

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/31/2026
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.			
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on a review of clinical records, facility policy, facility-provided investigative documentation, and staff interviews, it was determined the facility failed to protect one of 23 residents reviewed (Resident 110) from neglect by failing to ensure staff implemented the resident's individualized care plan requiring the assistance of two staff members for transfers resulting in actual harm in the form of a fracture of the right distal tibia and fibula (the two bones of the lower leg located between the knee and ankle) that required hospital evaluation and treatment. This deficient practice is cited as past noncompliance. Findings include: A review of the Abuse Policy last reviewed by the facility on May 1, 2026, revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy required the facility to implement processes to include screening, training, prevention, identification, protection, investigation, reporting, and response to allegations of potential or actual allegations to ensure they are treated seriously, reported promptly and investigated thoroughly, and addressed with appropriate corrective or disciplinary action based on the findings, severity, circumstances, and regulatory requirements. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. A review of Resident 110's clinical record revealed admission to the facility on June 11, 2026, with diagnosis that included a Tri malleolar fracture of the left lower leg (a severe and unstable type of ankle break where three parts of the ankle joint break), polyosteoarthritis (a degenerative joint disease where multiple joints break down from wear and loss of protective cartilage over time), and muscle weakness. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 11, 2026, revealed that Resident 110 was 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 through 15 indicates intact cognition). The assessment revealed the resident required total assistance from staff for transfers and toileting. A review of Resident 110's comprehensive care plan dated June 11, 2026, revealed the resident had an activities of daily living (ADL, routine self-care activities such as transferring and toileting) self-care performance deficit related to immobility and a left ankle fracture. The care plan required assistance from two staff members for transfers and toileting and directed staff to maintain the resident as non-weight-bearing through the left lower extremity (not allowing any body weight to be placed on the injured left leg). A review of physician orders dated June 11, 2026, revealed an order directing staff to transfer Resident 110 with the assistance of two staff members and to maintain non-weight-bearing status on the left lower extremity. A review of nursing documentation dated June 27, 2026, at 10:30 AM revealed Employee 3, Nurse Aide, reported that while transferring Resident 110 from the toilet to a (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 0600 Level of Harm - Actual harm Residents Affected - Few	wheelchair, the resident stood without difficulty; however, during the pivot transfer the resident's right foot turned inward and both the resident and Employee 3 heard a loud pop. The resident immediately complained of increased pain. Nursing documentation dated June 27, 2026, at 4:40 PM revealed a mobile radiology service completed an x-ray that identified an acute fracture of the right tibia (a new break in the shinbone). The nurse practitioner ordered the resident transferred to the hospital emergency department for further evaluation and treatment. Review of the hospital records dated June 27, 2026, at 8:39 PM revealed diagnostic imaging confirmed fractures of the distal right tibia and fibula (a broken lower right leg near the ankle, involving both the shinbone and the outer calf bone close to where they form the ankle joint). Hospital records revealed the resident was scheduled to undergo surgical repair the following day. A review of the facility's abuse and neglect investigative documentation dated June 27, 2026, revealed Employee 3 transferred Resident 110 from the toilet to the wheelchair using only one staff member despite the resident's physician order and care plan requiring assistance from two staff members. The investigation concluded the transfer was performed contrary to the resident's individualized plan of care and resulted in the resident sustaining a fracture of the right distal tibia. A review of a written statement completed by Employee 3 dated June 27, 2026, revealed Employee 3 documented that while assisting Resident 110 from the toilet to the wheelchair, both Employee 3 and the resident heard a pop as the resident turned to sit in the wheelchair. Employee 3 documented the resident was seated in the wheelchair and the nurse was immediately notified. Continued review of the facility's abuse and neglect investigative documentation revealed Employee 3 failed to follow the resident's individualized care plan requiring assistance from two staff members during transfers. The facility substantiated caregiver neglect and concluded that the failure to follow the resident's care plan directly resulted in the resident sustaining fractures of the right distal tibia and fibula. The investigation further revealed Employee 3 was suspended during the investigation and subsequently terminated following substantiation of neglect. During an interview conducted on August 29, 2026, at 9:00 AM the Nursing Home Administrator acknowledged Employee 3 did not follow Resident 110's physician order and care plan requiring assistance from two staff members for transfers. The Nursing Home Administrator acknowledged the facility's investigation determined the failure to implement the required transfer intervention resulted in Resident 110 sustaining fractures of the right distal tibia and fibula requiring hospital treatment and confirmed Employee 3's employment was terminated following the substantiated finding of neglect. The facility failed to ensure staff implemented Resident 110's physician order and individualized care plan requiring assistance from two staff members during transfers. As a result, Resident 110 sustained fractures of the distal right tibia and fibula requiring diagnostic testing, hospital transfer, and surgical intervention. The facility alleged corrective actions were completed following the incident, including; Upon Resident 110's return from the hospital, the facility completed an assessment and updated the resident's comprehensive care plan as appropriate based on the resident's current condition and care needs. The facility identified that all residents requiring assistance from two staff members for transfers had the potential to be affected. The facility provided re-education to staff regarding the requirement to review the Kardex (a resident-specific care summary that communicates current care instructions) before providing care and to consistently follow each resident's individualized plan of care. The facility also provided re-education regarding the facility's Abuse Policy. Licensed nurses and nurse aides conducted random observations to verify staff followed each resident's individualized plan of care for transfer assistance and transfer status. The facility provided additional re-education to licensed nurses and nurse aides regarding implementation of residents' individualized plans of care, including reviewing the Kardex before providing care and complying with the facility's Abuse Policy. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Nursing Home Administrator, or designee, monitored a sample of transfer observations through random audits to verify residents received transfer assistance as ordered. The facility implemented audits weekly for four weeks and monthly for two additional months, with audit results reviewed by the Quality Assurance and Performance Improvement Committee for recommendations and follow-up as indicated. Survey findings supported that substantial compliance was achieved on July 1, 2026. Therefore, this deficiency is cited as past noncompliance. 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.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(5) Nursing services.		

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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** Based on observations, a review of clinical records, physician orders, select facility policies, and staff interviews, it was determined that the facility failed to provide the necessary care and services to maintain residents' highest practicable physical well-being by failing to consistently implement physician-ordered treatments and care planned interventions to maintain skin integrity for two of 23 sampled residents (Residents 15 and 27). Findings include: A review of the facility policy titled Skin and Wound Management System, last reviewed by the facility on May 1, 2026, revealed it is facility policy to identify residents with existing wounds or pressure injuries, assess residents at risk for impaired skin integrity, implement appropriate preventive and treatment interventions, and provide ongoing monitoring to promote skin integrity and wound healing. Clinical record review revealed that Resident 15 was admitted to the facility on [DATE], with a Stage III pressure ulcer (a full-thickness skin loss that does not expose bone, tendon, or muscle and may have dead tissue identified and documented as slough or necrotic in nature). A review of Resident 15's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 22, 2026, revealed that Resident 15 was 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 12 through 15 indicates cognitively intact). It was also identified on this assessment the resident was at risk for impaired skin integrity, had an unhealed unstageable pressure injury of the sacrum (the lower back area immediately above the tailbone where the wound depth cannot be determined because it is covered with slough or dead tissue), and required staff assistance to turn and reposition in bed because the resident could not independently reposition herself. During interviews conducted on July 28, 2026, at 11:00 AM, and July 29, 2026, at 2:00 PM, Resident 15 stated she depended on staff to reposition her while in bed. The resident reported that on the evening of June 4, 2026, staff placed her on a bedpan. The resident stated she accidentally fell asleep while on the bedpan, was embarrassed that she had fallen asleep, and did not realize she remained on the bedpan until she awakened the following morning. The resident stated she activated the call bell after awakening and staff then removed the bedpan. A review of the nursing note and Pressure Ulcer Investigative Report, dated June 5, 2026, at 7:00 AM, and an interview with the Director of Nursing on July 30, 2026, at 2:00 PM, confirmed staff placed Resident 15 on a bedpan on June 4, 2026, at 10:30 PM. The documentation revealed the resident remained on the bedpan until approximately 6:30 AM on June 5, 2026, when the resident activated the call bell for assistance. After staff removed the bedpan, they identified a red outline corresponding to the shape of the bedpan measuring approximately 23 centimeters (cm) by 14 cm on the resident's skin. Resident 15 required turning and repositioning every two to three hours. Had staff implemented those interventions as documented in the resident's care, staff would have identified that the resident remained on the bedpan before 6:30 AM on June 5, 2026. During an interview on July 30, 2026, at 2:00 PM, the Director of Nursing was unable to provide evidence that staff completed the required turning and repositioning every two to three hours while Resident 15 remained on the bedpan or otherwise monitored the resident during that period. A review of the June 2026 physician orders revealed Resident 15 had an order for a calcium alginate dressing (a wound dressing made from seaweed fibers that absorbs wound drainage and promotes healing) to the resident's sacral pressure injury. A review of the nursing note and Skin Tear Investigation, dated June 6, 2026, at 10:00 PM, revealed staff removed an existing dressing from the resident's sacral (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound and, during removal, the resident sustained a skin tear to the left buttock measuring 1.5 cm in length by 1 cm in width by 0.1 cm in depth. The facility's investigation determined staff had failed to apply the physician-ordered dressing. During an interview on July 30, 2026, at 2:00 PM, the Director of Nursing stated the incorrect dressing closely resembled the physician-ordered dressing but lacked the silicone component intended to facilitate gentler removal and reduce trauma to the surrounding skin. The Director of Nursing was unable to provide evidence that staff consistently applied the physician-ordered dressing or otherwise ensured the resident received appropriate wound care to treat the existing pressure injury and minimize additional skin injury. A review of the clinical record revealed a similar failure to implement physician-ordered interventions intended to maintain skin integrity for Resident 27. A review of the clinical record revealed Resident 27 was admitted to the facility on [DATE], with diagnoses including intracerebral hemorrhage (bleeding within the brain caused by rupture of a blood vessel) and cerebral infarction (death of brain tissue caused by interruption of blood flow to the brain). A review of Resident 27's care plan, initiated on February 26, 2025, identified actual and potential impairment of skin integrity related to decreased mobility, environmental changes, and the need for extensive to total assistance with transfers, toileting, and mobility. Interventions included maintaining clean and dry skin, performing skin assessments each shift, and applying a left palm roll (a padded positioning device placed in the hand to keep the fingers open, reduce pressure from fingernails against the palm, absorb moisture, and decrease the risk of skin breakdown) as tolerated. A review of physician orders revealed an order dated June 5, 2025, directing staff to maintain the left palm roll as tolerated and remove it each shift for hygiene and range of motion (movement of a joint through its normal extent of motion) exercises. Observation on July 28, 2026, at 11:36 AM, revealed Resident 27 sitting in a chair in the resident's room with the left hand tightly clenched. The physician-ordered left palm roll was not in place. When prompted, the resident was unable to voluntarily open the hand. During an interview on July 28, 2026, at 11:38 AM, Employee 1, a Licensed Practical Nurse (LPN), confirmed the left palm roll was not in place. Employee 1 stated the device became soiled during the previous night shift and nursing assistants did not replace it with a clean palm roll. Employee 1 manually opened the resident's left hand and observed nail indentations on the resident's palm. A review of the July 2026 documentation survey report revealed documentation indicating Resident 27's left palm roll had been applied on July 28, 2026, at 2:22 AM. The clinical record contained no documentation indicating when the left palm roll was removed for hygiene, when it became soiled, or when a clean palm roll was reapplied after removal. During an interview on July 31, 2026, at 9:45 AM, the Nursing Home Administrator and Director of Nursing reviewed the above findings and were unable to provide evidence that staff consistently implemented the physician's order and the resident's care planned intervention requiring use of the left palm roll. As a result, the facility failed to implement the physician's order and care planned intervention intended to maintain skin integrity, placing Resident 27 at increased risk for skin breakdown and pressure-related injury to the left palm. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, select facility policy, resident interviews, and staff interviews, it was determined that the facility failed to consistently implement physician-ordered restorative nursing services in accordance with residents' physician orders and care plans to maintain or improve mobility for three of 23 residents reviewed (Residents 85, 15, and 64). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing the MDS dated [DATE], requires the assessment to accurately reflect the resident's status; a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. According to the RAI manual, Section O 0500: Restorative Nursing Programs, states that movement occurring incidentally during activities such as dressing, bathing, or other routine care does not constitute a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored, evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures. A review of the facility policy titled Restorative Nursing Services, last reviewed by the facility on May 1, 2026, revealed residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Restorative goals may include supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining, or strengthening his physiological and psychological resources; maintaining his dignity, independence, and self-esteem; and participating in the development and implementation of his plan of care. A clinical record review revealed Resident 85 was admitted to the facility on [DATE], with diagnoses that included muscular dystrophy (a group of inherited diseases that cause progressive muscle weakness and loss of muscle function). A review of Resident 85's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 16, 2026, revealed that Resident 85 was 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 through 15 indicates cognition is intact). A physician's order initiated on November 29, 2023, directed staff to provide passive range of motion exercises (movement of a resident's joints performed by another person without the resident actively moving the limb) to both lower extremities twice daily. The order required three sets of 10 repetitions through all joints and planes of motion (moving each joint through its full, normal range in every direction). A physical therapy Discharge summary dated [DATE], revealed recommendations for Resident 85 to receive restorative nursing program services that include bilateral lower extremity passive range of motion exercises across all joints and planes, three sets of ten repetitions daily. A review of Resident 85's annual MDS dated [DATE], Section O 0500: Restorative Nursing Programs, indicated the resident received passive range of motion restorative nursing services for at least 15 minutes on six of the seven days during the assessment look-back period. A review of the resident's care plan initiated on September 13, 2023, revealed Resident 85 was at risk for falls related to decreased mobility and muscular dystrophy. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of 15 a score of 13 through 15 indicates cognition is intact. Physician's orders for July 2026 directed staff to provide restorative nursing services to Resident 64 consisting of active and passive range of motion exercises to the right upper extremity and both lower extremities. The physician ordered three sets of 10 repetitions daily. During an interview on July 29, 2026, at 11:20 AM, Resident 64 stated staff were not providing restorative exercises and indicated a desire to participate in therapy to become stronger and improve the ability to return home. A review of the July 2026 restorative nursing documentation revealed active and passive range of motion exercises were documented as not applicable on July 1, July 3, July 7, July 8, July 23, and July 26, 2026. The clinical record contained no documentation explaining why the physician-ordered interventions were not completed. Review of the July 2026 restorative nursing documentation revealed treatment times ranging from five to 15 minutes without documentation explaining the variation in treatment duration. During an interview on July 30, 2026, at 9:05 AM, Employee 11, NA, stated range of motion exercises were sometimes completed while assisting residents with dressing and grooming. Employee 11 was unable to explain the physician-ordered restorative exercises, describe what was meant by exercises through all joints and planes, or explain the variation in documented treatment times. During an interview on July 30, 2026, at 9:30 AM, Employee 12, Occupational Therapist, stated physician-ordered active or passive range of motion exercises performed through all joints and planes would include the shoulders, elbows, wrists, and fingers for the upper extremities and the hips, knees, ankles, and toes for the lower extremities. During an interview on July 30, 2026, at 2:00 PM, the Director of Nursing was unable to provide evidence demonstrating that Residents 15 and 64 consistently received physician-ordered restorative nursing services or that nursing assistants had been instructed on how to perform the ordered restorative range of motion program in accordance with the physician's orders. The facility failed to consistently implement physician-ordered restorative nursing services for Residents 85, 15 and 64. 