

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Gardens at Orangeville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. (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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<p>F 0571</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, resident fund account information, facility admission documents, and staff and resident interviews, it was determined that the facility failed to protect the resident's personal funds by imposing charges against a resident's personal needs allowance (PNA) for a service for which payment is made under Medicaid for one of 22 sampled residents (Resident 7). Findings include: A review of the facility admission document titled Admissions Notice Packet revealed residents will pay the established Medicaid rate. The residents will be required to make payments towards the cost of care. The payment towards the cost of care is determined after allowing certain deductions. One such deduction is the monthly personal needs allowance (PNA the amount of a Medicaid recipient's monthly income they can keep for personal expenses in a nursing home or other long-term care facility. This money is not used to pay for their care and can be spent on items and services not covered by Medicaid, such as personal hygiene items, social activities, snacks, or gifts. The PNA amount varies significantly by state and is intended to allow residents to purchase extras to enhance their quality of life). The PNA is intended to allow residents to purchase non-covered items or services, such as toiletries, snacks, or gifts. As of January 1, 2025, the PNA for Pennsylvania residents is \$60.00 per month. A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it difficult to breathe). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 16, 2025, revealed that Resident 7 is cognitively intact with a BIMS score of 15 (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). A review of Resident 7's Medicaid benefit determination from the Pennsylvania Department of Human Services Office of Income Maintenance dated April 30, 2025, revealed Resident 7's total monthly income is \$1,006.01. Her monthly payment towards the cost of care is this amount minus her personal needs allowance (as of January 1, 2025, the PNA is \$60.00 for residents of Pennsylvania). Resident 7's liability for the cost of care each month was determined to be \$946.01 as of April 30, 2025. During an interview on September 16, 2025, at 12:50 PM, Resident 7 reported she was upset that the facility charged her an additional \$20.00 each month from her PNA. She stated she was told by the facility business office that the charge was to pay off her debt to the facility. She explained that at the beginning of her stay she maintained financial obligations to both the facility and her home in the community, which led to unpaid balances owed to the facility. An interview with Employee 5, the Business Office Manager (BOM), on September 18, 2025, at 11:00 AM confirmed Resident 7 accrued debt due to unpaid care charges. Employee 5 stated that in 2023, the facility became Resident 7's representative payee (a person or entity designated to manage a resident's Social Security or Supplemental Security Income benefits). Employee 5 stated Resident 7 agreed to pay an additional \$20.00 monthly from her funds to reduce the debt. A facility-provided form titled Payment Agreement, dated October 5, 2023, revealed Resident 7 would pay \$20.00 monthly until her balance was paid in full. The document included a clause stating, my failure to make payments without notification to the business office may result in further collection action. The document was signed by Resident 7. A review of Resident 7's financial account from October 5, 2023, through September 17, 2025, revealed the facility deducted \$20.00 monthly from her PNA on 23 occasions, totaling \$460.00. The account also reflected two additional debits of \$35.00 each in January 2025, labeled as care cost payment, with unclear origin dated January 7, 2025, and January 14, 2025. During an interview on September 19, 2025, at 9:30 AM, the Nursing Home Administrator (NHA) confirmed the facility deducted an additional \$20.00 each month from Resident 7's PNA since 2023. The NHA stated that while Resident 7 signed the payment agreement, the facility had no documented evidence to show that Resident 7 was informed she was not obligated to pay her outstanding balance from her PNA funds. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, 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 two nursing units (West and East Units), including experiences reported by one out of twenty-two residents sampled (Resident 43). Findings include: A clinical record review revealed Resident 43 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and paraplegia (a condition characterized by the loss or impairment of motor and sensory functions in the lower half of the body). A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 14, 2025, revealed that Resident 43 was 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 cognition is intact). Observations on September 16, 2025, at 9:15 AM and September 19, 2025, at 9:30 AM in the Short Hall of the East Nursing Unit revealed the outer surface of the ice machine and the floor area surrounding the ice machine were visibly soiled. The wall fabric on the opposite wall of where the ice machine was located was stained and discolored. The vinyl baseboard molding was wavy and in need of repair. Observations on September 16, 2025, at 9:20 AM, 9:45 AM, and 12:20 PM, and on September 18, 2025, at 11:45 PM revealed a strong urine like odor in the Short Hall of the East Nursing Unit between Resident room [ROOM NUMBER] and the kitchen. An observation on September 16, 2025, at 10:50 AM of resident room [ROOM NUMBER] revealed the floors had a sticky and tacky feel. The room and hallway outside the room had a foul odor. An observation on September 16, 2025, at 10:52 AM of the bathroom between resident room [ROOM NUMBER] and #216 