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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395708 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 05/01/2025 |
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| NAME OF PROVIDER OR SUPPLIER: GARDENS FOR MEMORY CARE AT EASTON, THE | STREET ADDRESS, CITY, STATE, ZIP CODE: 500 WASHINGTON STREET EASTON, PA 18042 |
| STATE LICENSE NUMBER: 163802 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE) | (X5) COMPLETE DATE |
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| F 0000 | INITIAL COMMENT | F 0000 | | |
| F 0584 SS=E | Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and an Abbreviated survey in response to a complaint, completed May 1, 2025, it was determined that The Gardens for Memory Care at Easton, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey. | F 0584 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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| F 0584 SS=E | Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all | F 0584 | 1. The facility has repaired the loose and wobbly assist bars in rooms 204, 307, and 309. The towel racks in room 307 were secured, and the scuffed and damaged table in the dining room across from room 215 was replaced. The dried orange substance in room 309, the brown stain in room 311, and the brown substance on the floor in room 313 were cleaned. Heater damages in rooms 311 and 313 were repaired. The soiled window curtain in room 312 and the privacy curtain in room 314 were removed and replaced with clean curtains. Additionally, the fall mat and bed pedal in room 312 were thoroughly cleaned and sanitized. The cracked tile and peeling wallpaper in the dining room were repaired, and the affected area was repainted. Peeling paint by the heater in rm 313 will be repaired. 2. An environmental audit of all resident rooms and common areas was conducted to identify any similar environmental concerns. Any issues identified were immediately | Completion Date: 06/03/2025 Status: APPROVED Date: 05/22/2025 |

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| F 0584 SS=E | Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: | F 0584 | addressed. 3. All Maintenance Department staff will be reeducated on Weekly Environmental Safety Rounds. All Housekeeping staff will be reeducated on daily cleaning protocols. 4. Environmental audits will be completed weekly. Findings from audits will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings, and QAPI will determine further action planning and discontinuation. | |
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| F 0584 SS=E | Continued from page 3 Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of two nursing units. (Second floor and Third floor) Findings include: Observations on April 29, 2025, from 9:30 a.m. through 12:50 p.m., and on April 30, 2025, from 8:54 a.m. through 11:58 a.m., revealed the following environmental issues: The assist bars on the toilet in room 204 were loose and wobbly. The table in the dining room across from room 215 was scuffed and damaged. The assist bars on the toilet in room 307 were loose and wobbly. The towel racks were loose. The assist bars on the toilet in room 309 were loose and wobbly. There was a dried orange substance | F 0584 | | |

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| F 0584 SS=E | Continued from page 4 on the floor in front of the closets for beds three and four. The bathroom doorway in room 311 was soiled with a dried brown stain. The heater was damaged. The window curtain in room 312 was soiled. For bed two, the fall mat had dust and several dried, gray spots on it and the pedal to control bed height was covered with a layer of dust. The floor in room 313 was soiled with a brown substance. The heater was damaged and there was peeling paint by the heater. There was a cracked tile and peeling wallpaper near the window in the dining room. The privacy curtain in room 314 (bed one) was soiled with brown stains. 28 Pa. Code 201.14(a) Responsibility of licensee. | F 0584 | | |

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| F 0584 SS=E | Continued from page 5 28 Pa. Code 201.18(b)(1) Management. | F 0584 | | | |

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| P 3450 | <p>Kitchen.</p> <p>(b) A service pantry shall be provided for each nursing unit. The pantry shall contain a refrigerator, device for heating food, sink, counter and cabinets. For existing facilities, a service pantry shall be provided for a nursing unit unless the kitchen is sufficiently close for practical needs and has been approved by the Department.</p> <p>This REGULATION is not met as evidenced by:</p> | P 3450 | <ol style="list-style-type: none"> 1. Microwave ovens for heating food have been installed in both nursing unit pantries. 2. All residents residing were reviewed to ensure that the lack of heating devices in the pantries did not negatively impact their nutritional services or access to hot meals. No adverse outcomes were identified. 3. All Licensed nursing staff will be re-educated on the purpose of the pantry appliances and the proper use of the machines. 4. Audits to confirm that both pantries have microwave ovens for use will be completed weekly. Findings from audits will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings, and QAPI will determine further action planning and discontinuation. | <p>Completion Date: 06/03/2025</p> <p>Status: APPROVED</p> <p>Date: 05/16/2025</p> |
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| P 3450 | Continued from page 1 Based on observation and staff interview, it was determined that the facility failed to provide a device for heating food on two of two nursing units. (Second floor and Third floor) Findings include: Observations on April 29, 2025, from 9:30 a.m. through 12:50 p.m., and on April 30, 2025, from 8:54 a.m. through 11:58 a.m., revealed that there were no devices on either unit's pantry to reheat food. In an interview on April 29, 2025, at 10:00 a.m., Registered Nurse (RN) 1 stated that the facility removed all microwave ovens from the nursing unit pantries because resident families were asking staff to reheat food too frequently. | P 3450 | | |
| P 5520 | | P 5520 | | |