28 Pa. Code: 211.5(f) (ii) Medical records.28 Pa. Code: 211.10 (c) Resident care policies.28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to implement, evaluate, and revise behavioral health interventions in response to persistent and escalating behavioral symptoms for one of 23 sampled residents reviewed for behavioral health services (Resident 63). Findings include: A review of the facility policy titled Behavioral Health Services, last reviewed by the facility on May 1, 2026, revealed it is facility policy to provide behavioral health services as needed to assist residents in attaining or maintaining their highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care, and staff must promote dignity, autonomy, privacy, socialization, and safety as appropriate for each resident and are trained in ways to support residents in distress. Clinical record review revealed Resident 63 was admitted to the facility on [DATE], with diagnoses including bipolar disorder (a mental health disorder that causes episodes of significant changes in mood, energy, activity, and concentration), anxiety (a condition characterized by excessive fear, nervousness, or worry), and intellectual disability (a lifelong condition involving limitations in intellectual functioning and adaptive skills such as learning, reasoning, and problem solving). A review of Resident 63's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 4, 2026, revealed that Resident 63 was 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 through 15 indicates cognition is intact). Review of nursing documentation revealed a persistent pattern of escalating behavioral symptoms occurring on multiple shifts throughout the day and night. Documented behaviors included yelling, screaming, cursing, verbal aggression, physical aggression, throwing objects, destruction of property, threats toward staff, self-injurious behaviors, sexualized behaviors, refusal of care, and behaviors that disrupted other residents. The clinical record documented, in part, the following: On March 2, 2026, at 2:50 PM, Resident 63 pulled a needle from his arm during a blood draw, spit at and cursed the phlebotomist (a healthcare professional trained to obtain blood samples), yelled obscenities (offensive language), and threw personal belongings into the hallway. April 7, 2026, at 4:36 AM, the resident became resistive and combative with care and threw staff out of his room, threatening to punch them if they returned, and resident then began throwing items from his room out into the hallway, including a garbage can, remote control, call bell and bed control. April 7, 2026, at 8:11 AM, the resident's room was noted to be disarrayed (messy) with soiled briefs, linen, and cereal scattered throughout the floor. The resident cursed and threw multiple staff members out of the room and threw a fork at a staff member, a butter knife at another staff member, and then continued to throw meal lids and cups out into the hallway and was unable to redirect. Female residents and surrounding residents reported to the nurse that they were fearful of the man yelling and throwing things. April 7, 2026, at 9:22 AM, the resident threw more items across the hall into the adjacent room while cursing at staff and yelling obscenities and threatened to hit staff if they came into the room. April 7, 2026, at 1:47 AM, the resident entered his room and ripped the hand sanitizer drip tray off the wall and yelled obscenities to staff. April 7, 2026, at 4:30 PM, resident was noted with behaviors throughout the shift and was evaluated by behavioral health support and (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided better coping skills, however shortly afterward the resident was noted to be throwing items in their room and smashing clock on the floor. April 7, 2026, at 10:28 PM, the resident was aggressive and yelling at staff and continued to throw items in the hall such as yogurt, utensils, cups, wall clock, and call bell, threatened to beat up staff, re-direction was ineffective and behaviors and threats continued. On April 8, 2026, at 11:24 AM, the resident ripped the call bell from the wall, threw objects throughout the room and into the hallway, struck another resident in the leg with a highlighter, threatened to kill a nurse by stating he would put his hands around the nurse's neck, and required staff to close the room door to protect other residents. On May 10, 2026, at 2:21 PM, the resident distributed sexually inappropriate notes to staff, threatened to kill a staff member, threw objects, and became increasingly agitated despite redirection. On May 13, 2026, at 5:30 PM, the Nursing Home Administrator (NHA) documented discussions with a case manager regarding possible hospital admission due to Resident 63's escalating behavioral symptoms. Later that day, on May 13, 2026, at 8:00 PM, nursing documentation revealed Resident 63 displayed unprovoked aggressive behaviors and made statements suggesting self-harm when staff approached to provide care. When staff asked whether the resident had a plan to harm himself, the resident did not respond, began yelling, and struck himself. Staff initiated one-to-one observation for resident safety. Documentation further revealed the resident screamed at staff, made sexually inappropriate gestures, and displayed an obscene hand gesture. When staff offered voluntary (willing) transfer to the hospital, the resident refused. The resident then became tearful, increasingly angry, and physically aggressive, throwing items from the bed onto the floor. The resident pulled the call bell from the wall and threw it across the room, then threw a knife that nearly entered the hallway. The resident repeatedly slapped himself and struck his head, chest, and upper thigh with closed fists and used a television remote to strike himself in the head. Staff documented the resident could not be calmed. A behavioral health crisis assessment was completed, and the evaluator recommended hospital transfer for inpatient psychiatric evaluation. A 302 (an involuntary emergency psychiatric commitment under Pennsylvania law) was initiated, and the resident was transferred to the hospital for further evaluation. On May 14, 2026, at 1:46 PM, the NHA documented the resident remained hospitalized for psychiatric concerns and noted discussions regarding the possibility of identifying an alternate placement upon the resident's discharge from the hospital. A review of outside hospital records provided by the facility, dated May 18, 2026, revealed Resident 63 presented to the hospital on May 13, 2026, for psychiatric evaluation following violent behaviors and statements expressing a desire to kill himself. Hospital documentation revealed the psychiatry service initially recommended involuntary psychiatric hospitalization through a 302 commitment. However, the resident experienced a decline in medical status requiring admission for medical treatment. After the resident's medical condition improved, psychiatry re-evaluated the resident and determined inpatient psychiatric hospitalization was no longer indicated. The resident was subsequently discharged from the hospital and returned to the skilled nursing facility on May 18, 2026. Following the resident's return from the hospital on May 18, 2026, the clinical record continued to document frequent and escalating behavioral symptoms despite implementation of behavioral interventions, including the following: May 23, 2026, at 11:23 AM the resident was yelling, cursing, striking himself with a television remote, and overturning furniture. On June 14, 2026, at 2:41 PM, Resident 63 became verbally aggressive toward housekeeping staff and refused to allow staff to enter the room. On June 15, 2026, at 2:56 PM, Resident 63 became impatient during