STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395899	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENS AT ORANGEVILLE, THE	**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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews it was determined that the facility failed to provide a dignified dining experience for one of three residents (Resident 54). Findings included: A review of Resident 54's clinical record revealed a quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) dated November 23, 2019, indicating that the resident was cognitively intact, required extensive assistance from staff for daily care tasks, including eating and had medical [DIAGNOSES REDACTED]. Observation of the lunch dining service on March 5, 2020, beginning at 12:00 p.m., on the East Wing of the facility at approximately 12:05 p.m. revealed that the cart carrying lunch trays was delivered for rooms 201 through 213. Staff began distributing the meal trays at approximately 12:10 p.m. At approximately 12:15 p.m. a staff member removed a lunch tray from the cart and delivered the meal tray to Resident 54's room (room [ROOM NUMBER]) located on the adjacent hallway and placed the tray on the resident's overbed table. Staff completed delivery of the lunch trays for rooms 214 through 219 at approximately 12:30 p.m. At that time Resident 54's lunch tray was observed to remain in his room on an over the bed table located across the room from the resident's bed, but in full view of resident. At approximately 12:40 p.m., staff was observed entering room the resident's room to assist resident 54 with his lunch. By this time, the resident's meal tray had been on the over the bed table for 25 minutes. A new meal tray was requested for Resident 54. During an interview on March 5, 2020, at 2:00 p.m.,the Corporate Certified Dietary Manager confirmed that Resident 54 was not provided a dignified dining experience. Refer F804 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.
F 0565 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on review of select facility policy and minutes from Resident Council meetings and resident and staff interviews it was determined that the facility failed to put forth sufficient efforts to promptly resolve continued resident complaints/grievances expressed during Resident Council Meetings including those voiced by five of five residents attending a group meeting (Residents 86, 35, 89, 7, and 70). Findings include: Review of the facility's Grievance policy indicated that it is the facility's policy to provide an opportunity for residents to express concerns at any time. The facility's goal is to resolve resident and family concerns in a timely basis. Review of the minutes from the August 30, 2019, through December 27, 2019, Resident Council meetings revealed that residents in attendance at these resident group meetings voiced their concerns regarding resident care and facility services during the meetings. Resident Council meetings were not held in January 2020 or February of 2020 due to illness in the facility. During the September 27, 2019, Resident Council meeting the residents relayed concerns regarding timeliness of staff response to their requests for assistance via the nurse call bell system. During a group meeting held on March 4, 2020 at 11:00 a.m., with five (5) alert and oriented residents, all residents in attendance complained that the facility does not consistently offer evening snacks. The residents also stated that untimeliness of staff response to their call bells and meeting their needs for assistance in a timely manner remains a problem for them. The residents also stated that they have multiple concerns with food in the facility. All residents in attendance stated that food is cold for every meal, every day. The residents in attendance at this meeting all eat their meals in their rooms. The residents stated that their vegetables are either too mushy or too hard, the hamburgers are always overcooked, bread is often stale, their food preferences are not always honored as evidenced by receiving items they don't like on their trays and the food in general is not palatable. The residents stated that they do not know what they are eating because they are not provided menus nor do their meal tickets identify what is being served. The residents stated that they have repeatedly brought these particular complaints to the facility's attention without resolution to date. A review of facility grievances from September 2019 through February 2020, revealed multiple grievances related to the facility's dietary services, including one in September 2019, two in October 2019, two in November 2019, one in December 2019 and four in January 2020. Grievances related to food and beverage preferences not being honored, trays not being checked and food palatability. A review of Food Committee meeting minutes from September 2019 through December 2019 revealed concerns regarding temperatures of food and palatability, food variety and food preferences. Food Committee Meetings were not held in January 2020 or February of 2020 due to illness in the facility. During the September 2019, food committee meeting residents had concerns with variety of food items on menu, temperature of food, specifically that food is cold and food preferences. During the October 25, 2019, food committee meeting residents expressed concerns with the temperature of food, specifically complaining that food is cold. During the November 29, 2019 food committee meeting residents had concerns with certain food temperatures and stated that bread is stale The facility was unable to provide documented evidence that the facility had determined if the residents' felt that their complaints/grievances had been resolved through any efforts taken by the facility in response to the residents' expressed concerns regarding untimely staff response to call bells and delays in meeting residents' needs for assistance, concerns with the food and nutrition services department and consistent offering of evening snacks. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 5, 2020, at 2:00 p.m. the NHA and DON were unable to provide documented evidence that the facility had followed-up with the residents to ascertain the effectiveness of the facility's efforts in resolving their complaints regarding facility services. 28 Pa. Code 201.18(e)(1)(3)(4) Management 28 Pa. Code 201.29(i)(j) Resident Rights
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff and resident interview it was determined that the facility failed to provide housekeeping services to maintain a clean and orderly resident environment, clean resident care equipment on one of two nursing units and clean bed and bath linens in good condition for at least three residents (Residents 73, 59 and 14) Findings include: An observation conducted on March 5, 2020, at 12 PM in resident room [ROOM NUMBER], revealed large clusters of dust, dirt, debris, paper, tissues and a plastic exam glove on the floor behind the recliner chair and under the resident's bed. A foul odor was detected in the room as well as the bathroom. Resident 73, present in the room at that time, confirmed these

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

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.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) observations An observation in resident room [ROOM NUMBER] on March 5, 2020, at 12:15 pm, revealed a used exam glove on the floor next to the garbage can at the entrance of the room. In resident room [ROOM NUMBER]D, dirt, paper and food debris were observed on the floor underneath the resident's bedside table. Dried liquid stains were also observed on the floor. An observation of the outside entrance on the east side of the building, March 4, 2020, at 9 AM and 2 PM there were multiple burnt cigarette butts on the ground in the grassy areas and also on the sidewalk area. On March 5, 2020, at 9 AM on the west side front entrance to the building, there were multiple cigarette butts, a plastic glove on the ground and a used face mask in the slats of the bench outside the facility door. On March 5, 2020, at 11:55 a.m. Resident 59 stated that her privacy curtain has had a spilled coffee stain on it for at least 2 months. The resident stated that an aide spilled the coffee months ago, but no one changed or washed the curtain. The resident was concerned it could be an infection control problem. A large brown stain was observed on bottom left side of the resident's privacy curtain. Observation on March 5, 2020, at 11:15 a.m. revealed multiple dried stains, which appeared to be dried food and liquids, were observed on Resident 14's over the bed table. The resident's personal items were observed placed on top of the soiled table. Observation on March 6, 2020, at 12:22 p.m. revealed that the resident's over bed table remained soiled and his personal items remained on top of the soiled table. A tour of the West nursing unit clean linen room March 6, 2020 at approximately 11:30 AM revealed multiple bath towels, hand towels and wash cloths that were ripped and appeared threadbare. There were multiple sheets and pillow cases observed to be stained. These observations were confirmed at the time of the observations by the Director of Nursing. Pa. Code 207.2 (a) Administrator's responsibility
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 clinical record review and staff interview, it was determined that the facility failed to consistently provide services prescribed to maintain the range of motion for one of seven sampled residents (Resident 44). Findings include: A review of Resident 44's clinical record revealed that the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident was admitted to hospice services on December 11, 2018. Further review of Resident 44's clinical record revealed that the resident had a physician order [REDACTED]. Review of tracking of the resident's RNP program from December 1, 2019 to February 29, 2020, revealed that Employee 1 (nurse aide) noted that the resident refused the services 18 times during the month of December 2019, 16 times during the month of January 2020, and 17 times during the month of February 2020, with all refusal occurring during the 7 AM to 3 PM shift. With the exception of Employee 1, all other nursing staff on the 7 AM to 3 PM shift, 3 PM to 11 PM shift and 11 PM to 7 AM shift documented the provision of the resident's RNP program as ordered by the physician. Interview with Employee 1 on March 6, 2020 at 11:50 a.m. revealed that the employee stated that when she went to perform the PROM with Resident 44, the resident would moan and had a facial expression of pain. Employee 1 stated, however, that she never informed her charge nurse that she was unable to complete the program because the resident displayed signs of pain and was not tolerating the prescribed program. Employee 1 solely documented that the resident refused the program. There was no indication that therapy was consulted for potential adjustments to the resident's program as needed. During Interview with the Administrator on March 5, 2020 at 11:30 a.m. she confirmed that Employee 1 did not complete the RNP program as ordered because of the resident's response, but confirmed that Employee 1 failed to inform supervisory staff that the resident appeared to display signs of discomfort and was not tolerating the program. 28 Pa. Code: 211.5(f)(g) Clinical records 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview, it was determined that the facility failed to timely identify and address a significant weight loss for one resident of five residents sampled (Resident 99). Findings include: A review of the clinical record revealed that Resident 99 has [DIAGNOSES REDACTED]. A review of the resident's weight record revealed that on November 19, 2019, a 16 lb or 10.52 % significant weight loss in the last four months was reflected. (July 2, 2019, the resident's was noted as 152 lbs; on November 19, 2019, the resident's weight was noted as 136 lbs). There was no documented evidence that the facility had identified and addressed this resident's significant weight loss noted on November 19, 2019, at the time of its occurrence and had developed and implement measures to deter further weight loss and promote adequate nutritional parameters. The next weight change note was dated December 27, 2019 at 1:34 p.m. which indicated that Resident 99's weight, on December 24, 2019, triggered for a significant weight loss of 16 pound or 10.52% in 180 days. It was noted that the resident receives nutritious shakes at all meals, which the resident usually consumes 75-100%. and a soft cookie at 10:00 a.m. 2:00 p.m. and 8:00 p.m. for a snack. At this time 120 milliters NSA Ready Care 1.7 Med Pass three times daily to prevent further weight loss was recommended. Interview with the Dietitian on March 6, 2020 at 11:30 a.m. confirmed that the resident's significant weight loss was first recorded on November 19, 2019, but was not addressed by the facility until December 27, 2019. 28 Pa Code 211.6(c)(d) Dietary services. 28 Pa Code 211.10 (a)(c)(d) Resident care policies. 28 Pa Code 211.12 (a)(c)(d)(3)(5)Nursing services.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and facility provided documentation, observation and staff interview it was determined that the facility failed to develop and implement effective person-centered plans to address dementia-related behavioral symptoms displayed by one resident out of 22 sampled (Resident 4). Findings included: A review of the clinical record revealed that Resident 4 was admitted on [DATE] and currently has [DIAGNOSES REDACTED]. An annual Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 9, 2020, indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of ,[DATE] equates to being severely cognitively impaired) score of 4 and required staff assistance for bed mobility, transfers, dressing and personal hygiene. A review of Resident 4's clinical record revealed that on [DATE], at 1:55 P.M. Resident 4 was agitated when a peer was yelling out. Resident 4 yelled shut up and argued with residents seated near nurses station awaiting a scheduled smoke time. Redirection caused Resident 4 to become more irritable. A review of Resident 4's clinical record revealed that on [DATE] at 8:24 P.M. Resident 4 was yelling at other residents. Staff quickly provided redirection, which was effective. Continued review of Resident 4's clinical record revealed that on [DATE] at 1:45 PM Resident 4 noted with severe behaviors. The resident was screaming in the hallway, kicking at the bedroom door and was pulling on a peer's chair. Staff provided redirection and calming techniques. Review of Resident 4's clinical record revealed on [DATE], at 5:42 PM Resident 4 was at the nurse's station when a peer touched his wheelchair with his foot. Resident 4 became angry and pulled his fist up and started to yell the peer. Staff intervened to prevent an altercation. Clinical record documentation noted on [DATE], at 12:32 PM that Resident 4 was screaming and threatening his roommate. Social Services was made aware and Resident 4 was seen by psychiatry this day. On [DATE] at 2:23 PM, according to the clinical record, Resident 4 had several outbursts with peers and was swearing at other residents in the hallway. Redirection away from peers and snack provided with positive effect. On [DATE] at 2:14 P.M. Resident 4's clinical record indicated that he had several outbursts towards peers. A review of facility provided incident report dated February 21, 2020 at approximately 4:35 PM, revealed that Resident 4 was observed wheeling himself behind a male peer, Resident 14. Resident 4 punched the back of Resident 14's head with a closed fist. Both residents were separated and assessed