicated that an earlier attempt to transfer the resident with two staff was ineffective. She explained that once the lift was removed, following the transfer, a small amount of blood was noticed on Resident 43's pants. An injury was identified, and Employee 1, NA, notified the charge nurse. A witness statement dated September 9, 2024, provided by Employee 2, NA, revealed Resident 43 was transferred from her bed to her chair using the sit-to-stand lift. Employee 2, NA, indicated that following the transfer, she identified a blood spot on Resident 43's pant leg. She explained that once the clothing was removed, she noticed Resident 43 had an injury on her leg. Employee 2, NA, indicated the charge nurse was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated September 9, 2024, at 10:33 AM revealed Resident 43 was noted with a 5.5 cm x 4.5 cm V-shaped skin tear/laceration to the right upper shin. The wound depth was unable to be measured. The area was cleansed, and dressing applied. Resident 43 denied pain and discomfort. A new physician's order was obtained indicating to transfer the resident to the community emergency department for further evaluation. A community emergency department report dated September 9, 2024, revealed Resident 43 reported to the emergency department with a 10.0 cm V-shaped laceration over the middle one-third of her right lower leg. Resident 43 was unable to provide a description of the incident to the emergency department staff. The wound was cleansed and repaired with sutures without complication. A progress note dated September 10, 2024, at 8:00 AM, revealed the resident returned from the emergency department. Resident 43 has a V-shaped wound to the right lower extremity with 10 intact sutures. Sutures to be removed in 10 days. A review of the facility's investigation notes dated September 13, 2024, revealed the cause of the injury was undetermined. The report indicates the injury may have occurred during the first attempt to transfer Resident 43 prior to utilizing the sit-to-stand lift. The report indicates Resident 43's leg may have hit the wheelchair. Competency evaluations revealed that both Employee 1, NA, and Employee 2, NA, had satisfactory transfer skills and knowledge. During an interview on December 3, 2024, at 11:00 AM, Resident 43 was unable to answer questions regarding the incident. During an interview on December 6, 2024, at 10:00 AM, the Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure effective safety measures are implemented to prevent accidents and injuries to residents. The NHA confirmed that Resident 43 sustained a laceration requiring sutures, likely during the transfer by two nurse aides from the resident's bed to her chair on September 9, 2024. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records, select facility policy, and staff interview it was determined the facility failed to ensure that physician ordered intravenous (giving medication or fluid through a needle or tube inserted into a vein) antibiotics were administered as prescribed for two residents out of two sampled (Residents CR1 and 122). Findings include: Review of a facility policy titled Administering Medications last reviewed by the facility on February 1, 2024, indicated that medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by the state to prepare, administer, and document the administration of medications may do so. Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time unless otherwise specified. The individual administering the medication must document such in the eMAR (electronic medication administration) system after giving each medication and before administering the next ones. A review of the clinical record revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses to include chronic osteomyelitis (inflammation of the bone caused by an infection) of the left ankle and foot. Review of physician admission orders dated October 31, 2024, included a PICC line (peripherally inserted central catheter- long flexible tube that is inserted into a vein in the upper arm and threaded into a large vein near the heart, used for the administration of medications or fluids into the bloodstream) to the right upper extremity. A physician order dated October 31, 2024, noted an order for Ampicillin (an antibiotic) Sulbactam Sodium Intravenous Solution Reconstituted give 3 grams intravenously every six hours until December 3, 2024, related to osteomyelitis left ankle and foot. A physician order dated October 31, 2024, noted an order for Vancomycin HCL (an antibiotic) Intravenous Solution 1000 mg/10 ml give 1000 mg intravenously two times per day until December 3, 2024, related to osteomyelitis left ankle and foot. Review of Resident CR1's November 2024 Medication Administration Record (MAR), indicated that he was scheduled to receive Ampicillin at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. The MAR indicated that on November 10, 2024, the 12:00 AM and 6:00 AM Ampicillin doses were not administered as scheduled. Review of nursing progress notes for November 10, 2024, revealed no documentation of the reason for the two missed doses of Ampicillin nor was there any documentation to indicate the physician was notified of the missed doses. Review of the November 2024 MAR indicated that on November 13, 2024, the 12:00 PM Ampicillin dose was not administered as scheduled. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident CR1's November 2024 MAR indicated that he was scheduled to receive Vancomycin at 9:00 AM and 9:00 PM. The MAR indicated that on November 13, 2024, the 12:00 PM dose was not administered as scheduled. A nurses note dated November 13, 2024, at 5:00 PM noted the CRNP (certified registered nurse practitioner) was made aware of the missed doses of Vancomycin and Ampicillin on November 13, 2024. A nurses note dated November 14, 2024, at 1:36 PM noted that infectious disease was made aware of the missed doses of Vancomycin and Ampicillin on November 13, 2024. Interview with the Nursing Home Administrator (NHA) on December 6, 2024, at approximately 10:30 AM failed to provide documented evidence that Resident CR1's intravenous antibiotic therapy was administered as ordered by the physician. The NHA failed to provide documented evidence that the physician was notified of the two missed dose of Ampicillin on November 10, 2024. The NHA confirmed that documentation in the resident's eMAR record is required after each medication is administered as per facility policy. A review of the