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| P 5520 | Continued from page 2 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by: | P 5520 | <ol style="list-style-type: none"> The facility has reviewed and adjusted staffing schedules to ensure compliance with minimum NA-to-resident ratios for all shifts. A comprehensive review of the resident census and care needs was conducted to verify that current NA staffing levels meet or exceed regulatory requirements. A proactive system was developed to forecast NA staffing needs based on anticipated resident census and staff availability trends. All nursing administrative staff will receive training on regulatory NA staffing requirements and the importance of timely shift coverage. Daily audits of NA to resident ratios will be conducted weekly. Findings from audits will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings, and QAPI will determine further action planning and discontinuation. | Completion Date: 06/03/2025 Status: APPROVED Date: 05/16/2025 |
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| P 5520 | Continued from page 3 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for 13 of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from January 1 through 7, 2025, March 9 through 16, 2025, and April 24 through 30, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on January 1 and 3, 2025, March 9, 10, and 15, 2025, and April 25, 26, 27, and 29, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on March 14, 2025, and April 24 and 27, 2025. | P 5520 | | |

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| P 5520 | Continued from page 4 The facility failed to meet the minimum NA to resident ratio of one NA for 15 residents on night shift (11:00 p.m. to 7:00 a.m.) on January 2 and 4, 2025, March 14, 2025, and April 27 and 28, 2025. During an interview on April 30, 2025, at 9:45 a.m., the Administrator confirmed that the facility did not meet the required NA to resident ratios on the days identified. | P 5520 | | |
| P 5640 | | P 5640 | | |

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| P 5640 | Continued from page 5 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by: | P 5640 | <p>1. The facility has reviewed and adjusted staffing schedules to ensure compliance with a minimum of 3.2 hours of direct care for each resident daily.</p> <p>2. A comprehensive review of the resident census and care needs was conducted to verify that current nursing staffing levels meet or exceed regulatory requirements. A proactive system was developed to forecast Nursing staffing needs based on anticipated resident census and staff availability trends.</p> <p>3. All nursing administrative staff received training on regulatory minimum 3.2 hours of direct care for each resident daily.</p> <p>4. Daily audits of a minimum of 3.2 hours of direct care for each resident daily will be conducted weekly. Findings from audits will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings, and QAPI will determine further action</p> | Completion Date: 06/03/2025 Status: APPROVED Date: 05/16/2025 |

Pennsylvania Department of Health

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| P 5640 | Continued from page 6 | P 5640 | planning and discontinuation. | | |
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| P 5640 | Continued from page 7 Based on a review of nursing time schedules, it was determined that the facility failed to provide a minimum of 3.2 hours of direct care for each resident for four of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from January 1 through 7, 2025, March 9 through 16, 2025, and April 24 through 30, 2025, revealed the following total nursing care hours below minimum requirements: Saturday, March 15, 2025: 3.11 care hours per resident. Friday, April 25, 2025: 3.05 care hours per resident. Saturday, April 26, 2025: 3.10 care hours per resident. Sunday, April 27, 2025: 2.86 care hours per resident. During an interview on April 30, 2025, at 9:45 a.m., | P 5640 | | |

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| P 5640 | Continued from page 8 the Administrator confirmed the facility did not meet the minimum required nursing care hours on the days identified. | P 5640 | | | |

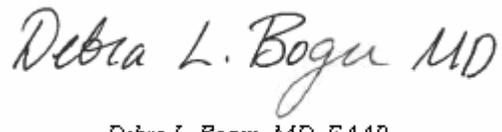


Certified End Page

GARDENS FOR MEMORY CARE AT EASTON, THE
STATE LICENSE NUMBER: 163802
SURVEY EXIT DATE: 05/01/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY