STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. Building B. Wing	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on clinical record review and interviews with staff, it was determined that the facility failed to ensure that necessary care and services were provided and that pressure ulcers were identified, assessed, and monitored, resulting in actual harm from development and worsening of pressure ulcers for one out of three residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed resident with diagnoses that included Cerebral Palsy (a group of disorders that affect movement, muscle tone, balance, and posture) and muscle weakness. Further review revealed resident was readmitted to the facility November 5, 2021, following a hospitalization . Review of Resident 1's readmission assessment dated [DATE] revealed that Resident 1 was admitted post hospitalization with redness to her left elbow, skin exfoliation to her coccyx (sacral area), redness to her rear right thigh, and a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to her left outer ankle. The assessment did not detail any further assessment or measurements of the wounds. Review of the physician orders for Resident 1 revealed an order with a start date of November 6, 2021, to cleanse wound to Right distal lateral leg with normal saline solution (NSS) (cleansing solution), pat dry and apply skin prep to the periwound and apply layer of Santyl (ointment that aids in wound healing) to the wound bed and cover with foam dressing. This wound was not identified on the resident's readmission assessment completed November 5, 2021. Review of Resident 1's clinical record revealed no further assessment regarding the wound. Further review revealed a physician order with a start date of November 6, 2021 to apply Venelex (ointment that aids in wound healing) to Coccyx/Buttocks twice daily, and a physician order with a start date of November 6, 2021 and a stop date of November 8, 2021, to cleanse the wound to left outer ankle with NSS pat dry, apply skin prep to the periwound, apply layer of Santyl to the wound bed and cover with foam dressing. Review of the contracted wound care company note dated November 8, 2021, noted Resident 1 with full-thickness ulceration of the left lateral malleolus (ankle) measuring 1.8 x 2.0 x 0.0 cm, with recommendations to cleanse the affected area with NSS or wound cleanser and apply Medi honey (decreases bacterial growth in wound) daily and cover with foam. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's physician orders revealed an updated order with a start date of November 9, 2021, to cleanse the wound to left outer ankle with NSS, pat dry, apply skin prep to the periwound, apply a layer of medi honey to the wound bed and cover with foam dressing. This order follows the recommendations from Wound Healing Solutions note dated November 8, 2021. Review of weekly nursing skin assessment form dated November 10, 2021, revealed documentation stating, treatment in place for left outer ankle and Right distal lateral leg. The assessment does not document size or characteristics of wounds on ankle or lateral leg. Nursing documentation also does not address exfoliation to coccyx (sacral area), redness to rear right thigh, or redness to left elbow that was identified on November 5, 2021. Review of the contracted wound care company note dated November 15, 2021 revealed Resident 1 with four wounds. The first wound was identified as a full-thickness ulceration of the left lateral malleolus (ankle) measuring 2.8 x 2.5 x 0.0 cm which has increased in size since previous assessment, with recommendations to cleanse affected area with NSS or wound cleanser, apply Medi honey daily and cover with foam. The second wound was identified as a new full-thickness ulceration of the right thigh measuring 1.5 x 1.0 x 0.1 cm, with recommendations to cleanse the site with normal saline or wound cleanser, apply Medi honey to open area daily and as needed and cover with bordered dressing. There is no evidence that the facility had identified or assessed this wound. The third wound was identified as a new full-thickness ulceration of the superior medial right thigh measuring 2.5 x 1.5 x 0.1 cm with recommendations to clean site with NSS or wound cleanser, apply skin prep to wound base twice a day and cover with foam dressing - not heavy white dressing. There is no evidence that the facility had identified or assessed this wound. The fourth wound was identified as a new full-thickness ulceration of the right inferior lateral thigh measuring 1.6 x 1.2 x 0.1 cm with recommendations to clean site with NSS or wound cleanser, apply skin prep to wound base twice a day and cover with foam dressing - not heavy white dressing. There is no evidence that the facility had identified or assessed this wound. Review of Resident 1's physician orders identified no new orders were entered that followed Wound Healing Solutions recommendations from November 15, 2021. Review of weekly nursing skin assessment form dated November 17, 2021, revealed documentation stating, treatment in place for left outer ankle and Right distal lateral leg. The assessment does not document size or characteristics of wounds on ankle or lateral leg. Nursing documentation does not address wound on coccyx (sacral area), redness to rear right thigh, or redness to left elbow that was identified on November 5, 2021 or ulcerations of the superior medial thigh and right inferior lateral thigh that were identified by Wound Solutions on November 15, 2021. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the contracted wound care company note dated November 22, 2021 revealed Nursing staff report patient now has a sacral wound. Staff report that sacral area was red and discolored upon readmission from her last hospitalization and site has rapidly declined. The note stated Resident 1 with a new infected wound that is a full-thickness ulceration of the sacral region measuring 7.0 x 5.0 x 2.5 cm with 7.0 cm tunnel, wound with odor, necrosis, purulent drainage, erythema, and induration. There is no evidence that this wound has been assessed by staff since readmission to facility on November 5, 2021. The note further shows resident with a full-thickness ulceration of the left lateral malleolus (ankle) measuring 3.0 x 3.5 x 0.5 cm with bone exposure, which has increased in size and depth since prior assessment. Two additional wounds were identified on the resident's right lateral thigh, a full-thickness ulceration of the right lateral thigh measuring 2.0 x 1.5 x 0.3 cm, and a full-thickness ulceration of the right lateral thigh (superior site) measuring 0.3 x 0.3 x utd cm. There is no evidence that the facility had assessed, identified, or treated these wounds. The recommendations made by Wound Healing Solutions were to send resident to ER for evaluation of new stage 4 pressure injury of sacral region with wound infection. Review of nursing progress note dated November 22, 2021 revealed resident with sacral deep tissue injury that has opened, wound CRNP recommended resident be sent to hospital due to area looking infected. Resident 1 was sent to the Emergency Department on November 22, 2021 for wound evaluation. While in the hospital Resident 1 received a full skin assessment on November 23, 2021 by the hospital's Wound Ostomy and Continence Nurse (WOCN). The WOCN assessment identified the wounds present upon admission to the hospital. Those wounds consisted of a stage 4 pressure injury over the sacrum that measured 8.2 x 8 x 3.5cm, a stage 4 pressure injury of the left lateral ankle with visible tendon, and an unstageable pressure injury noted on right lateral thigh (there are 2 areas measured as 1 injury). The assessment revealed two additional wounds that had not been identified by the facility prior to the hospital admission consisting of a deep tissue injury to the right lateral ankle and a stage 1 pressure injury located on the posterior head. While in the hospital, Resident 1 underwent debridement (the removal of damaged tissue) of the sacral wound under general anesthesia. The Operative Report dated November 24, 2021, detailed the procedure to involve excising (removing) the necrotic tissue along the right side, removing the underlying necrotic (dead) tissue down to the presacral fascia as well as exposing her underlying gluteus muscle. The wound was debrided enough for a wound VAC (a treatment for surgical wounds consisting of a pump that applies negative pressure to a wound space via tubing inserted into the wound) to be placed to promote healing. The Director of Nursing (DON) verified on December 13, 2021 at 2:10 PM, that the resident did not have any updated orders following the Wound Healing Solutions recommendations made on November 15, 2021, that included treatment of the newly identified ulcerations to the superior medial right thigh and the inferior lateral right thigh and the new order for the ulceration to the right thigh. On November 13, 2021 at 3:05 PM, the Director of Nursing (DON) explained the process that should be followed regarding wound assessments. The DON revealed the wound team assesses the resident weekly, that information regarding the wounds and recommendations is then given to the unit managers within 24 hours. The unit managers are then responsible to notify the physician of the wound team's recommendations and obtain orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Director of Nursing stated she spoke with the unit manager regarding the wound team assessment that was completed on November 15, 2021, the unit manager revealed the assessment was received by Wound Healing Solutions, but it was overlooked and the physician was not notified and treatments were not put in place. The DON was unable to locate any documentation from the nurses or physician regarding the wound to the coccyx (sacral area) since readmission to the facility on [DATE]. The DON was also unable to find any documentation regarding the newly identified wounds to the thigh. The DON stated the weekly skin assessment completed by the nurse should have included the progression of the sacral wound as well as the other wounds identified and did not contain that information. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5 (f)(h) Clinical Records 28 Pa. Code 211.10(d) Resident Care Policies 28 Pa. code 211.12(d)(1)(3)(5) Nursing Services