clinical record revealed that Resident 122 was admitted to the facility on [DATE], with diagnoses to included septic left knee prosthetic joint infection [bacterial infection that occurs around an artificial joint (prosthesis) causing inflammation and potential damage to the joint tissues]. Review of Resident 122's physician admission orders included a PICC line to the right upper extremity. A physician order dated November 26, 2024, noted an order for Cefazolin Sodium (an antibiotic) Intravenous Solution Reconstituted 2 gram intravenously every 8 hours related to infection and inflammatory reaction due to internal left knee prosthesis. Review of Resident 122's November 2024 MAR indicated that he was scheduled to receive Cefazolin Sodium at 6:00 AM, 2:00 PM, and 10:00 PM. The MAR indicated that on November 30, 2024, the 10:00 PM dose was not administered as scheduled. There was no documented evidence that the physician was notified of the missed dose of Cefazolin Sodium on November 30, 2024, at 10:00 PM. Interview with the NHA on December 6, 2024, at approximately 10:30 AM failed to provide documented evidence that Resident 122's intravenous antibiotic therapy was administered as ordered by the physician. The NHA failed to provide documented evidence that the physician was notified of the missed dose of Cefazolin Sodium on November 30, 2024, at 10:00 PM. The NHA confirmed that documentation in the resident's eMAR record is required after each medication is administered as per facility policy to confirm that the medication is administered as ordered. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interview, it was determined the attending physician failed to act upon pharmacist identified irregularities in the medication regimen of one of 19 residents sampled (Resident 22). Findings include: A review of Resident 22's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to extreme lows and schizoaffective disorder (a mental health condition that is marked by symptoms such as hallucinations and delusions and mood disorder symptoms such as depression). A review of an October 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicated the resident's order for Depakote ER 250mg (medication used to stabilize mood) was to be reviewed for a gradual dose reduction. Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it. The resident's attending physician failed to document in the resident's clinical record the rational and justification for the continued use of Depakote and rejection of the gradual dose reduction. An interview with the Director of Nursing (DON) on December 6, 2024, at approximately 11:00 AM confirmed that consultant psychiatric CRNP was responding to the pharmacy recommendations and the physician was cosigning off on them. Furthermore the DON confirmed the attending physician failed to provide justification in the clinical record for the continued use of Resident 22's Depakote. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 21738 Based on staff interview, a review of personnel files and employee credentials, it was determined the facility failed to ensure the full-time director of food and nutrition services, who was not a qualified dietitian or other clinically qualified nutrition professional, received frequently scheduled consultations from a qualified dietitian or other clinically qualified nutritional professional. Findings include: According to current federal regulatory guidance the facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. In the absence of a full-time qualified dietitian the director of food and nutrition services the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and must receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During initial tour of the food and nutrition services department on December 3, 2024, at 9:15 AM the food and nutrition services director (FSD) stated that she has been employed as the food and nutrition services director for four years. The FSD stated that she had recently completed the course to become a certified dietary manager but did not yet pass the exam. The FSD confirmed that she did have a Serv-Safe Certification (a national certification accredited by the American National Standards Institute) as of June 24, 2024. The FSD stated that the facility has a part-time Consultant Registered Dietitian (RD) who works remotely (works from outside of the facility) approximately 20 hours per week and is available as needed via telephone or email. The FSD confirmed that the RD does not come into the building. The FSD stated that although the Consultant RD is available as needed, there have been no frequently scheduled consultations between her and the Consultant RD. The FSD confirmed that it is the FSD's responsibility to visit the residents to review food preferences, do meal rounds, and attend resident care plan meetings. The FSD confirmed that she completes limited documentation in the clinical record which includes documenting that residents are visited, and food preferences obtained. Review of documentation provided by the facility revealed the current remote consultant RD has been employed by the facility since October 3, 2022. Interview with the part-time Consultant RD on December 6, 2024, at approximately 11:00 AM confirmed that she completes all job tasks including nutritional assessments remotely with input from the interdisciplinary team including nursing and the FSD. The Consultant RD confirmed that she accesses residents' clinical records remotely and does have the ability to do video calls with residents and videoconferencing with staff on an as needed basis. The Consultant RD stated that she does not contact residents on the phone before completing nutritional assessments and had not been in the facility to observe the residents' ability to eat, interview residents and provide nutritional consultation or observe the residents for signs and symptoms of nutritional and hydration inadequacies/deficiencies and provide oversight of the operations of the food and nutritional services department. Interview with the nursing home administrator (NHA) on December 6, 2024, at approximately 11:30 AM failed to provide documented evidence that the services of the Consultant RD included face to face interactions with residents to ensure appropriate nutritional oversight for residents in the facility. The NHA failed to provide documented evidence that the FSD received frequently scheduled consultations from the Consultant RD. 28 Pa Code 201.18(e)(1)(6) Management.