Printed: 11/24/2024 Form Approved OMB No. 0938-0391

| | | | 1 |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P 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. | | | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | on) |
| F 0554 | Allow residents to self-administer drugs if determined clinically appropriate. | | e. |
| Level of Harm - Minimal harm or potential for actual harm | 37116 | | |
| Residents Affected - Few | 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). | | ent was deemed capable of safely |
| | 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 and one ProAir inhalers (used to treat wheezing and breathing problems) on Resident 36's overbed to During an immediate interview, Resident stated that she sometimes forgets to use the inhalers. Resident 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 and Screen and Sc | | |
| | | | |
| | | or of Nursing on January 12, 2023, at 9 ave medications in her room since she | |
| | 28 Pa. Code 211.12(d)(1)(3)(5) Nu | rsing 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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 395223

If continuation sheet Page 1 of 22

| | | | NO. 0930-0391 |
|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLII Gardens at West Shore, The | NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | | P CODE |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | CIENCIES full regulatory or LSC identifying informati | on) |
| F 0684 | Provide appropriate treatment and | care according to orders, resident's pro | eferences and goals. |
| Level of Harm - Minimal harm or potential for actual harm | 37116 | | |
| Residents Affected - Some | 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 o 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 2022, and on January 8, 2023. | two nutritional supplements were not a | dministered on December 25, |
| | Resident 5: eight medications and | one nutritional supplement were not ac | ministered on December 25, 2022. |
| | Resident 6: 13 medications were not administered, and one blood sugar check was not completed on December 25, 2022. | | check was not completed on |
| | I . | o nutritional supplements were not adn ritional supplements were not administe | |
| | Resident 8: eight medications were | e not administered on December 25, 20 | 22. |
| | Resident 9: eight medications were | e not administered on December 25, 20 | 22, and on January 8, 2023. |
| | Resident 10: 11 medications and o | ne nutritional supplement were not adr | ninistered on December 25, 2022. |
| | Resident 11: five medications were | e not administered on December 25, 20 | 22. |
| | Resident 12: six medications and c | one nutritional supplement were not adr | ministered on December 25, 2022. |
| | (continued on next page) | | |
| | | | |
| | | | |
| | | | |

| | | | No. 0938-0391 |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | | P CODE | |
| For information on the nursing home's p | plan to correct this deficiency, please cont | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | IENCIES full regulatory or LSC identifying informati | on) |
| F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Resident 13: five medications were nutritional supplement were not adrived Resident 14: five medications were Resident 15: five medications and on the Resident 16: six medications were checks following a fall were not commedications and two nutritional supplements were resident 17: four medications and and on January 8, 2023. Resident 18: two medications were resident 19: 13 medications were resident 20: two medications were resident 21: one medication and on and two medications and one nutritional supplements were resident 23: six medications were resident 24: seven medications were resident 25: seven medications were resident 25: seven medications were nutritional supplements were not accompleted as ordered on December Resident 26: two medications were nutritional supplements were not accompleted as a resident 26: two medications were nutritional supplements were not accompleted as four medications were resident 28: four medications were resident 29: two medications were resident 29: two medications were resident 30: four medications were resident 30: four medications were resident 31: one medication was not supplement and supplement | not administered on December 25, 20 ministered on January 8, 2023. not administered on December 25, 20 more nutritional supplement were not administered on December 25, 202 more nutritional supplement were not administered on December 25, 202 more nutritional supplement were not administered on December 25, 202 more administered on December 25, 202 more nutritional supplement were not administered on December 25, 202 more nutritional supplement were not administered on December 25, 202 more administered on December 25, 202 more administered on December 25, 202 more not administered not December 25, 20 | 22, and five medications and one 22. ministered on December 25, 2022. 22. Additionally, neurological 25, 2022. Furthermore, six nuary 8, 2023. Iministered on December 25, 2022, 22, and on January 8, 2023. 22. 22. ministered on December 25, 2022, 22. ministered on December 25, 2022, 22. 22. 22. 22. 22. 22. 22. |
| | (continued on next page) | | |