revealed a large soiled brief in the bathroom sink. During an interview on September 16, 2025, at 11:15 AM, Resident 43 indicated that last week she had a bowel movement when in her wheelchair. She explained that staff cleaned it up but missed areas of her wheelchair, and it upsets her that her chair is not clean. An observation following the interview on September 16, 2025, at 11:20 AM revealed Resident 43's wheelchair was in her room. The wheelchair back support was observed with a rip in the fabric forming a pocket. Inside the ripped fabric was a thick brown and black residue lining the pocket walls and base. An observation on September 18, 2025, at 12:15 PM in the resident dining/activity area located in the [NAME] Nursing Unit revealed a buildup of cobwebs behind the counter located next to the refrigerator. During an interview on September 19, 2025, at 10:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to provide services to maintain a clean and homelike environment for all residents living at 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.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of clinical records and staff interviews, it was determined that the facility failed to develop a person-centered care plan to address a resident's limited range of motion to the left upper extremity and non-compliance with a therapeutic device to maintain skin integrity and prevent worsening range of motion for one resident out of 22 sampled (Resident 44). Findings include: A clinical record review revealed that Resident 44 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular accident (stroke) and depression. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 15, 2025, indicated the resident had a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 12 (8 to 12 indicates moderate cognitive impairment) and impairment of the upper extremity (shoulder, elbow, wrist, hand) on one side. A physician order dated June 18, 2024, noted an order for soft palm roll (therapeutic device, cylinder or cushion used to prevent and treat a hand contracture which is a condition where the muscles, tendons, or other tissues in the hand tighten and shorten, causing one or more fingers to be permanently bent or pulled towards the palm, making it difficult to straighten the fingers) to the left hand at all times and may remove for range of motion, hygiene, and skin checks. An Occupational Therapy Discharge Summary (for therapy dates June 7, 2024, through June 28, 2024) dated July 1, 2025, noted the occupational therapist (OT) placed a soft roll to the resident's left hand to maintain skin integrity and prevent further issues. The OT noted the resident had an impaired grasp of the left hand, maintained the left hand in a fist/flexed position, and was not compliant with therapy. Discharge recommendations included to continue the left hand soft palm roll and bilateral upper extremity passive range of motion three sets with 10 repetitions each all joints/planes once daily as tolerated. An observation of Resident 44 on September 18, 2025, at 9:20 AM revealed the resident was in bed without the soft palm roll in the left hand. The soft palm roll was lying on the left side of the bed next to the resident. The resident did not answer when asked why she was not wearing the soft palm roll. An interview with Employee 1 (LPN) on September 19, 2025, at 10:00 AM confirmed that Resident 44 is frequently non-compliant with care. Employee 1 (LPN) confirmed that Resident 44 can use her right hand to remove the soft palm roll after it is placed by staff to the resident's left hand. An observation with the director of nursing (DON) of Resident 44 on September 19, 2025, at 12:00 PM revealed the soft palm roll was on the left side of the bed next to the resident. During an interview with Resident 44 at this time the resident refused to allow the DON to reposition the soft palm roll on her hand. Resident 44 held her hand in a fist position and would not answer if she had the ability to open and close her hand. Review of the resident's care plan initially dated April 20, 2021, did not address Resident 44's concern with limited range of motion of the left hand and non-compliance with wearing soft palm roll to the left hand. During an interview on September 19, 2025, at 11:00 AM the Nursing Home Administrator (NHA) failed to provide documented evidence the facility developed a plan of care to address Resident 44's limited range of motion to the left hand and non-compliance with wearing the physician prescribed soft palm roll to maintain skin integrity and prevent a further range of motion decline to the resident's left hand. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on a review of scheduled activities and resident and staff interviews, it was determined the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents including experiences expressed by four out of five residents during a resident group interview (Residents 7, 8, 26, and 37). Findings include: During a resident group interview on September 17, 2025, at 10:00 AM, four out of five residents raised concerns that there were not enough evening activities available to meet their interests. Resident 8 explained that in the past, there were activities after dinner like a recreation card club that he participated in and enjoyed. He indicated there are no activities in the evening now and he would like to see them return. During the resident group interview Residents 7 and 26 explained they would like to have arts and craft activities offered in the evening after dinner. They indicated that currently there is not much to do in the evening and would like to have evening activities a few days a week. Resident 7 also indicated that she would like to have a movie night and bingo in the evening. Resident 37 indicated that he would like evening activities; however, he did not specify the type of activities that met his interests. A review of the Resident Activity Calendar, dated September 2025, revealed the latest activity is scheduled at 2:00 PM each day from September 1, 2025, through September 30, 2025. During an interview on September 17, 2025, at 11:30 AM, Employee 6, Director of Activities confirmed the facility did not currently have any scheduled workers facilitating programs in the evenings. Employee 6, Director of Activities, explained that residents have mentioned that they would like to have evening activities, but the facility has not been able to hire additional staff for evening activities. During an interview on September 19, 2025, at 9:15 AM the Nursing Home Administrator confirmed the facility did not currently offer structured evening activities for residents. The facility failed to provide an ongoing schedule of activities that support the physical, mental, and psychosocial well-being of residents by not providing activity that meets the needs and interests of residents, specifically evening activities. 