to have no injuries. Resident 4 was transferred to local emergency room for a psychiatric evaluation and returned with no new orders. A review of Resident 4's clinical record revealed on February 25, 2020 at 1:15 P.M. Resident 4 was in the hallway screaming and when approached by staff Resident 4 mimicked pulling a knife out of his waist band, swung it from left to right. Resident was transferred to local emergency room for a psychiatric evaluation and was admitted . A review of Resident 4's clinical record revealed on [DATE] at 2:30 P.M. Resident 4 returned to the facility. On [DATE], at approximately 10:40 AM Resident 4 was observed seated calmly in a wheelchair, but declined interview. Review of the Resident 4's current care plan last revised by the facility February 25, 2020, indicated that Resident 4 has a

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) chronic/progressive decline in cognitive functioning related to dementia and has history of problematic behaviors including obsessing over with peers, belief that previous deceased roommate threatening him, belief that he is not allowed in activities room, belief that he owns the facility and threatening harm to unknown persons. However, further review of the resident's care plan revealed no documented that the facility had included the resident's specific preferences, past habits, personal history and/or daily routines that may be incorporated into meaningful and/or diversional activities for the resident to address the resident's dementia-related behavioral symptoms. There was no indication that the facility had developed and implemented individualized, non-pharmacological interventions to address the resident's unsafe dementia related behaviors to promote the quality of life of residents residing in the facility and Resident 4's highest practical level of psychosocial well-being and safety. Interview with the Nursing Home Administrator (NHA) on [DATE], at approximately 10:20 AM confirmed the facility failed to develop and implement effective individualized person-center interventions to deter Resident 4's behaviors. 28 Pa. Code 211.16(a) Social Services 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa Code 211.11(d) Resident care plan
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined that pharmacist failed to identify drug irregularities in the medication regimen of one resident out of 22 sampled (Resident 94). Findings include: A review of the clinical record revealed that Resident 94 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. The resident had physician's orders [REDACTED]. This medication was increased on June 27, 2019, to 50 mg one time a day; increased on December 14, 2019 to 75 mg one time a day and again on January 10, 2020, [MEDICATION NAME] was increased to 100 mg one time a day. A review of the monthly Medication Regimen Reviews conducted by the pharmacist from March 2019 through February 2020, revealed no indication that the pharmacist identified the absence of an attempt at a gradual dose reduction of the [MEDICATION NAME] during the last year. Interview with the Director of Nursing on March 6, 2020, at approximately 12:25 p.m. confirmed that there was no evidence that the pharmacist had identified the lack of a gradual dose reduction attempt in the last year. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview it was determined that the facility failed to provide timely laboratory services to one resident out of 22 sampled (Resident 77). Findings included: Review of the clinical record revealed that Resident 77 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of physician orders [REDACTED]. A review of a laboratory report dated December 4, 2019 at 11:35 am revealed that Resident 77's [MEDICATION NAME] level was noted to be less that 1 ug/dl. There was no documented evidence that a [MEDICATION NAME] level was obtained every three months as ordered. During an interview March 6, 2020 at approximately 9 AM the Director of Nursing confirmed that the [MEDICATION NAME] acid level was completed, in error for Resident 77, instead of the [MEDICATION NAME] level. 28 Pa. Code 201.21(b) Use of Outside Resources 28 Pa. Code 211.12 (d)(3)(5) Nursing services
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on a review of the facility's planned cycle menu and recipes, observation and staff and resident interviews it was determined that the facility failed to follow the planned menu. Findings include: A review of the facility planned cycle menu four week cycle revealed that the planned entree for March 4, 2020, was meatballs with sauce. The entree planned for a mechanical soft texture was ground meatballs. The planned hot alternative for this meal was ground turkey and mashed potatoes and gravy. The facility also has a list of always available alternates of grilled cheese sandwich, deli sandwich, egg salad sandwich, cottage cheese and fruit plate, hamburger on a bun and a hot dog for lunch and dinner. An observation of lunch meal service March 4, 2020, at 11:30 AM on the 100 hall, the west short hall and the 200 hall revealed that the trays were plated and sent to the resident unit. During the plating of these meals, the meatballs had fallen apart and now were of a ground consistency. As a result, Employee 