| | | | NO. 0936-0391 |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLII Gardens at West Shore, The | | | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | ion) |
| F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Resident 32: one vital sign monitor 2022. Resident 39: one nutritional supple Resident 40: one nutritional supple During an interview with the Director revealed that on December 25, 202 medication pass. She also revealed During a telephone interview with E she revealed that she was schedul called into the facility early since of Employee 4 (Licensed Practical Nu December 25, 2022, but did not retemployee 1 confirmed that this was to the 1300 unit at that time. She the Supervisor) sometime after lunch to when she arrived on the ACU unit, completed. She stated that around text to inform him of the missed me she began notification of responsib revealed that she did not notify additional interview with 4 was scheduled for dayshift on the been quarantined, was due to come to return on that date. DON stated Employee 4 had not shown for her stated that she then called Employing feeling up to it. DON stated that, sincontact with Employee 1. DON stated AM, at which time Employee 1 told enroute at that time. DON revealed she figured they were covered. DO | ing for COVID-19 positive status was ment was not administered on January ment was not administered on January or of Nursing (DON) on January 10, 2022, a scheduled nurse overslept and call that she was sick and quarantining at Employee 1 (Licensed Practical Nurse) ed to come into the facility at 3:00 PM overage was needed. She revealed that itse), had been quarantined due to CO turn on that date and did not notify any alled that Employee 1 punched in at 11 is the time she arrived at the facility. Entero revealed that she received a call from assist with passing medications on the she discovered that morning and noon approximately 1:30 PM - 2:00 PM she addications. She stated that his reply was alle parties and documentation in reside ministration of the missed medications of the concern at the next morning medications of the concern at the next morning medications of the concern at the set advised Employee 2 around shift. DON stated that she advised Employee 2 was busy passing medications to the set of the stated she did not come to we make Employee 2 was busy passing medications of the stated she did not come to we make the spoke with Employee 1 sor DON she was on her way. DON stated that after she found out Employee 1 will revealed that she did not realize medication on Tuesday, December 27, 202 | not completed on December 25, 7 8, 2023. 7 8, 2023. 23, at approximately 12:27 PM, she ame in late, resulting in missed thome on the date in question. on January 11, 2023, at 11:45 AM, on December 25, 2022, but was to the scheduled nurse on the ACU, VID-19, was permitted to return on one before the scheduled shift. 246 AM on December 25, 2022, an exployee 1 stated that she reported on Employee 2 (Registered Nurse are ACU. Employee 1 revealed that an medication passes were not contacted the Medical Director via so OK. Employee 1 revealed that an trecords at that time. Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. AM, she confirmed that Employee 1 on December 25, 2022, but setting. |