care, yelled, screamed, swore, threw objects throughout the room, directed staff to leave the room, and refused care. On June 25, 2026, at 3:43 PM, nursing documentation revealed Resident 63 repeatedly yelled and threw objects throughout the room several times during the day after certain (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff members and visitors walked past the room. On June 29, 2026, at 3:42 AM, Resident 63 stood in the hallway yelling profanities at staff, punched a nearby door while continuing to curse, and threatened a staff member by stating that the next time he would get them in the face. On June 30, 2026, at 12:55 PM, Resident 63 yelled and cursed at staff and threw objects throughout the room against the walls and bed. On July 1, 2026, at 11:11 PM, Resident 63 screamed and threw objects throughout the room. On July 3, 2026, at 8:15 PM, Resident 63 attempted to transfer independently despite requiring the assistance of two staff members, became verbally aggressive toward staff, and spit prescribed medications onto the floor. On July 4, 2026, at 6:41 PM, nursing staff notified the physician of Resident 63's continued verbal aggression, use of vulgar language, and spitting prescribed medications onto the floor. On July 9, 2026, at 10:02 AM, Resident 63 became agitated, yelled and cursed at staff, and pushed a bowl from the bedside tray table to the floor. On July 10, 2026, at 6:04 PM, Resident 63 threw a hand sanitizer dispenser at a staff member in the hallway. Staff redirected other residents away from Resident 63 to maintain their safety. Resident 63 then threw his hat toward staff and spit at staff members. Staff informed the resident that the behavior was inappropriate and instructed him to return to his room. The resident then repeatedly slapped his forehead and kicked the metal door endplate with his foot. On July 11, 2026, at 3:22 PM, Resident 63 exhibited increased behavioral symptoms by yelling and swearing at staff as they walked past the room, throwing objects throughout the room, and striking himself in the head with a television remote control. On July 13, 2026, at 10:25 AM, nursing documentation revealed Resident 63 exhibited constant mood swings throughout the shift, yelled and cursed at staff, and threw objects into the hallway. When staff attempted to intervene, the resident threw a coffee cup at staff, called staff inappropriate names, threatened to wrap the call bell around his neck, and was placed on one-to-one supervision. On July 17, 2026, at 3:28 PM, Resident 63 yelled and cursed at staff and threw objects throughout the room. On July 18, 2026, at 5:48 PM, Resident 63 approached the nurse while screaming and holding a cord, stating that someone had cut the cord to his refrigerator. On July 19, 2026, at 10:49 AM, staff observed Resident 63's room in disarray, with objects scattered across the floor and a large puddle of red liquid, water, and cereal on the floor. Although the resident initially agreed to allow staff to clean the room, he began yelling and throwing objects when staff entered. On July 19, 2026, at 12:30 PM, Resident 63 yelled at staff to leave the room, stated that a housekeeper had cut the cord to his refrigerator, and became belligerent (angry and aggressive). On July 19, 2026, at 2:00 PM, Resident 63's sister contacted the facility and expressed concerns regarding the resident's behaviors, stating she believed the resident might require inpatient psychiatric admission. On July 20, 2026, at 2:10 PM, a social worker contacted the behavioral health service regarding Resident 63's increased yelling, swearing, throwing objects throughout the room, negative comments toward staff, threats of self-harm, and other inappropriate statements and behaviors. On July 21, 2026, at 6:06 AM, Resident 63 threw objects throughout the room and pulled the call light from the wall. On July 21, 2026, at 7:10 AM, staff found Resident 63 lying on the floor in the middle of the room. When staff attempted to assist him, the resident yelled, cursed at staff, and ordered them to leave the room. After staff assisted the resident to a position of safety, he threw objects within reach across the room and toward the doorway. The resident then attempted to wrap the call bell around his neck. Staff immediately intervened, and one-to-one supervision was initiated. On July 21, 2026, at 8:54 AM, Resident 63 yelled obscenities, threw objects throughout the room, and overturned the bedside tray table. The resident repeatedly struck himself in the head with the bed control while the assigned one-to-one observer remained positioned outside the room to promote the safety of the resident and staff. Staff contacted the behavioral health service for further evaluation. On July 25, 2026, at 3:43 (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, Resident 63 cursed and threw objects throughout the room while alone. On July 27, 2026, at 11:48 AM, Resident 63 pulled the call bell from the wall and threw it toward the doorway. Staff documented trash cans, briefs, shredded paper, colored pencils, and crayons scattered throughout the room. The resident repeatedly struck his head and legs with the bed control. On July 29, 2026, at 2:44 PM, Resident 63 approached staff and stated he was upset because his sisters were afraid of him and wanted him to go to the hospital. On July 30, 2026, at 2:04 AM, Resident 63 yelled, threw objects within reach, spit at staff, and repeatedly ordered staff to leave the room. A review of the resident's care plan dated July 24, 2025, identified they were at risk related to the resident engaging in self-harm behaviors, had a problematic manner characterized by physical abuse, inappropriate behavior identified as by cursing at staff, hits self, throwing trays and cups, throwing objects at staff, physical abuse of staff and striking staff members while providing care, inappropriate public sexual behavior, and rejection of care due to anger and cognitive impairment. Resident 63's care plan directed staff to allow the resident to freely express feelings, leave the resident's door ajar to promote self-soothing and behavioral de-escalation, monitor and document behavioral triggers associated with potential self-injurious behaviors, position the resident in the lowest position when agitated, reinforce that inappropriate behaviors were unacceptable, leave the room and reapproach after five to ten minutes, and discourage the resident from throwing objects from the room into the hallway. However, review of the clinical record revealed a persistent pattern of escalating behavioral symptoms documented throughout April, May, June, and July 2026, including yelling, screaming, cursing, verbal threats, throwing objects, destruction of property, self-injurious behaviors, aggression toward staff, and behaviors that disrupted other residents and required repeated behavioral health evaluations, one-to-one