STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396079	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Spot Village	433 S Kinzer Avenue New Holland, PA 17557

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records review and staff interviews, it was determined the facility failed to implement an intervention to prevent a wound on the foot of a resident identified as high risk for skin impairment. The facility also failed to initiate a wound treatment, which resulted in actual harm of the wound worsening and getting infected for one of the two residents reviewed (Resident CL1).Findings include: Review of Resident CL1's demographic sheet revealed the resident was admitted to the facility on [DATE], post amputation of the right foot toe. The resident had diagnoses of Diabetes (group of metabolic disorders characterized by high blood sugar level over a prolonged period of time) and Peripheral Vascular Disease (PVD -circulatory condition that affects blood vessels outside the heart and brain, particularly in the legs and arms).Review of Resident CL1's care plan revealed interventions were developed on September 15, 2025, indicating resident was at risk for skin issues due to decreased mobility, edema (swelling), and circulatory issues.Review of Resident CL1's admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents), dated September 21, 2025, revealed the resident's cognition was intact. The same MDS assessment revealed resident was independent while rolling in bed, left to right.Review of Resident CL1's nursing progress notes revealed an entry dated September 27, 2025, at 11:07 p.m., indicating a small amount of blood was noted by Resident CL1's daughter on the resident's left foot sock after assisting the resident to bed and removing the shoes. A small skin tear was noted on (the resident's) left foot pinky toe. Area measured 1.0 x 0.5 cm (centimeters). The area was cleansed with NSS (sterile salt water) and covered with a band aid. Fax placed in CRNP (Certified Registered Nurse Practitioner) binder to note. TX (treatment) placed in TAR (Treatment Administration Record).Review of the nursing progress, weekly skin check note dated September 28, 2025, at 10:18 p.m., revealed treatment to the left foot. The same note revealed New interventions: Heel Boots.Review of Resident CL1's clinical records failed to reveal the new intervention, heel boots, was added to the resident's care plan. Further review of the clinical records failed to reveal the new intervention, heel boots, was implemented by the facility until October 4, 2025, as evidenced by a Weekly Skin Check Note dated October 4, 2025, at 9:26 p.m. indicating New Intervention: Heel Boots.Additional review of Resident CL1's progress notes revealed a Health Status note dated October 6, 2025, at 9:35 p.m., indicating LPN (Licensed Practical Nurse) called RN (Registered Nurse) to room to report a new opened area on resident's lateral (side) left foot. Area with opened area measuring 4.2x1.8x0.1cm with 25% granulation (new tissue), 25% epithelial (skin), and 50% thin layer of yellow slough (dead) tissue. Edges are intact with some peeling skin along edges. Periwound (tissue surrounding the wound) skin intact, edematous (swollen), and with ecchymosis (bruising) along dorsal (upper) edge. Resident reporting that area is due to abrasion (superficial injury caused by rubbing or scraping) from when lying in bed. Resident with air mattress with hanger over footboard of bed and reporting hitting it.Review of Resident CL1's October MAR revealed the left lateral foot was not treated from October 6, 2025, till October 8, 2025. The wound was treated with Medihoney (dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) on October 8, 2025, two days after it was initially identified on October 6, 2025.Further review of the Progress Notes revealed a Secure Conversation dated October 9, 2025, at 2:26 p.m., indicating the resident with worsening abrasion on the left lateral foot with increasing redness and warmth to the dorsal foot. The wound base is now with 50% yellow/tan slough tissue with hypergranulation (excessive growth of red granulation tissue that sits above the wound's skin level, usually caused by excessive moisture, infection, or irritation) on the dorsal edge of the wound. The resident reports less tenderness to the area, but the area appears more inflamed (reddened, warm, and swollen), and drainage has also increased to moderate to heavy serous (clear). The wound treatment was changed to Silver Alginate (dressing used for moderate to heavy exuding wounds to help control infection and promote a wound environment for healing).Review of the Nurse Practitioner (NP) notes revealed an entry dated October 10, 2025, indicating the resident had an abrasion on the left foot that occurred when the foot rubbed on the footboard of the bed, as stated by the resident. Staff noted that the area was extremely erythematous (abnormal redness of the skin due to accumulation of blood in the area) yesterday, with concerns over possible infection. Today, the erythema of the foot has improved, but still very tender to touch. The resident was diagnosed with left foot cellulitis (skin infection that causes a red, painful, and swollen area of skin, which is commonly caused by Staphylococcus bacteria that enter the body through a cut or break in the