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	01/12/2023

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 37116 Based on surveyor observation, clinical record review, facility policy review, as well as staff and resident interviews, it was determined that the facility failed to ensure that a resident was deemed capable of safely self-administering medications prior to allowing resident to do so for one of 40 residents sampled (Resident 36). Findings include: Review of facility policy, Self-administration of Medications, revised December 2016, revealed, As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Review of facility policy, Medication Administration - General Guidelines, undated, revealed, Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. Review of Resident 36's clinical record revealed diagnoses that included unspecified psychosis (abnormal condition of the mind that involves a loss of contact with reality) and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs). Observation on January 10, 2023, at 10:00 AM, revealed two Trelegy Ellipta (used to treat long-term COPD) and one ProAir inhalers (used to treat wheezing and breathing problems) on Resident 36's overbed table. During an immediate interview, Resident stated that she sometimes forgets to use the inhalers. Resident then picked up one of the Trelegy inhalers and took a puff. Review of Medication Self-Administration Screen, dated April 28, 2021, revealed that at that time Resident 36 was deemed unable to safely administer medications. During an interview with the Director of Nursing on January 12, 2023, at 9:00 AM, she revealed that she would not expect Resident 36 to have medications in her room since she has not determined to be safe to self-administer these medications. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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 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. 37116 Based on clinical record review, review of select facility reports, as well as staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice for medication administration that met each resident's physical, mental, and psychosocial needs for 34 of 41 residents sampled, (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 39, 40). Findings include: Review of medication administration records, missed medication administration reports, and nursing progress notes revealed the following: Resident 1: one nutritional supplement was not administered on December 25, 2022, and a total of six medications and two nutritional supplements were not administered on January 8, 2023. Resident 2: two nutritional supplements and five medications were not administered on December 25, 2022. Resident 3: five medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Resident 4: eight medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Resident 5: eight medications and one nutritional supplement were not administered on December 25, 2022. Resident 6: 13 medications were not administered, and one blood sugar check was not completed on December 25, 2022. Resident 7: 12 medications and two nutritional supplements were not administered on December 25, 2022, and eight medications and two nutritional supplements were not administered on January 8, 2023. Resident 8: eight medications were not administered on December 25, 2022. Resident 9: eight medications were not administered on December 25, 2022, and on January 8, 2023. Resident 10: 11 medications and one nutritional supplement were not administered on December 25, 2022. Resident 11: five medications were not administered on December 25, 2022. Resident 12: six medications and one nutritional supplement were not administered on December 25, 2022. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 13: five medications were not administered on December 25, 2022, and five medications and one nutritional supplement were not administered on January 8, 2023. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Additionally, neurological checks following a fall were not completed on one occasion on December 25, 2022. Furthermore, six medications and two nutritional supplements were not administered on January 8, 2023. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022, and on January 8, 2023. Resident 18: two medications were not administered on December 25, 2022, and on January 8, 2023. Resident 19: 13 medications were not administered on December 25, 2022. Resident 20: two medications were not administered on December 25, 2022. Resident 21: one medication and one nutritional supplement were not administered on December 25, 2022, and two medications and one nutritional supplement were not administered on January 8, 2023. Resident 22: 12 medications were not administered on December 25, 2022. Resident 23: six medications were not administered on December 25, 2022. Resident 24: seven medications were not administered on December 25, 2022. Resident 25: seven medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Additionally, orthostatic blood pressure and pulse readings were not completed as ordered on December 25, 2022. Resident 26: two medications were not administered on December 25, 2022, and two medications and two nutritional supplements were not administered on January 8, 2023. Resident 27: 12 medications were not administered on December 25, 2022, and one medication was not administered on January 8, 2023. Resident 28: four medications were not administered on December 25, 2022, and on January 8, 2023. Resident 29: two medications were not administered on December 25, 2022. Resident 30: four medications were not administered on December 25, 2022, and five medications were not administered on January 8, 2023. Resident 31: one medication was not administered on December 25, 2022, and on January 8, 2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32: one vital sign monitoring for COVID-19 positive status was not completed on December 25, 2022. Resident 39: one nutritional supplement was not administered on January 8, 2023. Resident 40: one nutritional supplement was not administered on January 8, 2023. During an interview with the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she revealed that on December 25, 2022, a scheduled nurse overslept and came in late, resulting in missed medication pass. She also revealed that she was sick and quarantining at home on the date in question. During a telephone interview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11:45 AM, she revealed that she was scheduled to come into the facility at 3:00 PM on December 25, 2022, but was called into the facility early since coverage was needed. She revealed that the scheduled nurse on the ACU, Employee 4 (Licensed Practical Nurse), had been quarantined due to COVID-19, was permitted to return on December 25, 2022, but did not return on that date and did not notify anyone before the scheduled shift. Review of employee timecard revealed that Employee 1 punched in at 11:46 AM on December 25, 2022. Employee 1 confirmed that this was the time she arrived at the facility. Employee 1 stated that she reported to the 1300 unit at that time. She then revealed that she received a call from Employee 2 (Registered Nurse Supervisor) sometime after lunch to assist with passing medications on the ACU. Employee 1 revealed that when she arrived on the ACU unit, she discovered that morning and noon medication passes were not completed. She stated that around approximately 1:30 PM - 2:00 PM she contacted the Medical Director via text to inform him of the missed medications. She stated that his reply was OK. Employee 1 revealed that she began notification of responsible parties and documentation in resident records at that time. Employee 1 revealed that she did not notify administration of the missed medications on December 25, 2022, but confirmed that they became aware of the concern at the next morning meeting. During an additional interview with the DON on January 12, 2023, at 8:35 AM, she confirmed that Employee 4 was scheduled for dayshift on the ACU on December 25, 2022. She also revealed that Employee 4 had been quarantined, was due to come back on that date, and hadn't notified anyone that she was not planning to return on that date. DON stated that she spoke with Employee 2 around 8:30 AM - 8:45 AM to discuss that Employee 4 had not shown for her shift. DON stated that she advised Employee 2 to call Employee 1. DON stated that she then called Employee 4 who stated she did not come to work because she was not yet feeling up to it. DON stated that, since Employee 2 was busy passing medications, she attempted to get in contact with Employee 1. DON states she finally reached Employee 1 somewhere between 8:30 AM - 9:30 AM, at which time Employee 1 told DON she was on her way. DON stated did not know if she was actually enroute at that time. DON revealed that after she found out Employee 1 was coming in, she dropped it since she figured they were covered. DON revealed that she did not realize medications were not administered until it was discussed at morning meeting on Tuesday, December 27, 2022. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Employee 2 (Registered Nurse Supervisor) on January 12, 2023, at 10:46 AM, she revealed that she was scheduled to work from 7:00 AM to 7:00 PM on December 25, 2022. She revealed she was assigned as house supervisor and was also assigned a medication cart on the 1300 unit. Employee 2 revealed that she contacted the DON at 7 something to inform her that Employee 4 did not show for her shift on the ACU. Employee 2 stated that DON informed her that she wound attempt to contact Employee 1 since she had said she could work. Employee 2 stated she did not wait around to see if Employee 4 showed, since she had a medication pass that needed to be completed on another unit. She stated that she followed-up with the DON via text at 8:30 AM to see if she was able to reach Employee 1. Employee 2 stated that Employee 1 reported to work around 12:00 PM. She stated that Employee 1 reported to the 1300 unit when she arrived and began to pass lunchtime medications. Employee 2 revealed that she was on the ACU when Employee 1 arrived, attempting to look through missed medications to see what could still be given. Employee 2 stated that she requested Employee 1's assistance on the ACU. When Employee 1 arrived on the ACU, Employee 2 stated Employee 1 suggested they just let the physician know medications weren't administered. Employee 2 revealed that Employee 1 contacted the physician. Employee 2 stated she was unaware of what the physician's response was. Employee 2 stated they then split the responsibility of notifying the responsible parties and documenting in resident records. Employee 2 revealed she was aware of missed morning medications on the ACU and had not contacted the physician earlier to notify of these missed medications since she was planning to go through resident orders to see what could still be administered. During an interview with the Assistant DON on January 10, 2023, at 12:52 PM, she confirmed a staffing shortage on January 8, 2023. She revealed that the physician was notified of the situation, and that he instructed them to administer cardiac and diabetic medications. She revealed that this was done and, for the residents who received either diabetic or cardiac medications, all of their other medications were also administered During a later interview with the DON on January 12, 2023, at 11:07 AM, she revealed that on January 8, 2023, they did not have sufficient staff scheduled to cover all medication carts. She revealed that the Assistant DON, unit manager, and one other agency nurse were called in to cover medication carts. She revealed that one of the nurses was assigned two medication carts. The DON revealed that it was known that medication administration was going to be late for some of the residents. She confirmed that the physician was notified of the situation. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18 (e)(1)(2)(3)(6) Management

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37116 Based on observations, facility policy review, and staff interview, it was determined that the facility failed to maintain an environment that was free of accident hazards during medication administration on one of five units observed (AACU - Advanced Alzheimer's Care Unit). Findings Include: Review of facility policy, titled Medication Administration - General Guidelines, undated, revealed During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. Observation on January 10, 2023, at approximately 9:30 AM, revealed Employee 5 (Licensed Practical Nurse) standing at the medication cart in the dining area of the AACU. Employee 5 was observed walking away from the cart to an area where the cart was outside of her line of sight. 11 residents were present in the dining area at that time. At approximately 9:34 AM, Employee 6 (Registered Nurse) entered the unit, noted the cart was unlocked, and locked the cart. During an interview with Employee 6 at 9:38 AM, she confirmed that she had locked the cart and addressed the concern with Employee 5. During an interview with the Director of Nursing on January 12, 2023, at 9:12 AM, she revealed the expectation that the medication cart should have been locked. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37116 Based on clinical record review, review of facility staffing data, and resident and staff interviews, it was determined that the facility failed to provide adequate and sufficient nursing staff to provide medication administration in accordance with professional standards of practice and physician orders for 32 out of 33 residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32) on the Alzheimer's Care Unit (ACU). These staffing failures resulted in missed medication doses, missed nursing assessments including insulins, antipsychotics, antibiotics, antihypertensives, seizure medications, heart medications, pain medications, nutritional supplements, blood sugar level checks, neurological checks, and blood pressure checks. These missed medications and assessments had the potential to cause the residents discomfort or pain, to exacerbate behaviors and medical conditions including blood pressure, cardiac and diabetic issues, increase the potential for seizures, and jeopardized the health and safety, resulting in Immediate Jeopardy. Additionally, the facility failed to ensure appropriate staffing coverage on three of five nursing units (ACU, 800/900 unit, 1300 unit) to ensure that medications, nutritional supplements or assessments were administered/completed timely and per physician order for 18 of 104 residents residing on those units (Residents 1, 3, 4, 7, 9, 13, 16, 17, 18, 21, 25, 26, 27, 28, 30, 31, 39, 40). Findings include: During an interview with Employee 7 on January 10, 2023, at 9:05 AM Employee 7 expressed concern that residents on the ACU unit did not receive all of their medications on December 25, 2022 and again on January 8, 2023, due to staffing shortages. Review of medication administration records and nursing progress notes revealed the following: Resident 1: one nutritional supplement was not administered on December 25, 2022, and a total of six medications and two nutritional supplements were not administered on January 8, 2023. Resident 2: two nutritional supplements and five medications were not administered on December 25, 2022. Resident 3: five medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Resident 4: eight medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Resident 5: eight medications and one nutritional supplement were not administered on December 25, 2022. Resident 6: 13 medications were not administered and one blood sugar check was not completed on December 25, 2022. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 7: 12 medications and two nutritional supplements were not administered on December 25, 2022, and eight medications and two nutritional supplements were not administered on January 8, 2023. Resident 8: eight medications were not administered on December 25, 2022. Resident 9: eight medications were not administered on December 25, 2022, and on January 8, 2023. Resident 10: 11 medications and one nutritional supplement were not administered on December 25, 2022. Resident 11: five medications were not administered on December 25, 2022. Resident 12: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 13: five medications were not administered on December 25, 2022, and five medications and one nutritional supplement were not administered on January 8, 2023. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Additionally, neurological checks following a fall were not completed on one occasion on December 25, 2022. Furthermore, six medications and two nutritional supplements were not administered on January 8, 2023. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022, and on January 8, 2023. Resident 18: two medications were not administered on December 25, 2022, and on January 8, 2023. Resident 19: 13 medications were not administered on December 25, 2022. Resident 20: two medications were not administered on December 25, 2022. Resident 21: one medication and one nutritional supplement were not administered on December 25, 2022, and two medications and one nutritional supplement were not administered on January 8, 2023. Resident 22: 12 medications were not administered on December 25, 2022. Resident 23: six medications were not administered on December 25, 2022. Resident 24: seven medications were not administered on December 25, 2022. Resident 25: seven medications and two nutritional supplements were not administered on December 25, 2022, and on January 8, 2023. Additionally, orthostatic blood pressure and pulse readings were not completed as ordered on December 25, 2022. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 26: two medications were not administered on December 25, 2022, and two medications and two nutritional supplements were not administered on January 8, 2023. Resident 27: 12 medications were not administered on December 25, 2022, and one medication was not administered on January 8, 2023. Resident 28: four medications were not administered on December 25, 2022, and on January 8, 2023. Resident 29: two medications were not administered on December 25, 2022. Resident 30: four medications were not administered on December 25, 2022, and five medications were not administered on January 8, 2023. Resident 31: one medication was not administered on December 25, 2022, and on January 8, 2023. Resident 32: one vital sign monitoring for COVID-19 positive status was not completed on December 25, 2022. Resident 39: one nutritional supplement was not administered on January 8, 2023. Resident 40: one nutritional supplement was not administered on January 8, 2023. During an interview with the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she revealed that on December 25, 2022, a scheduled nurse overslept and came in late, resulting in missed medication pass. She also revealed that she was sick and quarantining at home on the date in question. During a telephone interview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11:45 AM, she revealed that she was scheduled to come into the facility at 3:00 PM on December 25, 2022, but was called into the facility early since coverage was needed. She revealed that the scheduled nurse on the ACU, Employee 4 (Licensed Practical Nurse), had been quarantined due to COVID-19, was permitted to return on December 25, 2022, but did not return on that date and did not notify anyone before the scheduled shift. Review of employee timecard revealed that Employee 1 punched in at 11:46 AM on December 25, 2022. During her interview, Employee 1 confirmed that this was the time she arrived at the facility. Employee 1 stated that she reported to the 1300 unit at that time. She then revealed that she received a call from Employee 2 (Registered Nurse Supervisor) sometime after lunch to assist with passing medications on the ACU. Employee 1 revealed that when she arrived on the ACU unit, she discovered that morning and noon medication passes were not completed. She stated that around approximately 1:30 PM - 2:00 PM she contacted the Medical Director via text to inform him of the missed medications. She stated that his reply was OK. Employee 1 revealed that she began notification of responsible parties and documentation in resident records at that time. Employee 1 revealed that she did not notify administration of the missed medications on December 25, 2022, but confirmed that they became aware of the concern at the next morning meeting. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an additional interview with the DON on January 12, 2023, at 8:35 AM, she confirmed that Employee 4 was scheduled for dayshift on the ACU on December 25, 2022. She also revealed that Employee 4 had been quarantined, was due to come back on that date, and hadn't notified anyone that she was not planning to return on that date. DON stated that she spoke with Employee 2 around 8:30 AM - 8:45 AM to discuss that Employee 4 had not shown for her shift. DON stated that she advised Employee 2 to call Employee 1. DON stated that she then called Employee 4 who stated she did not come to work because she was not yet feeling up to it. DON stated that since Employee 2 was busy passing medications, she attempted to get in contact with Employee 1. DON states she finally reached Employee 1 somewhere between 8:30 AM - 9:30 AM, at which time Employee 1 told DON she was on her way. DON stated did not know if she was actually enroute at that time. DON revealed that after she found out Employee 1 was coming in, she dropped it since she figured they were covered. DON revealed that she did not realize medications were not administered until it was discussed at morning meeting on Tuesday, December 27, 2022. During an interview with Employee 2 (Registered Nurse Supervisor) on January 12, 2023, at 10:46 AM, she revealed that she was scheduled to work from 7:00 AM to 7:00 PM on December 25, 2022. She revealed she was assigned as house supervisor and was also assigned a medication cart on the 1300 unit. Employee 2 revealed that she contacted the DON at 7 something to inform her that Employee 4 did not show for her shift on the ACU. Employee 2 stated that DON informed her that she wound attempt to contact Employee 1 since she had said she could work. Employee 2 stated she did not wait around to see if Employee 4 showed, since she had a medication pass that needed to be completed on another unit. She stated that she followed-up with the DON via text at 8:30 AM to see if she was able to reach Employee 1. Employee 2 stated that Employee 1 reported to work around 12:00 PM. She stated that Employee 1 reported to the 1300 unit when she arrived and began to pass lunchtime medications. Employee 2 revealed that she was on the ACU when Employee 1 arrived, attempting to look through missed medications to see what could still be given. Employee 2 stated that she requested Employee 1's assistance on the ACU. When Employee 1 arrived on the ACU, Employee 2 stated Employee 1 suggested they just let the physician know medications weren't administered. Employee 2 revealed that Employee 1 contacted the physician. Employee 2 stated she was unaware of what the physician's response was. Employee 2 stated they then split the responsibility of notifying the responsible parties and documenting in resident records. Employee 2 revealed she was aware of missed morning medications on the ACU and had not contacted the physician earlier to notify of these missed medications since she was planning to go through resident orders to see what could still be administered. During an interview with the Assistant DON on January 10, 2023, at 12:52 PM, she confirmed a staffing shortage on January 8, 2023. She revealed that the physician was notified of the situation, and that he instructed them to administer cardiac and diabetic medications. She revealed that this was done and, for the residents who received either diabetic or cardiac medications, all of their other medications were also administered. During a later interview with the DON on January 12, 2023, at 11:07 AM, she revealed that on January 8, 2023, they did not have sufficient staff scheduled to cover all medication carts. She revealed that the Assistant DON, unit manager, and an agency nurse were called in to cover medication carts. She revealed that one of the nurses was assigned two medication carts. The DON revealed that it was known that medication administration was going to be late for some of the residents. She confirmed that the physician was notified of the situation. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nursing Home Administrator (NHA) and DON were notified of the concern regarding missed medication and treatment administration that occurred on December 25, 2022, and were provided with the immediate jeopardy template on January 10, 2023, at 3:35 PM. An immediate action plan was requested at that time. On January 10, 2023, at 6:24 PM, the facility's immediate action plan was accepted, which included: - The facility is maintaining sufficient licensed nursing staff on site during all nursing shifts by offering additional shifts and incentives and utilizing agency staff to provide nursing care including medications and treatments are administered timely as per physician orders. - The identified residents were reviewed to determine any negative effects. - All residents in house will be reviewed per the missed medication report for the past 72 hours. Any residents identified will be evaluated for signs and symptoms of adverse reactions to missed medications, they will have a Medication Error Report completed, and the physician and responsible party will be made aware. - Administrative staff will ensure the appropriate number of nursing staff are provided daily. If not, administrative staff will be contacted and the on-call system will be implemented also utilizing administrative staff to meet these needs. - Current licensed nursing staff will be educated by January 12, 2023, on ensuring medications and treatments are administered timely as per physician orders, and that residents will be free from significant medication errors caused by omitted medications. Any new staff will be educated prior to the start of their next shift. - The NHA and DON were educated on January 10, 2023, on ensuring sufficient nursing staff is onsite 24/7 to provide medications and treatments per physician orders. - DON, NHA, or designee will audit missed medication reports every shift for two weeks, then daily for four weeks to ensure medications and treatments are administered timely as per physician orders. Results will be reported to QAPI for review and further recommendations. On January 12, 2023, at 10:35 AM, the Immediate Jeopardy was lifted during an onsite survey after ensuring that the immediate action plan had been implemented. 28 Pa. Code 211.12 (a)(c)(d)(1)(4)(5) Nursing Services 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. 37116 Based on clinical record review and staff interviews, it was determined that the facility failed to follow accepted professional standards and principles for administering medications to ensure the prevention of significant medication errors for 29 out of 33 residents sampled (Residents 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 31, 32) on the ACU (Alzheimer Care Unit). This resulted in an Immediate Jeopardy situation since the missed medications had the potential to cause the residents discomfort or pain, to exacerbate behaviors and medical conditions including blood pressure, cardiac and diabetic issues, increase the potential for seizures, and jeopardized the health and safety of 29 of 33 residents reviewed. Findings include: Review of Resident 2's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), psychotic disorder (a mental state marked by loss of contact with reality, disorganized speech and behaviors, and often hallucinations or delusions), and hypertension (high blood pressure). Orders included diltiazem daily for hypertension, Risperdal (antipsychotic) daily for psychotic disorder, and Namenda (used to treat confusion) for dementia. Review of medication administration record revealed that Resident 2 was not administered these medications on December 25, 2022. Review of Resident 3's clinical record revealed diagnoses that included major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations) and vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory). Orders included venlafaxine daily for major depressive disorder. Review of medication administration record revealed that Resident 3 was not administered the aforementioned medication on December 25, 2022. Review of Resident 4's clinical record revealed diagnoses that included vascular dementia. Orders included memantine (used to treat confusion) daily for vascular dementia. Review of medication administration record revealed that Resident 4 did not receive the aforementioned medication on December 25, 2022. Review of Resident 5's clinical record revealed diagnoses that included hypertension. Orders included Norvasc and hydrochlorothiazide daily for hypertension. Review of medication administration record revealed that Resident 5 was not administered the aforementioned medications on December 25, 2022. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 6's clinical record revealed diagnoses that included type 2 diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar), dementia with behavioral disturbance, major depressive disorder, and atrial fibrillation (irregular heart beat). Orders included Zoloft (antidepressant) daily for major depressive disorder, Eliquis (anticoagulant) two times a day for atrial fibrillation, metoprolol two times per day for hypertension, Namenda two times a day for dementia, Novolin (insulin) twice a day for diabetes mellitus, and Zyprexa (antipsychotic) two times a day for dementia with behavioral disturbance. Review of medication administration record revealed that Resident 6 was not administered the Zoloft on December 25, 2022. It also revealed that Resident 6 was not administered the Eliquis, metoprolol, Namenda, Novolin, or Zyprexa in the morning on December 25, 2022. Review of Resident 7's clinical record revealed diagnoses that included dementia with behavioral disturbance and cerebral infarction (area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain). Orders included apixaban (anticoagulant) two times a day for cerebral infarction, and Zyprexa two times per day for dementia with behavioral disturbance. Review of medication administration record revealed that Resident 7 was not administered the morning dose of the aforementioned medications on December 25, 2022. Review of Resident 8's clinical record revealed diagnoses that included Alzheimer's (gradually progressive brain disorder that causes problems with memory, thinking and behavior), dementia with behavioral disturbance, major depressive disorder, and hypertension. Orders included amlodipine daily for hypertension, escitalopram (antidepressant) daily for major depressive disorder, and Seroquel (antipsychotic) two times a day for dementia with behavioral disturbance. Review of medication administration record revealed that Resident 8 was not administered amlodipine and escitalopram on December 25, 2022. It also revealed that Resident 8 did not receive the morning dose of Seroquel on December 25, 2022. Review of Resident 10's clinical record revealed diagnoses that Alzheimer's disease, major depressive disorder, and hypertension. Orders included amlodipine daily for hypertension, Celexa (antidepressant) daily for major depressive disorder, lisinopril-hydrochlorothiazide daily for hypertension, and Namenda two times a day for Alzheimer's. Review of medication administration record revealed that Resident 10 was not administered the amlodipine, Celexa, and lisinopril-hydrochlorothiazide on December 25, 2022. It also revealed that Resident 10 was not administered the morning dose of Namenda on December 25, 2022. Review of Resident 11's clinical record revealed diagnoses that included hypertension. Orders included Cozaar daily for hypertension, hydrochlorothiazide daily for hypertension, and Norvasc daily for hypertension. Review of medication administration record revealed that Resident 11 was not administered the aforementioned medications on December 25, 2022. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 12's clinical record revealed diagnoses that included Alzheimer's disease. Orders included memantine two times a day for Alzheimer's. Review of medication administration record revealed that Resident 12 was not administered the morning dose of memantine on December 25, 2022. Review of Resident 13's clinical record revealed diagnoses that included dementia. Orders included escitalopram daily for depression. Review of medication administration record revealed that Resident 13 was not administered the aforementioned medication on December 25, 2022. Review of Resident 14's clinical record revealed diagnoses that included hypertension and anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events). Orders included Buspar (antianxiety medication) two times a day for anxiety, Losartan two times a day for hypertension, and hydralazine every eight hours for hypertension. Review of medication administration record revealed that Resident 14 was not administered the morning dose of Buspar and Losartan and the 2:00 PM dose of hydralazine on December 25, 2022. Review of Resident 15's clinical record revealed diagnoses the included schizophrenia (mental disease characterized by loss of reality contact, delusions, hallucinations, and/or feelings of persecution), hypertension, and Alzheimer's disease. Orders included Lisinopril daily for elevated blood pressure readings, Risperdal .5 mg daily for schizophrenia, torsemide daily for hypertension, and memantine daily for Alzheimer's. Review of medication administration record revealed that Resident 15 was not administered the aforementioned medications on December 25, 2022. Review of Resident 16's clinical record revealed diagnoses that included dementia, psychotic disorder, and major depressive disorder. Orders included depakote 250 mg daily for agitation and bipolar manic episodes, Zoloft daily for major depressive disorder, and quetiapine two times a day for psychosis. Review of medication administration record revealed that Resident 16 was not administered depakote and Zoloft, nor the morning dose of quetiapine on December 25, 2022. Review of Resident 17's clinical record revealed diagnoses that included dementia and psychosis. Orders included Risperdal daily for psychosis and depakote two times per day for mood stabilization. Review of medication administration record revealed that Resident 17 was not administered Risperdal nor morning dose of depakote on December 25, 2022. Review of Resident 18's clinical record revealed diagnoses that included Alzheimer's disease and unspecified psychosis. Orders included olanzapine daily for psychosis. Review of medication administration record revealed that Resident 18 was not administered olanzapine on December 25, 2022. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 19's clinical record revealed diagnoses that included bipolar disorder (mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior), atherosclerotic heart disease of the native coronary artery (condition where arteries get narrow or hardened), and major depressive disorder. Orders included depakote 125 mg daily for major depressive disorder, isosorbide nitrate (used to prevent chest pain) daily for angina (chest discomfort or shortness of breath caused when heart muscles receive insufficient oxygen-rich blood), Zoloft daily for major depressive disorder, depakote 325 mg two times a day for bipolar disorder, and Eliquis two times a day for deep vein thrombosis prevention. Review of medication administration record revealed that Resident 19 was not administered depakote 125 mg, isosorbide nitrate, and Zoloft on December 25, 2022. It also revealed that Resident 19 was not administered the morning dose of depakote 325 mg or Eliquis on that date. Review of Resident 20's clinical record revealed diagnoses that included frontotemporal neurocognitive disorder (result of damage to nerve cells in the frontal and temporal lobes of the brain that gradually causes difficulties in thinking and behaviors normally controlled by these parts of the brain). Orders included Prozac (antidepressant) daily for frontotemporal neurocognitive disorder and depakene two times per day for manic episodes. Review of medication administration record revealed that Resident 20 was not administered Prozac nor the morning dose of depakene on December 25, 2022. Review of Resident 21's clinical record revealed diagnoses that included major depressive disorder. Orders included Zoloft daily for major depressive disorder. Review of medication administration record revealed that Resident 21 was not administered Zoloft on December 25, 2022. Review of Resident 22's clinical record revealed diagnoses that included Alzheimer's, type 2 diabetes mellitus, major depressive disorder, and hypertension. Orders included enalapril daily for hypertension, hydrochlorothiazide daily for hypertension, Zoloft daily for major depressive disorder, and metformin two times per day for diabetes mellitus. Review of medication administration record revealed that Resident 22 was not administered enalapril, hydrochlorothiazide, or Zoloft on December 25, 2022. Review also revealed that Resident was not administered the morning dose of metformin on December 25, 2022. Review of Resident 23's clinical record revealed diagnoses that included hypertension, major depressive disorder, and dementia. Orders included amlodipine daily for hypertension, metoprolol daily for hypertension, Seroquel 50 mg daily for dementia, and sertraline daily for major depressive disorder. Review of medication administration record revealed the aforementioned medications were not administered to Resident 23 on December 25, 2022. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 24's clinical record revealed diagnoses that included hypertension, major depressive disorder, and pain in unspecified left foot. Orders included amlodipine daily for hypertension, Lexapro daily for major depressive disorder, and gabapentin (used to relieve nerve pain) three times per day for pain. Review of medication administration record revealed that amlodipine and Lexapro were not administered to Resident 24 on December 25, 2022, and that the 2:00 PM dose of gabapentin was not administered on this date. Review of Resident 25's clinical record revealed diagnoses that included major depressive disorder and dementia with behavioral disturbance. Orders included Lexapro daily for major depressive disorder and Risperdal two times per day for dementia with behavioral disturbance. Review of medication administration record revealed that Lexapro as well as the morning dose of Risperdal were not administered to Resident 25 on December 25, 2022. Review of Resident 27's clinical record revealed diagnoses that included major depressive disorder, dementia with behavioral disturbance, hypertension, and congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues). Orders included citalopram daily for major depressive disorder, rivastigmine patch (used to treat confusion related to Alzheimer's) daily for dementia with behavioral disturbance, Toprol daily for hypertension, furosemide (diuretic) two times per day for congestive heart failure, and hydralazine three times per day for hypertension. Review of medication administration record revealed that citalopram, rivastigmine, and Toprol were not administered to Resident 27 on December 25, 2022. Review also revealed that the 2:00 PM doses of furosemide and hydralazine were also not administered on that date. Review of Resident 28's clinical record revealed diagnoses that included dementia with behavioral disturbance, and delusional disorder (disorder in which a person holds fixed false beliefs and is unable to tell what is real from what is imagined). Orders included escitalopram daily for dementia with behavioral disturbance and olanzapine two times per day for delusional disorder. Review of medication administration record revealed that escitalopram as well as the morning dose of olanzapine was not administered on December 25, 2022. Review of Resident 29's clinical record revealed diagnoses that included schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and vascular dementia. Orders included fluoxetine (antidepressant) daily for schizoaffective disorder and Namenda daily for vascular dementia. Review of medication administration record revealed that the aforementioned medications were not administered to Resident 29 on December 25, 2022. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 30's clinical record revealed diagnoses that included unspecified psychosis, epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors), type 2 diabetes mellitus, and dementia with agitation. Orders included Seroquel 75 mg daily for psychosis, Keppra (anticonvulsant) two times per day for seizures, metformin two times per day for diabetes mellitus, and Namenda two times per day for dementia. Review of medication administration record revealed that Seroquel 75 mg was not administered to Resident 30 on December 25, 2022. Review also revealed the the morning doses of Keppra, metformin, and Namenda were also not administered on this date. Review of Resident 31's clinical record revealed diagnoses that included Alzheimer's disease and major depressive disorder. Orders included Zoloft daily for major depressive disorder. Review of medication administration record revealed that Zoloft was not administered to Resident 31 on December 25, 2022. Review of Resident 32's clinical record revealed diagnoses that included heart failure and psychotic disorder with hallucinations. Orders included lasix (diuretic) daily for fluid overload and Zyprexa daily for psychotic disorder. Review of medication administration record revealed that the aforementioned medications were not administered to Resident 32 on December 25, 2022. During an interview with the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she revealed that on December 25, 2022, a nurse overslept and came in late, resulting in a missed medication pass. She also revealed that she was sick and quarantining at home on the date in question. During a telephone interview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11:45 AM, she revealed that she was scheduled to come into the facility at 3:00 PM on December 25, 2022, but was called into the facility early since coverage was needed. She revealed that the scheduled nurse on the ACU, Employee 4 (Licensed Practical Nurse), had been quarantined due to COVID-19, was permitted to return on December 25, 2022, but did not return on that date and did not notify anyone before the scheduled shift. Review of employee time card revealed that Employee 1 punched in at 11:46 AM on December 25, 2022. During the telephone interview, Employee 1 confirmed that this was the time she arrived at the facility. Employee 1 stated that she reported to the 1300 unit at that time. She then revealed that she received a call from Employee 2 (Registered Nurse Supervisor) sometime after lunch to assist with passing medications on the ACU. Employee 1 revealed that when she arrived on the ACU unit, she discovered that morning and noon medication passes were not completed. She stated that around approximately 1:30 PM - 2:00 PM she contacted the Medical Director via text to inform him of the missed medications. She stated that his reply was OK. Employee 1 revealed that she began notification of responsible parties and documentation in resident records at that time. Employee 1 revealed that she did not notify administration of the missed medications on December 25, 2022, but confirmed that they became aware of the concern at the next morning meeting. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an additional interview with the DON on January 12, 2023, at 8:35 AM, she confirmed that Employee 4 was scheduled for dayshift on the ACU on December 25, 2022. She also revealed that Employee 4 had been quarantined, was due to come back on that date, and hadn't notified anyone that she was not planning to return on that date. DON stated that she spoke with Employee 2 around 8:30 AM - 8:45 AM to discuss that Employee 4 had not shown for her shift. DON stated that she advised Employee 2 to call Employee 1. DON stated that she then called Employee 4 who stated she did not come to work because she was not yet feeling up to it. DON stated that, since Employee 2 was busy passing medications, she attempted to get in contact with Employee 1. DON states she finally reached Employee 1 somewhere between 8:30 AM - 9:30 AM, at which time Employee 1 told DON she was on her way. DON stated did not know if she was actually enroute at that time. DON revealed that, after she found out Employee 1 was coming in, she dropped it since she figured they were covered. DON revealed that she did not realize medications were not administered until it was discussed at morning meeting on Tuesday, December 27, 2022. During an interview with Employee 2 (Registered Nurse Supervisor) on January 12, 2023, at 10:46 AM, she revealed that she was scheduled to work from 7:00 AM to 7:00 PM on December 25, 2022. She revealed she was assigned as house supervisor and was also assigned a medication cart on the 1300 unit. Employee 2 revealed that she contacted the DON at 7 something to inform her that Employee 4 did not show for her shift on the ACU. Employee 2 stated that DON informed her that she wound attempt to contact Employee 1 since she had said she could work. Employee 2 stated she did not wait around to see if Employee 4 showed, since she had a medication pass that needed to be completed on another unit. She stated that she followed-up with the DON via text at 8:30 AM to see if she was able to reach Employee 1. Employee 2 stated that Employee 1 reported to work around 12:00 PM. She stated that Employee 1 reported to the 1300 unit when she arrived and began to pass lunchtime medications. Employee 2 revealed that she was on the ACU when Employee 1 arrived, attempting to look through missed medications to see what could still be given. Employee 2 stated that she requested Employee 1's assistance on the ACU. When Employee 1 arrived on the ACU, Employee 2 stated Employee 1 suggested they just let the physician know medications weren't administered. Employee 2 revealed that Employee 1 contacted the physician. Employee 2 stated she was unaware of what the physician's response was. Employee 2 stated they then split the responsibility of notifying the responsible parties and documenting in resident records. Employee 2 revealed she was aware of missed morning medications on the ACU, and had not contacted the physician earlier to notify of these missed medications since she was planning to go through resident orders to see what could be still be administered. The Nursing Home Administrator (NHA) and DON were notified of the concern and were provided with the immediate jeopardy template on January 10, 2023 at 3:35 PM. An immediate action plan was requested at that time. On January 10, 2023, at 6:24 PM, the facility's immediate action plan was accepted, which included: - The facility is maintaining sufficient licensed nursing staff onsite during all nursing shifts by offering additional shifts and incentives, utilizing agency staff to provide nursing care including medications and treatments, and ensuring these meds and treatments are administered timely as per physician orders. - The identified residents were reviewed to determine any negative effects. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- All residents in house will be reviewed per the missed medication report for the past 72 hours. Any residents identified will be evaluated for signs and symptoms of adverse reactions to missed medications, they will have a Medication Error Report completed and the physician and responsible party will be made aware. - Administrative staff will ensure the appropriate number of nursing staff are provided daily. If not, administrative staff will be contacted and the on-call system will be implemented, also utilizing administrative staff to meet these needs. - Current licensed nursing staff will be educated by January 12, 2023, on ensuring medications and treatments are administered timely as per physician orders, that residents will be free from significant medication errors caused by omitted medications. Any new staff will be educated prior to the start of their next shift. - The NHA and DON were educated on January 10, 2023, on ensuring sufficient nursing staff is onsite 24/7 to provide medications and treatments per physician orders. - DON, NHA, or designee will audit missed medication reports every shift for two weeks, then daily for four weeks to ensure medications and treatments are administered timely as per physician orders. Results will be reported to QAPI for review and further recommendations. On January 12, 2023, at 10:35 AM, the Immediate Jeopardy was lifted during an onsite survey after ensuring that the immediate action plan had been implemented. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.9(d) Pharmacy services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37116 Based on review of select facility reports, clinical record review, and staff interview, it was determined that the facility failed to administer in an effective manner by failing to utilize its resources to ensure sufficient staffing to administer medications, nutritional supplements, and/or nursing assessments on three of five nursing units (ACU - Alzheimer's Care Unit, 800/900 unit, and 1300 unit). This failure resulted in missed administration of medications, nutritional supplements and completion of ordered nursing assessments resulting in an immediate jeopardy situation for one of two dates reviewed (December 25, 2022). Findings include: During an interview with Employee 7 on January 10, 2023 at 9:05 AM, Employee 7 expressed concern that residents on the ACU unit did not receive all of their medications on December 25, 2022 and again on January 8, 2023, due to staffing shortages. Clinical record review as well as review of missed medication administration reports for December 25, 2022 and January 8, 2023, revealed that on December 25, 2022, 17 nutritional supplements were not administered, 190 medications were not administered, and 4 nursing assessments were not completed as ordered as a result of no daytime nurse being available to pass medications on the ACU. Further review revealed that on January 8, 2023, 17 nutritional supplements and 77 medications were not administered to residents on the 800/900 unit, 1300 unit, and ACU due to insufficient nursing staff to pass medications timely. During an interview with the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she revealed that on December 25, 2022, a scheduled nurse overslept and came in late, resulting in missed medication pass. She also revealed that she was sick and quarantining at home on the date in question. During a telephone interview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11:45 AM, she revealed that she was scheduled to come into the facility at 3:00 PM on December 25, 2022, but was called into the facility early since coverage was needed. She revealed that the scheduled nurse on the ACU, Employee 4 (Licensed Practical Nurse), had been quarantined due to COVID-19, was permitted to return on December 25, 2022, but did not return on that date and did not notify anyone before the scheduled shift. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of employee timecard revealed that Employee 1 punched in at 11:46 AM on December 25, 2022. Employee 1 confirmed that this was the time she arrived at the facility. Employee 1 stated that she reported to the 1300 unit at that time. She then revealed that she received a call from Employee 2 (Registered Nurse Supervisor) sometime after lunch to assist with passing medications on the ACU. Employee 1 revealed that when she arrived on the ACU unit, she discovered that morning and noon medication passes were not completed. She stated that around approximately 1:30 PM - 2:00 PM she contacted the Medical Director via text to inform him of the missed medications. She stated that his reply was OK. Employee 1 revealed that she began notification of responsible parties and documentation in resident records at that time. Employee 1 revealed that she did not notify administration of the missed medications on December 25, 2022, but confirmed that they became aware of the concern at the next morning meeting. During an additional interview with the DON on January 12, 2023, at 8:35 AM, she confirmed that Employee 4 was scheduled for dayshift on the ACU on December 25, 2022. She also revealed that Employee 4 had been quarantined, was due to come back on that date, and hadn't notified anyone that she was not planning to return on that date. DON stated that she spoke with Employee 2 around 8:30 AM - 8:45 AM to discuss that Employee 4 had not shown for her shift. DON stated that she advised Employee 2 to call Employee 1. DON stated that she then called Employee 4, who stated she did not come to work because she was not yet feeling up to it. DON stated that, since Employee 2 was busy passing medications, she attempted to get in contact with Employee 1. DON states she finally reached Employee 1 somewhere between 8:30 AM - 9:30 AM, at which time Employee 1 told DON she was on her way. DON stated did not know if she was actually enroute at that time. DON revealed that after she found out Employee 1 was coming in, she dropped it since she figured they were covered. DON revealed that she did not realize medications were not administered until it was discussed at morning meeting on Tuesday, December 27, 2022. During an interview with Employee 2 (Registered Nurse Supervisor) on January 12, 2023, at 10:46 AM, she revealed that she was scheduled to work from 7:00 AM to 7:00 PM on December 25, 2022. She revealed she was assigned as house supervisor and was also assigned a medication cart on the 1300 unit. Employee 2 revealed that she contacted the DON at 7 something to inform her that Employee 4 did not show for her shift on the ACU. Employee 2 stated that DON informed her that she would attempt to contact Employee 1 since she had said she could work. Employee 2 stated she did not wait around to see if Employee 4 showed, since she had a medication pass that needed to be completed on another unit. She stated that she followed-up with the DON via text at 8:30 AM to see if she was able to reach Employee 1. Employee 2 stated that Employee 1 reported to work around 12:00 PM. She stated that Employee 1 reported to the 1300 unit when she arrived and began to pass lunchtime medications. Employee 2 revealed that she was on the ACU when Employee 1 arrived, attempting to look through missed medications to see what could still be given. Employee 2 stated that she requested Employee 1's assistance on the ACU. When Employee 1 arrived on the ACU, Employee 2 stated Employee 1 suggested they just let the physician know medications weren't administered. Employee 2 revealed that Employee 1 contacted the physician. Employee 2 stated she was unaware of what the physician's response was. Employee 2 stated they then split the responsibility of notifying the responsible parties and documenting in resident records. Employee 2 revealed she was aware of missed morning medications on the ACU and had not contacted the physician earlier to notify of these missed medications since she was planning to go through resident orders to see what could still be administered. (continued on next page)

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	01/12/2023

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant DON on January 10, 2023, at 12:52 PM, she confirmed a staffing shortage on January 8, 2023. She revealed that the physician was notified of the situation, and that he instructed them to administer cardiac and diabetic medications. She revealed that this was done and, for the residents who received either diabetic or cardiac medications, all of their other medications were also administered. During a later interview with the DON on January 12, 2023, at 11:07 AM, she revealed that on January 8, 2023, they did not have sufficient staff scheduled to cover all medication carts. She revealed that the Assistant DON, unit manager, and one other agency nurse were called in to cover medication carts. She revealed that one of the nurses was assigned two medication carts. The DON revealed that it was known that medication administration was going to be late for some of the residents. She confirmed that the physician was notified of the situation. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services