supervision, and hospital transfer. Despite the resident's continued pattern of behavioral escalation while receiving the care-planned behavioral interventions, the clinical record did not demonstrate the interdisciplinary team evaluated the effectiveness of those interventions or revised the comprehensive care plan in response to the resident's changing behavioral needs. During an interview on July 31, 2026, at 1:00 PM, the Nursing Home Administrator (NHA) was unable to provide evidence the interdisciplinary team evaluated the effectiveness of the resident's existing behavioral interventions, including allowing the resident to self-soothe, monitoring behavioral triggers, reapproaching the resident after periods of agitation, and discouraging the resident from throwing objects into the hallway, or revised the resident's behavioral care plan in response to the persistent pattern of escalating behaviors documented throughout April, May, June, and July 2026, despite repeated behavioral health evaluations, physician notification, one-to-one supervision, and psychiatric hospitalization. Refer to F610.28 Pa. Code 211.12 (c)(d)(3) (5) Nursing services.28 Pa. Code 211.10(a) Resident care policies.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined that the facility failed to implement physician-ordered Enhanced Barrier Precautions and failed to maintain appropriate infection prevention and control practices for one resident (Resident 109) with an indwelling urinary Foley catheter out of 23 residents reviewed. Findings include: A review of facility policy titled Enhanced Barrier Precautions, last reviewed by the facility on May 1, 2026, indicated enhanced barrier precautions (EBPs) are infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organism (MDRO's, bacteria that are resistant to multiple antibiotics) during high contact resident care activities. EBPs apply when: a resident is infected or colonized with a MDRO but does not have a wound or indwelling medical device and does not have secretions or excretions that cannot be covered or contained; a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained. The policy stated indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheotomies. The policy required signage to be posted outside the resident's room identifying the required precautions and the personal protective equipment (PPE, specialized clothing or equipment worn to reduce exposure to infectious organisms) to be used before providing care. A clinical record review revealed Resident 109 was admitted to the facility on [DATE], with diagnoses including an unstageable pressure ulcer of the sacral region (severe full-thickness skin and tissue loss at the tailbone area at the base of the spine. The true depth cannot be measured because the wound bed is completely covered by thick, dead tissue), and osteomyelitis of the vertebra, sacral and sacrococcygeal region (a serious bacterial or fungal infection and inflammation of the bone and bone marrow at the base of the spine, specifically involving the sacrum and tailbone. It often develops when a pressure ulcer breaks the skin or when an infection spreads through the blood). Nursing documentation dated June 8, 2026, at 3:57 PM documented Resident 109 was admitted with an indwelling Foley catheter (a flexible tube inserted through the urinary opening and into the bladder to drain urine into a drainage bag) and a Stage IV sacral pressure ulcer (a full-thickness pressure injury with exposed muscle, tendon, or bone). A physician's order July 20, 2026, indicated Resident 109 required enhanced barrier precautions due to the presence of a Foley catheter and wounds. Observations conducted on July 28, 2026, at 10:40 AM and July 29, 2026, at 10:08 AM revealed no Enhanced Barrier Precautions signage was posted outside Resident 109's room and no instructions identified the required PPE before entering the room, contrary to the physician's order and facility policy. During these observations, Resident 109 was resting in bed, and the Foley catheter drainage bag was lying directly on the floor on its side rather than being maintained off the floor, creating the potential for contamination of the urinary drainage system. During an interview on July 29, 2026, at 10:08 AM, Employee 4, Nurse Aide, confirmed the Foley catheter drainage bag was lying directly on the floor. During an interview on July 29, 2026, at 10:22 AM, Employee 5, Registered Nurse Supervisor, confirmed Resident 109 required Enhanced Barrier Precautions because of the Foley catheter and wounds and acknowledged the required precaution signage was not posted outside the resident's room. During an interview on July 30, 2026, at 1:55 PM, the Nursing Home Administrator acknowledged Resident 109 required Enhanced Barrier Precautions, confirmed the required signage was not in place, acknowledged the Foley catheter drainage bag had been left on the floor, and stated the facility is responsible for implementing infection prevention and control practices to reduce the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of infection. 28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, employee records, the facility assessment, facility policies and procedures, and staff interviews, it was determined the facility failed to develop, implement, and maintain an effective training program, based on the facility assessment, to ensure licensed nursing staff demonstrated the knowledge, skills, and documented competencies necessary to provide care for a resident with a peripherally inserted central catheter (PICC) line for one of 23 residents reviewed (Resident 6). Findings included: Federal regulation requires that a facility develop, implement, and maintain an effective training program for all new and existing staff. The training program must be based on the facility assessment and designed to ensure staff possess the knowledge and competencies necessary to care for residents according to their assessed needs and care plans. Pennsylvania State Board of Nursing Regulations (49 Pa. Code Chapter 21) require Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) who perform intravenous therapy, including central venous catheter care, to complete Board-approved education, receive supervised clinical instruction, and demonstrate competency. LPNs may perform only those intravenous therapy functions for which they have documented knowledge, skills, and abilities under appropriate supervision. A review of the facility assessment section titled Resident Acuity Affecting Licensed Nurses revealed the facility routinely cared for an average of three residents receiving high-risk intravenous or intramuscular medications or infusions. The facility assessment further indicated staff would receive education consistent with their assigned responsibilities and that staff competencies and skill sets necessary to meet resident needs would be identified. A clinical record review revealed Resident 6 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis (an infection of the bone). A physician's order dated June 24, 2026, directed the maintenance of a peripherally inserted central catheter (PICC a long, thin, flexible tube inserted into a vein in the upper arm and advanced into a large vein near the heart for the administration of medications and other therapies) with instructions to monitor the catheter insertion site each shift for signs and symptoms of infection or infiltration (the unintended leakage of IV fluid or medication into the surrounding tissue). A physician's order dated July 14, 2026, directed Vancomycin (antibiotic) Intravenous Solution 1,000 milligrams (mg) to be administered intravenously once daily for treatment of osteomyelitis. A review of the July 2026 Medication Administration Record (MAR) revealed Employee 8, LPN, documented administering Vancomycin Intravenous Solution 1,000 mg through the PICC line on July 20, 2026, at 4:00 PM. The July 2026 MAR revealed Employee 9, LPN, documented administering Vancomycin Intravenous Solution 1,000 mg through the PICC line on July 21, 2026, at 4:00 PM, and again on July 28, 2026, at 4:00 PM. A review of employee records revealed Employee 8 was hired on February 16, 2026, and Employee 9 was hired on June 30, 2026. The employee files contained no documented competency assessment or validation demonstrating either employee had completed competency requirements related to PICC line management, maintenance of central venous catheter patency (keeping the catheter open and functioning properly), or administration of medications through a central venous catheter. Additionally, the competency documentation section designated for recording completion dates contained no entries for either employee. During an interview conducted on July 31, 2026, at 9:45 AM, the findings were reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA and DON were unable to provide documentation demonstrating that Employees 8 or 9 had completed competency validation for PICC line management or intravenous (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration through a PICC line before providing care to Resident 6. The facility did not provide evidence demonstrating it had developed, implemented, and maintained an effective training program, based on its facility assessment, to ensure licensed nursing staff possessed the documented knowledge, skills, and competencies necessary to provide specialized PICC line care before assigning Employees 8 and 9 to administer intravenous medications through Resident 6's PICC line. 28 Pa. Code 201.20(a) Staff development.28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to promptly notify the attending physician of a significant change in condition for one out of three closed records reviewed (Resident 107). Findings include: A review of the facility policy titled Change in a Resident's Condition or Status, last reviewed by the facility on May 1, 2026, revealed it is the facility's policy to promptly notify the attending physician of changes in the resident's medical condition or status. The policy indicates the nurse will notify the resident's attending physician or physician on call when there has been a refusal of treatment or medication two or more consecutive times, or a significant change in the resident's physical condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing clinical interventions and impacts more than one area of the resident's health status. A clinical record review revealed Resident 107 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (a condition where the lungs fail to adequately oxygenate the blood or remove carbon dioxide, leading to insufficient oxygen to meet the body's needs) and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 26, 2026, revealed that Resident 107 was 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 through 15 indicates cognition is intact). A physician's progress note dated June 30, 2026, at 10:25 AM revealed Resident 107 was seen for weight gain and increasing oxygen requirement. The note indicated Resident 107 refused his intramuscular diuretic (a medication that makes the body produce more urine, helping to clear out extra salt and water) this morning but did take it yesterday. He has lost 0.5 lbs since Sunday. Resident 107 continues to refuse to go to the hospital or change his code status. New orders to increase resident oxygen to 5.0 liters per minute (L/min). A progress note dated June 30, 2026, at 10:56 AM revealed the physician is aware the resident refused intramuscular diuretic medication. New order to increase oral furosemide to 80 mg and oxygen to 5.0 L/min. A physician's order for furosemide oral tablet with the direction to give 80 mg by mouth two times a day was initiated on June 30, 2026. A physician's order for oxygen at 5.0 L/min by way of nasal cannula as needed for shortness of breath initiated on June 30, 2026. A progress note dated June 30, 2026, at 5:58 PM indicated Resident 107 refused furosemide 80 mg oral tablet. A review of Resident 107's blood oxygen saturation (the percentage of red blood cells carrying oxygen through your body; a measure of 95% to 100% is normal, a measure below 90% means the body's organs and tissues are not getting enough oxygen to work properly) vital records from June 1, 2026, through June 29, 2026, revealed the resident average blood oxygenation on room air or while receiving oxygen was 95%. A review of Resident 107's blood oxygen saturation (a measure of 95% to 100% is normal; a measure below 90% means the body's organs and tissues are not getting enough oxygen to work properly) revealed that on: June 30, 2026, at 4:39 AM, 87.0% with oxygen via nasal cannula. June 30, 2026, at 8:34 AM, 89.0% with oxygen via nasal cannula. June 30, 2026, at 10:02 AM, 89.0% with oxygen via nasal cannula. June 30, 2026, at 9:49 PM, 88.0% with oxygen via nasal cannula. July 1, 2026, at 12:06 AM, 88.0% with oxygen via nasal cannula. A clinical record review (continued on next page)		

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documented evidence the facility notified the physician of Resident 107's refusal to take another diuretic medication (furosemide 80 mg) on July 30, 2026, at 5:58 PM. There was no documented evidence the facility notified the physician of the resident's continued low blood oxygen saturation despite the increase of oxygen to 5.0 L/min on June 30, 2026, or July 1, 2026. A progress note dated July 1, 2026, at 5:30 AM documented Resident 107 was found unresponsive. Review of the clinical record revealed no documented evidence the physician had been notified after the resident continued to demonstrate oxygen saturation levels between 87% and 89% despite the increased oxygen order or after the resident refused the newly prescribed oral furosemide. During an interview on July 31, 2026, at 9:45 AM, the Nursing Home Administrator and Director of Nursing reviewed the above findings. The clinical record contained no documented evidence the facility notified the physician after Resident 107 refused the newly prescribed oral furosemide or after the resident continued to exhibit oxygen saturation levels of 87% to 89% despite implementation of the physician's revised oxygen order. The facility failed to promptly notify the physician of the resident's continued change in condition in accordance with facility policy. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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 07/31/2026
NAME OF PROVIDER OR SUPPLIER Gardens at Orangeville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Berwick Road Orangeville, PA 17859	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's Abuse Policy, documentation provided by the facility, observations, and staff and resident interviews, it was determined that the facility failed to conduct a thorough internal investigation after receiving an allegation of possible misappropriation of resident property for one of 23 residents reviewed (Resident 63). Findings include: A review of the facility policy titled Abuse Policy, last reviewed by the facility on May 1, 2026, revealed it is facility policy that the facility will have processes in place to include screening, training, prevention identification, protection, investigation, reporting and response to allegations of potential or actual abuse and neglect. The policy defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy required all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source, or a reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies as defined by current regulations and thoroughly investigated by the administrator and/or designee. Investigations should be timely and thorough and include investigations into all reports and allegations of abuse. If the investigation revealed findings of abuse, such findings will be reported to the state abuse registry. If the investigation revealed that the allegations of abuse are founded, the employees may have disciplinary action up to and including termination taken. The resident and/or representative may be notified of the outcome upon conclusion of the investigation. A clinical record review revealed Resident 63 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety (a mental condition that causes a feeling of worry, nervousness or unease), and intellectual disability (a lifelong condition marked by limits in functioning and adaptive behavior such as trouble with learning, reasoning, and solving problems. A review of Resident 63's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 4, 2026, revealed that Resident 63 was 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 through 15 indicates cognition is intact). A review of a nurse's progress note dated July 18, 2026, at 5:48 PM documented that Resident 63 approached the nurses' station carrying the electrical cord from the resident's personal refrigerator. The note documented that the cord had been cut in two places. The resident stated someone had entered the room and cut the cord, demanded that someone be held responsible, and stated the resident intended to contact law enforcement and a family member. The nurse documented that the resident's sister was notified and that the Nursing Home Administrator and Director of Nursing were informed. Maintenance was contacted to respond. A witness statement completed by Employee 6, Registered Nurse, dated July 18, 2026, documented that Resident 63 reported someone had cut the refrigerator cord and stated someone owed the resident a new refrigerator. A review of a nurse progress note from Employee 7, Licensed Practical Nurse, dated July 19, 2026, at 12:30 PM, documented that Resident 63 alleged a housekeeper cut the refrigerator cord. Employee 7 documented that housekeeping staff did not work during the time identified by the resident. The resident then became belligerent (angry and verbally aggressive) and yelled obscenities (offensive language). During an interview on July 28, 2026, at 11:30 AM Resident 63 stated someone had cut the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refrigerator cord but did not know who damaged it or how it occurred. Observation at the time of the interview revealed the resident's personal refrigerator remained in the room with the electrical cord cut completely at one location and partially cut at a second location. The refrigerator was not operational. During an interview on July 29, 2026, at 12:00 PM, the Nursing Home Administrator and Director of Nursing confirmed they did not know how the cord was cut, who cut it, why it was cut, or the location of the severed portion of the cord until surveyor inquiry prompted additional discussion. The Nursing Home Administrator then stated the Maintenance Director possessed the severed portion of the cord. During an interview on July 30, 2026, at 1:00 PM, Employee 10, Maintenance Director, stated Employee 6 contacted him on July 18, 2026, at approximately 5:21 PM to report that Resident 63's refrigerator cord had been cut and that electrical power had been lost to rooms [ROOM NUMBER]. The Maintenance Director stated he responded to the facility, restored electrical service by resetting the circuit breaker, spoke with Resident 63, and was told the resident had been moving the refrigerator when the cord became damaged. The Maintenance Director stated he later located the severed portion of the electrical cord concealed in the resident's room and removed it because it presented a safety hazard. During an interview on July 30, 2026, at 2:00 PM, the Nursing Home Administrator confirmed the facility could not provide documentation demonstrating that it completed a comprehensive investigation into the resident's allegation. The Nursing Home Administrator confirmed the facility did not provide documentation demonstrating that it: obtained a statement from Resident 63;obtained a statement from the Maintenance Director;identified and interviewed all relevant witnesses;documented review of staff assignments or other relevant investigative information;completed a written investigative summary; ordocumented investigative findings or a conclusion regarding the allegation. The facility produced nine employee witness statements; however, documentation demonstrating completion of the remaining investigative activities was not available. During a follow-up interview on July 31, 2026, at 2:00 PM, the Nursing Home Administrator again confirmed the facility could not provide documentation demonstrating that all relevant witnesses were interviewed or that the allegation was fully investigated in accordance with the facility's Abuse Policy. Cross Refer F740 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(2) Management.28 Pa. Code 211.10(a) Resident care policies.		