5 (cook) changed serving scoops several times during the service, but the portion sizes served were inconsistent. It could not be determined if the residents were receiving the portion size planned for this entree. At approximately 12:10 PM the dietary staff began plating the meals for the residents residing on the west long hallway. The facility ran out of the regular consistency meatball entree prepared. Employee 5 (cook) utilized the ground consistency meatballs for the regular diets until this entree was also depleted. The ground turkey and mashed potatoes were then served as the main entree for until both the turkey and mashed potatoes were depleted. Employee 5 (cook) began to make additional mashed potatoes in the same container. The CDM intervened and made additional mashed potatoes away from the serving area. At approximately 12:15 PM dietary staff began to serve the residents on the east short hallway trays. At the time six (6) residents remained to be served, the facility ran out of the planned entrees. The facility also ran out of mashed potatoes. The CDM (certified dietary manager) then went to the freezer, removed approximately 8 hamburgers, thawed, cooked and ground the meat. The ground hamburgers were then plated and covered with tomato sauce, which resulted in only a small portion of ground entree served. Interview with the CDM confirmed that this ground hamburger was not a full portion of the entree planned for the remaining residents to be served. The CDM further confirmed that she did not know why there was not enough of the meatball entree or the mashed potatoes, prepared in advance of the lunch meal. The CDM stated that the cook on duty for the meal, would decide if there was going to be a hot alternative for that particular meal. She confirmed that the facility does not plan an alternative entree at meals except the always available to order items. A review of the facility recipe for meatballs indicated that a portion size was 2 meatballs for each meal. As per the CDM, on that day, the cook needed to prepare 67 regular consistency meals, 29 ground consistency meals and 13 puree consistency meals, for a total of 109 servings. The CDM indicated that the recipe was followed for 110 servings. The recipe indicated to mix all ingredients on low speed until blended. Shape into balls using a #16 scoop. Place in pans close together in a single layer. Bake in oven at 325 F for 45 minutes, until brown and firm. The meatballs were observed to fall apart during the lunch meal service. During an observation in the kitchen on March 4, 2020, at approximately 2:10 PM two large pans of kielbasa (sausage rings) were observed. The CDM stated that the afternoon cook had taken 20 pounds of the kielbasa rings out of the freezer and placed them in the steamer to thaw for the dinner meal that day. The CDM then stated that in approximately 30 minutes, the afternoon cook would remove the meat from the steamer, cut it into portion sizes, place it on trays and place it in the oven to cook. The facility would then hold the sausage rings until the dinner meal service starting at 5:20 PM. The CDM took the temperature of the kielbasa (while in the steamer) at this time. The temperature was 135 Farenheit, 3 hours and 10 minutes prior to meal service. A review of a facility recipe for Kielbasa revealed that a serving portion size was 1 1/2 each. As per the CDM on that day, the cook needed to prepare 33 regular consistency meals, 29 ground consistency meals and 13 puree consistency meals, for a total of 75 servings. Pork chops were planned on the menu for residents with dietary issues preventing them from eating the sausage. The recipe indicated that for 75 servings of the kielbasa, use 26 pounds 8 ounces of the product (the facility prepared only 20 pounds). Cooking instructions included to lay the sausage links in a single layer on the baking sheet. Bake in the oven at 325 degrees F for 25-30 minutes, or until done. Cook to a minimum internal temperature of 155 degrees F for 15 seconds. The amount of Kielbasa and the method, including cooking time was not consistent with the written facility recipe. There was no evidence at the time of the survey that the method of cooking, including the total cooking time was consistent with optimal nutritive value or consistent palatability of the food served to the residents. 28 Pa. Code 211.6 (a)(b) Dietary services
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on review of test tray results and Food Committee meeting minutes and resident and staff interviews, it was determined that the facility failed to serve foods at palatable temperatures as discerned by at least three of 21 residents sampled (Residents 54, 38 and 59). Findings include: According to federal regulatory guidance at 483.60(i)-(2) Food safety requirements - the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. A review of Food Committee meeting minutes from September 2019 through December 2019 revealed residents attending these meetings voices concerns regarding temperatures of food and palatability, food variety and honoring food preferences. Food committee meetings were not held in the facility in January 2020 or February of 2020 due to illness in the facility. During the September 2019 food