28 Pa. Code 202.18 (b)(3)(e)(6) Management.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to obtain physician orders and develop and implement a person-centered comprehensive care plan in accordance with standards of practice for one resident out of 22 sampled residents (Resident 15). Findings include: 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: AssessmentsClinical problemsCommunications with other health care professionals regarding the patientCommunication with and education of the patient, family, and the patient's designated support person. A review of the clinical record revealed that Resident 15 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and hypertension (blood pressure that is higher than normal). A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 31, 2025, revealed that Resident 15 had moderately impaired cognition with a BIMS score of 12 (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 8-12 indicates cognition is moderately impaired). A review of Resident 15's clinical record revealed a physician's order, dated August 25, 2025, for Eliquis (a blood thinner), 5 milligrams (mg), one tablet every morning and at bedtime related to atrial fibrillation. A review of a nurse's progress note dated September 1, 2025, at 10:05 AM, revealed that Resident 15 was experiencing uncontrollable bleeding from the bilateral nares (nostrils). Further review of the note revealed the resident's morning dose of Eliquis was held due to the bleeding, and the resident was transferred to a local emergency room for evaluation and treatment. A review of a nurse's progress note dated September 1, 2025, at 4:30 PM, revealed a report from the emergency room that stated that dissolvable fibrinogen (a protein that is made by the liver that is essential for blood clotting) was placed in the resident's nares, and if bleeding were to occur, then apply ice and hold the pressure for ten minutes. Further review revealed that if Resident 15 was still bleeding, repeat the process and check for bleeding, and if bleeding was to still occur after two rounds of ice and pressure, then return the resident to the emergency department. A review of a nurse progress note dated September 1, 2025, at 6:15 PM, revealed that Resident 15's nose was dripping blood, and it was noted that a small amount of the fibrinogen was in the left nostril and none in the right nostril and Resident 15 was refusing ice and pressure and was sent back to the emergency room for evaluation and treatment. A review of a nurse's progress note dated September 1, 2025, at 7:50 PM, revealed they received a report from the emergency room nurse, and it was advised for Resident 15 to see an ENT (a medical specialist who is focused on the ears, nose, and throat). A review of a nurse's progress note dated September 3, 2025, at 7:49 PM, revealed that Resident 15 was experiencing a lot of bleeding from the nose, despite efforts that included holding pressure and applying ice, and the resident was sent to the emergency room for evaluation and treatment. A review of emergency room department discharge instructions for Resident 15 dated September 3, 2025, revealed instructions for Resident 15 to sneeze with their mouth open for two weeks, to not blow their nose for two weeks, to not pick their nose, and to not bend over. Further instructions for Resident 15 to use saline nasal spray every two hours while awake and to apply Afrin Saline gel (prevents drying and crusting) to the inside of the nostrils twice per day, especially before bed. It was advised to consider using a humidifier, especially at night. It was instructed that if Resident 15's nose began to bleed, to give two generous sprays of Afrin into the affected nostril and pinch the soft parts of the nose together for a minimum of fifteen minutes without releasing, and to not put anything inside the nose to stop the bleeding. It was noted that Resident 15 was provided with Afrin spray (nasal spray used to constrict blood vessels in the nasal passages) to take back to the facility. There was a discharge order noted for an ENT referral as an outpatient for persistent left-sided epistaxis (nosebleed), as resident 15 was seen three times in the emergency department for the same complaint. A review of Resident 15's physician orders failed to identify the emergency room doctor's medication</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, select policy review, and staff interviews, it was determined the facility failed to ensure enteral feeding syringes in use were labeled and dated, and failed to provide direction on the maximum time such syringes may remain in service, to prevent contamination and other complications, for one resident receiving enteral nutrition out of 22 residents sampled (Resident 40). Findings include: Review of the facility policy titled Checking Gastric Residual Volume (GVR) Policy last reviewed by the facility January 24, 2025, indicated that nurses should assess tolerance of enteral feeding (any method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories) and minimize the potential for aspiration (when material such as gastric contents, saliva, food, or nasopharyngeal secretions are inhaled into the airway or respiratory tract). The policy did not address the labeling, dating, rinsing, or disposal timeframes of syringes used for enteral administration. According to the CMS Tube Feeding Status Critical Element Pathway (Form CMS-20093), when feeding syringes are reused, they must be: Stored in a clean area. Labeled with the resident's name and the date opened. Rinsed with hot water after each use; and Disposed of within 24 hours. Failure to ensure syringes used for enteral nutrition were labeled, dated, and discarded within an appropriate timeframe created the potential for syringes to be reused beyond their safe period, increasing the risk of bacterial contamination, gastrointestinal infection, or other complications related to compromised enteral administration. Clinical record review revealed Resident 40 was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) and non-traumatic intracerebral hemorrhage (bleeding into brain tissue). Resident 40 required a PEG tube (percutaneous endoscopic gastrostomy, a tube placed through the abdominal wall into the stomach to deliver nutrition). A review of the clinical record revealed Resident 40 had a physician order, dated September 15, 2025, for continuous enteral feeding with Glucerna 1.5 at 70 ml/hour (a liquid high calorie enteral feeding formula) from 8:00 PM to 8:00 AM. Further review revealed a physician order dated September 18, 2025, to direct staff to check PEG placement prior to each use via auscultation (method of listening for air blown into the gastrointestinal tract via enteral syringe) and aspiration, administer 30 mls of water before and after medications and 5 mls of water between medications. Observation of Resident 40 on September 16, 2025, at 1:08 PM revealed a 60 mL enteral syringe (a syringe used to deliver medications, flushes or feedings directly into the gastrointestinal tract via the PEG tube) lying on the room windowsill with a clear plastic bag beneath it containing tan residue. Neither the syringe nor the bag was labeled or dated. Interview with Employee 4 on September 16, 2025, at 1:12 PM, confirmed that the enteral syringe was opened but was not labeled or dated. An interview with the Director of Nursing on September 19, 2025, at 12:00 PM revealed it was the expectation that supplies used for enteral feeding, flushes, and medications be labeled and dated upon opening. However, review of the facility's written policy revealed no such requirement. An interview with the Nursing Home Administrator on September 19, 2025, at 12:15 PM confirmed the expectation that syringes should be labeled and dated, although the requirement was not reflected in facility policy. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, observation, and staff interview, it was determined the facility failed to maintain respiratory equipment in a manner to promote optimal functioning for one resident out of 22 sampled residents. (Resident 9). Findings include: A review of facility policy entitled Equipment Management Policy last reviewed on January 24, 2025, revealed the nebulizer machine tubing and masks are to be changed weekly and as needed to ensure sanitary conditions and safe function. A nebulizer machine is a device that converts liquid medication into a fine mist for inhalation to treat respiratory conditions. A review of Resident 9's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses including hemiplegia (paralysis affecting one side of the body), hemiparesis (weakness affecting one side of the body), and aphasia (a communication disorder resulting from damage to the language areas of the brain). An observation conducted on September 17, 2025, at approximately 12:15 PM revealed a clear plastic bag attached to Resident 9's nebulizer machine containing a tubing and mask without any dating to identify when it was last changed. Further observation revealed the nebulizer bowl (the medication chamber) was labeled with the date June 16, 2025, and the nebulizer tubing was wrapped with a piece of nursing tape also marked with June 16, 2025. An interview with Employee 3 confirmed that the nebulizer mask and tubing had last been dated as June 16, 2025, and had not been replaced according to policy. A review of Resident 9's clinical record revealed no current physician's order for nebulizer treatments. An interview conducted with the Director of Nursing (DON) on September 18, 2025, at 1:00 PM revealed that Resident 9 had received nebulizer treatments earlier in the year, but when the treatments were discontinued, the nebulizer machine was not removed from the resident's room. A subsequent interview with the DON on September 19, 2025, at approximately 9:00 AM confirmed that the respiratory equipment remained in the resident's room and had not been maintained in accordance with the facility's policy. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and one of two resident pantry areas (West Nursing Unit). 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). Observation on September 16, 2025, at 9:20 AM during the initial tour of the food and nutrition services department conducted with the foodservice director revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: There was a three-quarter inch hole in the wall grout located to the right of the handwashing sink. The floors area along the perimeter of the kitchen and under the tray line counter area in the kitchen had a build-up of dirt and debris. Observation on September 18, 2025, at 12:15 PM of the resident pantry area located on the [NAME] Nursing Unit revealed two four-ounce containers of applesauce, two four-ounce containers of canned pears, and two covered eight-ounce glasses of milk which were not dated when available for use. Interview with the food service director (FSD) on September 19, 2025, at 9:40 AM confirmed the food and nutrition services department was to be maintained in a sanitary manner and confirmed food items were to be dated to ensure quality and food safety to prevent opportunities for foodborne illness. 28 Pa Code 211.6(f) Dietary services. 28 Pa Code 210.18 (e) (2.1) Management.</p>		