committee meeting residents voiced concerns with the variety of food items on menu, the temperature of food, specifically expressing that food is cold and food preferences are not honored. During the October 25, 2019, food committee meeting residents relayed concerns with temperature of food, specifically complaining that food is cold. During the November 29, 2019, food committee meeting residents expressed concerns with certain food temperatures and stated that the bread is stale. During a group meeting held on March 4, 2020 at 11:00 a.m., with five (5) alert and oriented residents, all residents in attendance stated that they continued to have many concerns with food served in the facility. All residents in attendance stated that food is cold for every meal, every day (the residents in attendance all eat their meals in their rooms). The residents stated that the vegetables are either too mushy or too hard, the hamburgers are always overcooked, bread is often stale, their preferences not always honored as evidenced by receiving items they don't like on their trays and the food in general is not palatable. The residents stated that they do not know what they are eating because they do not get menus and its not marked on their meal tickets. Observation of the lunch meal on March 5, 2020, on the East Wing nursing unit revealed the following: Resident 54's lunch tray was brought to his room at approximately 12:15 p.m., Resident 54 requires extensive assistance with eating. At approximately 12:40 p.m., staff entered the resident's room to assist with feeding. At this time resident's lunch tray was taken to be tested for temperature and palatability. Puree meat - 108.9 degrees Fahrenheit (cool to taste) Puree carrots - 125.6 degrees Fahrenheit (lukewarm to taste) Mashed potatoes and gravy - 126.2 degrees Fahrenheit (lukewarm to taste) Puree bread- 48 degrees Fahrenheit (cool to taste) Puree apple dessert- 48 degrees Fahrenheit (cool to taste) Apple juice - 52.5 degrees Fahrenheit (lukewarm to taste) Interview with the certified dietary manager (CDM) on March 5, 2019, at approximately 12:50 p.m., confirmed these unpalatable food temperatures. An inteview with Resident 38 on March 2, 2020 at 11:50 a.m the resident stated that the vegetables can be very mushy at times, especially broccoli and brussel sprouts. She also stated that when carrots and potatoes are in stew they are very hard. She states that she eats what she is served because the alternate is mostly hamburgers. An interview and observation of the lunch meal on March 5, 2020 at 12:30 p.m. with Resident 59 revealed the resident seated in the dining room with her lunch meal completely untouched in front of her. When asked why she was not eating she stated while lifting the cover off the meal the resident stated Would you eat this? On her plate was a brown colored meat patty covered in a brown sauce. The planned meal was herb chicken, but the resident stated that she does not eat poultry. She stated she was not able to select an alternate meal. A review of the facility menu did not include an alternate selection for the lunch meal other than a choice of an item on the always available items which include a variety of cold sandwiches, salad, and hamburger or hot dog. On March 4, 2020 at approximately 12:50 PM a lunch meal tray was tested for palatability. The tray included ground turkey (the alternative entree for lunch) with gravy, mashed potatoes and gravy and mixed vegetables. All of the food items were lukewarm and not palatable. The turkey and gravy was very salty and the vegetables were a mushy consistency. During an observation in the kitchen on March 4, 2020, at approximately 2:10 PM two large pans of kielbasa (sausage rings) were observed. The CDM stated that the afternoon cook had taken 20 pounds of the kielbasa rings out of the freezer and placed them in the steamer to thaw for the dinner meal that day. The CDM then stated that in approximately 30 minutes, the afternoon cook would remove the meat from the steamer, cut it into portion sizes, place it on trays and place it in the oven to cook. The facility would then hold the sausage rings until the dinner meal service starting at 5:20 PM. The CDM took the temperature of the kielbasa (while in the steamer) at this time. The temperature was 135 Farenheit, 3 hours and 10 minutes prior to meal service. A review of a facility recipe for Kielbasa revealed that a serving portion size was 1 1/2 each. As per the CDM on that day, the cook needed to prepare 33 regular consistency meals, 29 ground consistency meals and 13 puree consistency meals, for a total of 75 servings. The recipe indicated cooking instructions included to lay the sausage links in a single layer on the baking sheet. Bake in the oven at 325 degrees F for 25-30 minutes, or until done. Cook to a minimum internal temperature of 155 degrees F for 15 seconds. The method of cooking as well as the cooking time was not consistent with the written facility recipe. There was no evidence at the time of the survey that the method of cooking, including the total cooking time was consistent with optimal nutritive value or consistent palatability of the food served to the residents. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.6(c) Dietary services.
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** Based on a review of select facility policy, resident and staff interviews, it was determined that the facility failed to routinely offer evening snacks to at least 5 out of 5 sampled residents (Residents 86, 35, 89, 7, and 70). Findings include: A review of the facility's policy entitled Snack Policy(no revision date noted), indicated that the facility will make snacks available in accordance to residents' preferences and plan of care. During a group interview with five alert and oriented residents on March 4, 2020, at 11:00 a.m, five of five residents (Residents 86, 35, 89, 7, and 70) in attendance stated that they are not offered snacks during the evening hours before bed as desired. A review of resident 86's care plan revealed that the resident was to receive snacks at 10:00 a.m, 2:00 p.m., and 8:00 p.m The resident stated that she does not receive snacks at those times as planned. She stated that for a time she was receiving snacks at times indicated, but that presently it has fallen to the wayside. During an interview with the Nursing Home Adminstrator (NHA) on March 5, 2020 at 2:00 p.m., the NHA was was unable to explain why the residents are not consistently offered a snack at bedtime and as desired. 28 Pa. Code: 211.6 (b)(c) Dietary services 28 Pa. Code 211.2(a) Nursing Services 28 Pa. Code 201.29(i) Resident rights 28 Pa. Code 211.10 (c) Resident care policies
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations during a tour of the dietary department and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for microbial growth in food, which increased the risk of food-borne illness. 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). During the initial tour of the dietary department on March 3, 2020, at approximately, 9:30 a.m., with the Dietary Manager, the following sanitation issues, with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: The food preparation room floor was dirty with food and paper debris. There were multiple plastic bowls, that the facility identified as clean, stored in a large tray. Dried food stuffs and white scale was observed on the inside surface of these bowls. Flatware/silverware was observed stored together while wet in a multiple unit container. Multiple silver serving pans to be utilized for the lunch meal were observed with dried food debris on the surface and water within the pans. The CDM (certified dietary manager) stated that the cook had pulled these clean pans out and placed them on the top of the stove in advance of the lunch meal. Observation revealed food debris and dirt on the floor behind the stove. Multiple silver serving pans, identified as clean, were observed stored on a silver cart in the food preparation room. The pans were soiled with dried food debris. During an observation of the lunch meal service on March 4, 2020, at approximately 9:30 AM Employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395899	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENS AT ORANGEVILLE, THE	**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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) 4 (dietary aide) with gloved hands, was observed to place dirty dishes into the dishwasher and with the same gloved hands removed the clean dishes from the clean side of the dishmachine. She then went back to the dirty side of the dishwasher and started to rinse plates and bowls and placed them into the rack and into the wash cycle. Employee 4 with the same gloved hands removed the clean dishes from the dishwasher. These failures to maintain a separate flow of work for clean and dirty dishware was confirmed by the Dietary Manager at the time of the observation. Interview with the Dietary Manager at this time, confirmed that these observations were food safety, sanitation and management concerns. 28 Pa. Code 211.6 (c)(f) Dietary services. 28 Pa Code 201.18(e)(6) Management