| | | | No. 0938-0391 |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIE Gardens at West Shore, The | ER | STREET ADDRESS, CITY, STATE, Z | IP CODE |
| | | Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by | CIENCIES full regulatory or LSC identifying informat | ion) |
| F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | revealed that she was scheduled to she was assigned as house superv. 2 revealed that she contacted the E shift on the ACU. Employee 2 states ince she had said she could work since she had a medication pass the followed-up with the DON via text at that Employee 1 reported to work a when she arrived and began to pass when Employee 2 stated that she request the ACU, Employee 2 stated Employee 2 stated Employee 2 stated Employee 2 movealed unaware of what the physician's renotifying the responsible parties and of missed morning medications on missed medications since she was administered. During an interview with the Assists shortage on January 8, 2023. She instructed them to administer cardial residents who received either diabeted administered. During a later interview with the DO 2023, they did not have sufficient so Assistant DON, unit manager, and revealed that one of the nurses was | rsing services | scember 25, 2022. She revealed ion cart on the 1300 unit. Employee Employee 4 did not show for her and attempt to contact Employee 1 round to see if Employee 4 showed, runit. She stated that she ach Employee 1. Employee 2 stated loyee 1 reported to the 1300 unit revealed that she was on the ACU to see what could still be given. CU. When Employee 1 arrived on sician know medications weren't cian. Employee 2 stated she was then split the responsibility of apployee 2 revealed she was aware as to see what could still be 2 PM, she confirmed a staffing dof the situation, and that he aled that this was done and, for the other medications were also she revealed that on January 8, carts. She revealed that the to cover medication carts. She DON revealed that it was known |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
|--|---|--|---|
| NAME OF PROVIDER OR CURRU | FD. | CTREET ADDRESS SITV STATE 7 | D. CODE |
| NAME OF PROVIDER OR SUPPLI | ER | STREET ADDRESS, CITY, STATE, ZI | P 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 con | tact 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) | | ion) |
| F 0689 | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prever accidents. | | des adequate supervision to prevent |
| Level of Harm - Minimal harm or potential for actual harm | 37116 | | |
| Residents Affected - Few | 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 the concern with Employee 5. | 6 at 9:38 AM, she confirmed that she | had locked the cart and addressed |
| | 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. | | 2:12 AM, she revealed the |
| | 28 Pa. Code 211.12 (d)(5) Nursing | services | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 395223 R. Building B. Wing IDENTIFICATION NUMBER: A. Building B. Wing B. Wing B. Wing B. Wing B. Wing B. All Total IDENTIFICATION B. ACHAPATION IDENTIFICATION IDENTIF | | |
|--|---|--|
| 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 agence (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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; an charge on each shift. 37116 Based on clinical record review, review of facility staffing data, and resident and determined that the facility failed to provide adequate and sufficient nursing staff administration in accordance with professional standards of practice and physic residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 24, 25, 26, 27, 28, 29, 30, 31, 32) on the Alzheimer's Care Unit (ACU). These s missed medication doses, missed nursing assessments including insulins, antij antihypertensives, seizure medications, heart medications, pain medications, nurside assessments had the potential to cause the residents discomfort or pain, to exa medical conditions including blood pressure, cardiac and diabetic issues, increa and jeopardized the health and safety, resulting in Immediate Jeopardy. Addition ensure appropriate staffing coverage on three of five nursing units (ACU, 8009) that medications, nutritional supplements or assessments were administered/or physician order for 18 of 104 residents residing on those units (Residents 1, 3, 42, 27, 28, 30, 31, 39, 40). Findings include: During an interview with Employee 7 on January 10, 2023, at 9.05 AM Employer residents on the ACU unit did not receive all of their medications on December January 8, 2023, due to staffing shortages. Review of medication administration records and nursing progress notes reveal | Building COMPLETED | |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Provide enough nursing staff every day to meet the needs of every resident; an charge on each shift. 37116 Based on clinical record review, review of facility staffing data, and resident and determined that the facility failed to provide adequate and sufficient nursing staf administration in accordance with professional standards of practice and physic residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 24, 25, 26, 27, 28, 29, 30, 31, 32) on the Alzheimer's Care Unit (ACU). These s missed medication doses, missed nursing assessments including insulins, antig antihypertensives, seizure medications, heart medications, pain medications, nursing assessments had the potential to cause the residents discomfort or pain, to exa medical conditions including blood pressure, cardiac and diabetic issues, increa and jeopardized the health and safety, resulting in Immediate Jeopardy. Addition ensure appropriate staffing coverage on three of the nursing units (ACU, 800/9) that medications, nutritional supplements or assessments were administered/cophysician order for 18 of 104 residents residing on those units (Residents 1, 3, 26, 27, 28, 30, 31, 39, 40). Findings include: During an interview with Employee 7 on January 10, 2023, at 9:05 AM Employer residents on the ACU unit did not receive all of their medications on December January 8, 2023, due to staffing shortages. Review of medication administration records and nursing progress notes reveal Resident 1: one nutritional supplement was not administered on December 25, | • | |
| (Each deficiency must be preceded by full regulatory or LSC identifying information) Provide enough nursing staff every day to meet the needs of every resident; an charge on each shift. 37116 Based on clinical record review, review of facility staffing data, and resident and determined that the facility failed to provide adequate and sufficient nursing staff administration in accordance with professional standards of practice and physic residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 24, 25, 26, 27, 28, 29, 30, 31, 32) on the Alzheimer's Care Unit (ACU). These s missed medication doses, missed nursing assessments including insulins, antipy and the potential to cause the residents discomfort or pain, to examedical conditions including blood pressure, cardiac and diabetic issues, increase and jeopardized the health and safety, resulting in Immediate Jeopardy. Addition ensure appropriate staffing coverage on three of five nursing units (ACU, 800/9 that medications, nutritional supplements or assessments were administered/cc physician order for 18 of 104 residents residing on those units (Residents 1, 3, 26, 27, 28, 30, 31, 39, 40). Findings include: During an interview with Employee 7 on January 10, 2023, at 9:05 AM Employer residents on the ACU unit did not receive all of their medications on December January 8, 2023, due to staffing shortages. Review of medication administration records and nursing progress notes reveal Resident 1: one nutritional supplement was not administered on December 25, | he nursing home or the state survey agency. | |
| charge on each shift. 37116 Based on clinical record review, review of facility staffing data, and resident and determined that the facility failed to provide adequate and sufficient nursing staff administration in accordance with professional standards of practice and physic residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 24, 25, 26, 27, 28, 29, 30, 31, 32) on the Alzheimer's Care Unit (ACU). These s missed medication doses, missed nursing assessments including insulins, antipantihypertensives, seizure medications, heart medications, pain medications, nursugar level checks, neurological checks, and blood pressure checks. These mis assessments had the potential to cause the residents discomfort or pain, to exa medical conditions including blood pressure, cardiac and diabetic issues, increa and jeopardized the health and safety, resulting in Immediate Jeopardy. Addition ensure appropriate staffing coverage on three of five nursing units (ACU, 800/9) that medications, nutritional supplements or assessments were administered/coc physician order for 18 of 104 residents residing on those units (Residents 1, 3, 426, 27, 28, 30, 31, 39, 40). Findings include: During an interview with Employee 7 on January 10, 2023, at 9:05 AM Employer residents on the ACU unit did not receive all of their medications on December January 8, 2023, due to staffing shortages. Review of medication administration records and nursing progress notes reveal Resident 1: one nutritional supplement was not administered on December 25, | | |
| medications and two nutritional supplements were not administered on January Resident 2: two nutritional supplements and five medications were not administ Resident 3: five medications and two nutritional supplements were not administ and on January 8, 2023. Resident 4: eight medications and two nutritional supplements were not administ 2022, and on January 8, 2023. Resident 5: eight medications and one nutritional supplement were not administ Resident 6: 13 medications were not administered and one blood sugar check to December 25, 2022. (continued on next page) | to meet the needs of every resident; and have a licensed nurse in of facility staffing data, and resident and staff interviews, it was ide adequate and sufficient nursing staff to provide medication sisional standards of practice and physician orders for 32 out of 33, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 20 Alzheimer's Care Unit (ACU). These staffing failures resulted in a gassessments including insulins, antipsychotics, antibiotics, heart medications, pain medications, nutritional supplements, blood, and blood pressure checks. These missed medications and the residents discomfort or pain, to exacerbate behaviors and sure, cardiac and diabetic issues, increase the potential for seizures, esulting in Immediate Jeopardy. Additionally, the facility failed to three of five nursing units (ACU, 800/900 unit, 1300 unit) to ensure so rassessments were administered/completed timely and per esiding on those units (Residents 1, 3, 4, 7, 9, 13, 16, 17, 18, 21, 25, 17, 18, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The STREET ADDRESS, CITY, STATE, ZIP CODE 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) Resident 7: 12 medications and two nutritional supplements were not administered on December 25, 2022, and eight medications were not administered on December 25, 2022, and on January 8, 2023. Resident 8: eight medications 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 14: five medications were not administered on December 25, 2022. Resident 15: five medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 17: four medications were not administered on December 25, 2022. Furthermore, six medications and two nutritional supplement were not administered on January 8, 2023. Resident 17: four medications and one nutritional supplement 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 were not administered on December | | | | No. 0938-0391 | |
|--|---|--|---|---|--|
| 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) 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, and on January 8, 2023. Resident 10: 11 medications were not administered on December 25, 2022. Resident 11: five medications were not administered on December 25, 2022. Resident 12: six medications were not administered on December 25, 2022. Resident 13: five medications were not administered on December 25, 2022. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered 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. | | IDENTIFICATION NUMBER: | A. Building | COMPLETED | |
| 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. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0725 Level of Harm - Immediate jeopardy to resident health or safety Resident 8: 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 10: 11 medications were not administered on December 25, 2022. Resident 11: five medications were not administered on December 25, 2022. Resident 12: six medications were not administered on December 25, 2022. Resident 13: five medications were not administered on December 25, 2022. Resident 14: five medications were not administered on December 25, 2022. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 17: five medications were not administered on December 25, 2022. Resident 17: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 17: five medications were not administered on December 25, 2022. Resident 17: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 17: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 17: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 17: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 17: five medications were not administered on December 25, 2022. Resident 17: five medi | NAME OF PROVIDER OR SUPPLIER STREET AD | | STREET ADDRESS, CITY, STATE, ZI | ET ADDRESS, CITY, STATE, ZIP CODE | |
| SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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. Residents Affected - Some Resident 8: eight medications were not administered on December 25, 2022. Resident 9: eight medications were not administered on December 25, 2022. Resident 10: 11 medications 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. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications were not administered on December 25, 2022. Resident 16: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Furthermore, six medications and two nutritional supplements were not administered on December 25, 2022. Furthermore, six medications and two nutritional supplements were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Furthermore, six medications and two nutritional supplements were not administered on December 25, 2022. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022. Resident 18: two medications 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. | Gardens at West Shore, The | | • | | |
| 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 8: eight medications were not administered on December 25, 2022. Resident 10: 11 medications were not administered on December 25, 2022, and on January 8, 2023. Resident 11: five medications and one nutritional supplement were not administered on December 25, 2022. Resident 12: six medications were not administered on December 25, 2022. Resident 13: five medications were not administered on December 25, 2022. Resident 14: five medications were not administered on December 25, 2022. Resident 15: five medications were not administered on December 25, 2022. Resident 16: six medications were not administered on December 25, 2022. Resident 16: six medications 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 one nutritional supplements were not administered on January 8, 2023. Resident 17: four medications and one nutritional supplement 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 one nutritional supplements were not administered on December 25, 2023. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022. Resident 18: two medications were not administered on December 25, 2022, and on January 8, 2023. | For information on the nursing home's | plan to correct this deficiency, please conf | tact the nursing home or the state survey | agency. | |
| Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some 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 were not administered on December 25, 2022. Resident 16: six medications and one nutritional supplement were not administered on December 25, 2022. Resident 16: six medications were not administered 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. Resident 17: four medications and one nutritional supplement were not administered on December 25, 2022. Resident 18: two medications were not administered on December 25, 2022, and on January 8, 2023. | (X4) ID PREFIX TAG | | | on) | |
| 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) | Level of Harm - Immediate jeopardy to resident health or safety | Resident 7: 12 medications and two and eight medications and two nutring Resident 8: eight medications were Resident 9: eight medications were Resident 10: 11 medications and on Resident 11: five medications were nutritional supplement were not addressed and the Resident 14: five medications were nutritional supplement were not addressed and the Resident 15: five medications were Resident 16: six medications were checks following a fall were not commedications and two nutritional supplement 17: four medications and and on January 8, 2023. Resident 18: two medications were Resident 19: 13 medications were Resident 20: two medications were Resident 21: one medication and on and two medications and one nutritional supplement 22: 12 medications were Resident 23: six medications were Resident 24: seven medications were Resident 25: seven medications and 2022, and on January 8, 2023. Add completed as ordered on December | on nutritional supplements were not administered on December 25, 20 not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 ne nutritional supplement were not administered on December 25, 20 not administered on December 25, | ninistered on December 25, 2022, ered on January 8, 2023. 222. 222, and on January 8, 2023. ninistered on December 25, 2022. 223. ministered on December 25, 2022. 224. ministered on December 25, 2022. 225. ministered on December 25, 2022. 226. ministered on December 25, 2022. 227. ministered on December 25, 2022. 228. ministered on December 25, 2022. ministered on December 25, 2022. ministered on December 25, 2022, ministered | |

| | 1 | 1 | 1 | |
|--|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. Building | (X3) DATE SURVEY COMPLETED | |
| | 395223 | B. Wing | 01/12/2023 | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P 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 con | tact 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) | | on) | |
| F 0725 Level of Harm - Immediate | 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. | | | |
| jeopardy to resident health or safety | Resident 27: 12 medications were 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. | | |
| Residents Affected - Some | Resident 28: four medications were | e not administered on December 25, 20 | 022, and on January 8, 2023. | |
| | Resident 29: two medications were | e not administered on December 25, 20 | 22. | |
| | Resident 30: four medications were not administered on December 25, 2022, and five medications we administered on January 8, 2023. | | 022, and five medications were not | |
| | Resident 31: one medication was not administered on December 25, 2022, and on January 8, 2023. | | 2, 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. | | | |
| | revealed that on December 25, 202 | the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she ber 25, 2022, a scheduled nurse overslept and came in late, resulting in missed so revealed that she was sick and quarantining at home on the date in question. | | |
| | she revealed that she was schedul called into the facility early since co Employee 4 (Licensed Practical Nu | e interview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11: she was scheduled to come into the facility at 3:00 PM on December 25, 2022, but villity early since coverage was needed. She revealed that the scheduled nurse on the nsed Practical Nurse), had been quarantined due to COVID-19, was permitted to ret 22, but did not return on that date and did not notify anyone before the scheduled sh | | |
| | Review of employee timecard reve | aled that Employee 1 punched in at 11 | :46 AM on December 25, 2022. | |
| | stated that she reported to the 1300 Employee 2 (Registered Nurse Sup ACU. Employee 1 revealed that who medication passes were not complicated the Medical Director via OK. Employee 1 revealed that she records at that time. Employee 1 revealed that she records at that time. | confirmed that this was the time she arr 0 unit at that time. She then revealed the cervisor) sometime after lunch to assist the she arrived on the ACU unit, she dieted. She stated that around approximate to inform him of the missed medical began notification of responsible participated that she did not notify administration that they became aware of the concertification. | nat she received a call from t with passing medications on the scovered that morning and noon ately 1:30 PM - 2:00 PM she ations. She stated that his reply was as and documentation in resident ration of the missed medications on | |
| | (continued on next page) | | | |

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

| | | | 10. 0736-0371 |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | STREET ADDRESS, CITY, STATE, ZI 770 Poplar Church Road Camp Hill, PA 17011 | P CODE |
| For information on the nursing home's | plan to correct this deficiency, please conf | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | | on) |
| 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 Emp4 was scheduled for dayshift on the ACU on December 25, 2022. She also revealed that Employee 4 he been quarantined, was due to come back on that date, and hadn't notified anyone that she was not pla to return on that date. DON stated that she spoke with Employee 2 around 8:30 AM - 8:45 AM to discue Employee 4 had not shown for her shift. DON stated that she advised Employee 2 to call Employee 1. 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 ge contact with Employee 1. DON states she finally reached Employee 1 somewhere between 8:30 AM - AM, at which time Employee 1 told DON she was on her way. DON stated did not know if she was act enroute at that time. DON revealed that after she found out Employee 1 was coming in, she dropped it she figured they were covered. DON revealed that she did not realize medications were not administer 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 revealed that she was scheduled to work from 7:00 AM to 7:00 PM on December 25, 2022. She reveal she was assigned as house supervisor and was also assigned a medication cart on the 1300 unit. Emp 2 revealed that she contacted the DON at 7 something to inform her that Employee 4 did not show for shift on the ACU. Employee 2 stated that DON informed her that she wound attempt to contact Employ since she had said she could work. Employee 2 stated she did not wait around to see if Employee 4 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 that Employee 1 reported to work around 12:00 PM. She stated that Employee 1 reported to t | | or revealed that Employee 4 had anyone that she was not planning at 8:30 AM - 8:45 AM to discuss that ployee 2 to call Employee 1. DON ork because she was not yet ications, she attempted to get in newhere between 8:30 AM - 9:30 It did not know if she was actually as coming in, she dropped it since dications were not administered 2. Inuary 12, 2023, at 10:46 AM, she cember 25, 2022. She revealed on cart on the 1300 unit. Employee Employee 4 did not show for her and attempt to contact Employee 1 bound to see if Employee 2 stated on cart on the 1300 unit. She stated that she ch Employee 1. Employee 2 stated on yee 1 reported to the 1300 unit revealed that she was on the ACU to see what could still be given. CU. When Employee 1 arrived on ician know medications weren't ian. Employee 2 stated she was been split the responsibility of ployee 2 revealed she was aware yisician earlier to notify of these to see what could still be 2 PM, she confirmed a staffing at of the situation, and that he alled that this was done and, for the other medications were also |

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

(continued on next page)

Facility ID: 395223

If continuation sheet Page 10 of 22

| MMARY STATEMENT OF DEFICE the deficiency must be preceded by e Nursing Home Administrator (led treatment administration that copardy template on January 10, 20 and January 10, 2023, at 6:24 PM, the facility is maintaining sufficient ditional shifts and incentives and atments are administered timely | full regulatory or LSC identifying information NHA) and DON were notified of the concurred on December 25, 2022, and w 2023, at 3:35 PM. An immediate action the facility's immediate action plan was not licensed nursing staff on site during a dutilizing agency staff to provide nursing as per physician orders. | agency. on) accern regarding missed medication ere provided with the immediate plan was requested at that time. accepted, which included: all nursing shifts by offering g care including medications and |
|---|---|--|
| MMARY STATEMENT OF DEFICE the deficiency must be preceded by e Nursing Home Administrator (I defined the administration that copardy template on January 10, 2011). In January 10, 2023, at 6:24 PM, The facility is maintaining sufficient ditional shifts and incentives and atments are administered timely the identified residents were review. | CIENCIES full regulatory or LSC identifying information NHA) and DON were notified of the conscurred on December 25, 2022, and w 2023, at 3:35 PM. An immediate action the facility's immediate action plan was not licensed nursing staff on site during a distribution of the distribution of the provide nursing as per physician orders. ewed to determine any negative effects | on) acern regarding missed medication ere provided with the immediate plan was requested at that time. accepted, which included: all nursing shifts by offering g care including medications and |
| e Nursing Home Administrator (I d treatment administration that opardy template on January 10, 20 n January 10, 2023, at 6:24 PM, The facility is maintaining sufficient ditional shifts and incentives and atments are administered timely | full regulatory or LSC identifying information NHA) and DON were notified of the concurred on December 25, 2022, and w 2023, at 3:35 PM. An immediate action the facility's immediate action plan was not licensed nursing staff on site during a dutilizing agency staff to provide nursing as per physician orders. | accern regarding missed medication ere provided with the immediate plan was requested at that time. accepted, which included: all nursing shifts by offering g care including medications and |
| d treatment administration that operated template on January 10, 20, and January 10, 2023, at 6:24 PM, the facility is maintaining sufficient ditional shifts and incentives and atments are administered timely the identified residents were review. | occurred on December 25, 2022, and was 2023, at 3:35 PM. An immediate action the facility's immediate action plan was not licensed nursing staff on site during a dutilizing agency staff to provide nursing as per physician orders. | ere provided with the immediate plan was requested at that time. accepted, which included: all nursing shifts by offering g care including medications and |
| edications, they will have a Medications, they will have a Medications, they made aware. I be made aware. I definition aware. I definition aware staff will ensure the ministrative staff will be contacted aff to meet these needs. I definition aware administered timely edication errors caused by omitted at shift. I he NHA and DON were educated provide medications and treatments are medications and treatments are administered by the NHA, or designee will audited to DON, NHA, or designee will audited to QAPI for review and further and January 12, 2023, at 10:35 AM at the immediate action plan had the Pa. Code 211.12 (a)(c)(d)(1)(4) Pa. Code 201.18 (b)(1)(3)(e)(1) | be evaluated for signs and symptoms of cation Error Report completed, and the eappropriate number of nursing staff and and the on-call system will be implended and the on-call system will be implended as per physician orders, and that resided medications. Any new staff will be easied on January 10, 2023, on ensuring sugents per physician orders. It missed medication reports every shift treatments are administered timely as parther recommendations. In the Immediate Jeopardy was lifted during the implemented. (5) Nursing Services (2)(3)(6) Management | of adverse reactions to missed physician and responsible party are provided daily. If not, mented also utilizing administrative densuring medications and lents will be free from significant ducated prior to the start of their discrete from the start of their discr |
| | I be made aware. Administrative staff will ensure the ministrative staff will be contacted off to meet these needs. Current licensed nursing staff will atments are administered timely edication errors caused by omitted at shift. The NHA and DON were educated provide medications and treatments are administered timely edication errors caused by omitted at shift. The NHA and DON were educated provide medications and treatment endowed to ensure medications and treatment endowed to QAPI for review and further and the immediate action plan had at the immediate action plan had Pa. Code 211.12 (a)(c)(d)(1)(4) Pa. Code 201.18 (b)(1)(3)(e)(1) | administrative staff will ensure the appropriate number of nursing staff and ministrative staff will be contacted and the on-call system will be implement to meet these needs. Current licensed nursing staff will be educated by January 12, 2023, on a state at a dministered timely as per physician orders, and that residedication errors caused by omitted medications. Any new staff will be educated. |

| | | | NO. 0936-0391 |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLII Gardens at West Shore, The | NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | | P CODE |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICE | CIENCIES full regulatory or LSC identifying informati | on) |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | Ensure that residents are free from 37116 Based on clinical record review and accepted professional standards at significant medication errors for 29 14, 15, 16, 17, 18, 19, 20, 21, 22, 2 resulted in an Immediate Jeopardy residents discomfort or pain, to exacardiac and diabetic issues, increas of 33 residents reviewed. Findings include: Review of Resident 2's clinical recordisturbance (loss of memory, languate to interfere with daily life), psychotic disorganized speech and behaviors pressure). Orders included dilitiazer disorder, and Namenda (used to transcript of the professional processional processiona | full regulatory or LSC identifying information of the significant medication errors. It is significant medication errors. It is staff interviews, it was determined that and principles for administering medication out of 33 residents sampled (Resident 23, 24, 25, 27, 28, 29, 30, 31, 32) on the situation since the missed medications acerbate behaviors and medical conditions are the potential for seizures, and jeopal ord revealed diagnoses that included deage, problem-solving, and other thinking disorder (a mental state marked by local significant and in the problem of the potential state marked by local significant and in the problem of the pr | at the facility failed to follow fons to ensure the prevention of is 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, at ACU (Alzheimer Care Unit). This is had the potential to cause the ons including blood pressure, rdized the health and safety of 29 rementia with behavioral ing abilities that are severe enough isso of contact with reality, and hypertension (high blood tipsychotic) daily for psychotic root administered these realign depressive disorder (mental across most situations) and gen and nutrient to a part of the reality). Orders included venlafaxine root administered the rescular dementia. Orders included root receive the aforementioned receive the aforementioned |
| | | | |

| | | | NO. 0930-0391 |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | ion) |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | Review of Resident 6's clinical recoresults from insufficient production disturbance, major depressive disconsideration, metoprolol two times peresive of dishillation, metoprolol two times peresive of medication administration december 25, 2022. It also revealed Novolin, or Zyprexa in the morning Review of Resident 7's clinical reconsideration and cerebral infarction the arteries supplying blood and oxiday for cerebral infarction, and Zyprexa of the aforementioned medications. Review of Resident 8's clinical reconsideration of the aforementioned medications. Review of Resident 8's clinical reconsideration of the aforementioned medications. Review of Resident 8's clinical reconsideration disorder that causes problem disturbance, major depressive disorderation, escitalopram (antide (antipsychotic) two times a day for Review of medication administration escitalopram on December 25, 2022. Review of Resident 10's clinical reconsideration, and hypertension. Orders for major depressive disorder, lising day for Alzheimer's. Review of medication administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration of Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administered the morning dose of the Review of Resident 11's clinical reconsideration administration celexa, and lisinopril-hydrochlorothy administration celexa, and lisinopril-hydrochlorothy | ord revealed diagnoses that included type of insulin, causing high blood sugar), corder, and atrial fibrillation (irregular heap pressive disorder, Eliquis (anticoagular reday for hypertension, Namenda two the ellitus, and Zyprexa (antipsychotic) two an record revealed that Resident 6 was ad that Resident 6 was not administere on December 25, 2022. Ford revealed diagnoses that included described for the brain). Orders included apprexa two times per day for dementia we have record revealed that Resident 7 was non December 25, 2022. Ford revealed diagnoses that included A is with memory, thinking and behavior) order, and hypertension. Orders included pressant) daily for major depressive disdementia with behavioral disturbance. For record revealed that Resident 8 was 22. It also revealed that Resident 8 did cord revealed diagnoses that Alzheimes included amlodipine daily for hyperter opril-hydrochlorothiazide daily for hyperter opril-hydrochlorothiazide daily for hyperterson record revealed that Resident 10 was niazide on December 25, 2022. It also revealed that Resident 10 was niazide on December 25, 2022. It also revealed that Resident 10 was niazide on December 25, 2022. It also revealed diagnoses that included record revealed diagnoses that Resident 10 was niazide on December 25, 2022. It also record revealed diagnoses that included record revealed diagnoses that included record revealed diagnoses that Resident 10 was niazide on December 25, 2022. It also record revealed diagnoses that included record revealed diagnoses that included record revealed diagnoses that Resident 11 was not record revealed diagnoses that Resident 11 was not record revealed that Resident 11 was not record reve | rpe 2 diabetes mellitus (condition dementia with behavioral art beat). Orders included Zoloft att) two times a day for dementia, Novolin imes a day for dementia, Novolin of times a day for dementia with a day for dementia with a day for dementia with a mot administered the Zoloft on dementia with behavioral disturbance. The sementia with behavioral disturbance and disturbance and disturbance. The sementia with behavioral disturbance and dementia with behavioral disturbance. The sementia with behavioral dementia with behavioral dementia with behavioral dementia with dementia with dementia dementia dementia with dementia dementia dementia with dementia dementia dementia with dementia dementia dementia dementia with dementia dementia dementia with dementia dementia dementia with dementia dementia dementia with dementia |
| | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC | CIENCIES full regulatory or LSC identifying informati | on) |
| 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 reading 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. | | s not administered the hypertension and anxiety disorder addor fear in reaction to current for anxiety, Losartan two times a so not administered the morning cember 25, 2022. chizophrenia (mental disease elelings of persecution), and memantine daily for so not administered the dementia, psychotic disorder, and |
| | Zoloft daily for major depressive dis Review of medication administration Zoloft, nor the morning dose of que Review of Resident 17's clinical reconstruction included Risperdal daily for psychological Review of medication administration morning dose of depakote on Decensia Review of Resident 18's clinical reconstruction included psychosis. Orders included the construction of the cons | cord revealed diagnoses that included on sis and depakote two times per day for n record revealed that Resident 17 was | for psychosis. s not administered depakote and dementia and psychosis. Orders mood stabilization. s not administered Risperdal nor Alzheimer's disease and |

| | | | NO. 0936-0391 |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | ion) |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | Review of Resident 19's clinical recorders brings severe high and low moods heart disease of the native coronar depressive disorder. Orders include (used to prevent chest pain) daily for muscles receive insufficient oxyger two times a day for bipolar disorder. Review of medication administration mg, isosorbide nitrate, and Zoloft of administered the morning dose of the Review of Resident 20's clinical recording disorder (result of damage to nerved difficulties in thinking and behaviors (antidepressant) daily for frontotemenisodes. Review of medication administration morning dose of depakene on Decordinal Review of Resident 21's clinical recording disorder (result of daily for major depressive of medication administration morning dose of depakene on Decordinal Review of Resident 22's clinical recordinal Review of medication administration December 25, 2022. Review of Resident 22's clinical recordinal recordinal Review of medication administration hydrochlorothiazide, or Zoloft on Deadministered the morning dose of recordinal Review of Resident 23's clinical rec | cord revealed diagnoses that included and changes in sleep, energy, thinking by artery (condition where arteries get in the depakote 125 mg daily for major de or angina (chest discomfort or shortnessin-rich blood), Zoloft daily for major depire, and Eliquis two times a day for deep on record revealed that Resident 19 was in December 25, 2022. It also revealed depakote 325 mg or Eliquis on that date cord revealed diagnoses that included the cells in the frontal and temporal lobes is normally controlled by these parts of apporal neurocognitive disorder and depire and record revealed that Resident 20 was ember 25, 2022. Cord revealed diagnoses that included the cells in the frontal and temporal lobes in record revealed that Resident 20 was ember 25, 2022. Cord revealed diagnoses that included the record revealed that Resident 21 was cord revealed diagnoses that included the tension, Zoloft daily for major depression record revealed that Resident 22 was ecember 25, 2022. Review also revealed metformin on December 25, 2022. Cord revealed diagnoses that included in the record revealed the afo | bipolar disorder (mental illness that g, and behavior), atherosclerotic larrow or hardened), and major pressive disorder, isosorbide nitrate is of breath caused when heart ressive disorder, depakote 325 mg vein thrombosis prevention. Is not administered depakote 125 that Resident 19 was not e. If of the brain that gradually causes the brain). Orders included Prozac akene two times per day for manic is not administered Prozac nor the major depressive disorder. Orders is not administered Zoloft on Alzheimer's, type 2 diabetes halapril daily for hypertension, we disorder, and metformin two is not administered enalapril, ed that Resident was not hypertension, major depressive in, metoprolol daily for hypertension, ive disorder. |
| | | | |

| | | | No. 0936-0391 |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by | CIENCIES full regulatory or LSC identifying informati | ion) |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | disorder, and pain in unspecified le for major depressive disorder, and Review of medication administratio Resident 24 on December 25, 2023 date. Review of Resident 25's clinical redementia with behavioral disturban Risperdal two times per day for der Review of medication administratio were not administered to Resident Review of Resident 27's clinical redementia with behavioral disturban leads to build-up of fluid in the lung major depressive disorder, rivastign dementia with behavioral disturban for congestive heart failure, and hyw. Review of medication administration administered to Resident 27 on Defurosemide and hydralazine were at Review of Resident 28's clinical redeisturbance, and delusional disorder what is real from what is imagined) disturbance and olanzapine two times Review of Resident 29's clinical redeisturbance and olanzapine two times Review of Resident 29's clinical redealth disorder that is marked by a delusions, and mood disorder sympincluded fluoxetine (antidepressant dementia. | n record revealed that Lexapro as well 25 on December 25, 2022. Ford revealed diagnoses that included a ce, hypertension, and congestive hear is and surrounding body tissues). Orderine patch (used to treat confusion relace, Toprol daily for hypertension, furos dralazine three times per day for hyper in record revealed that citalopram, rivast cember 25, 2022. Review also revealed also not administered on that date. Ford revealed diagnoses that included a cert (disorder in which a person holds fixed). Orders included escitalopram daily for esper day for delusional disorder. In record revealed that escitalopram as in December 25, 2022. Ford revealed diagnoses that included is combination of schizophrenia symptomotoms, such as depression or mania), and ally for schizoaffective disorder and in record revealed that the aforemention in record revealed that the aforemention is considered. | ly for hypertension, Lexapro daily three times per day for pain. Lexapro were not administered to entin was not administered on this major depressive disorder and major depressive disorder and as the morning dose of Risperdal major depressive disorder, trailure (weakness of the heart that res included citalopram daily for ated to Alzheimer's) daily for emide (diuretic) two times per day tension. Stigmine, and Toprol were not dithat the 2:00 PM doses of dementia with behavioral ed false beliefs and is unable to tell rementia with behavioral experience with the disorder (mental mental menta |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. Building | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|--|
| | 395223 | B. Wing | 01/12/2023 | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P 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 con | tact 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) | | on) | |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety | 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. | | | |
| Residents Affected - Some | 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. | | | |
| | | | | |
| | revealed that on December 25, 202 | th the Director of Nursing (DON) on January 10, 2023, at approximately 12:27 PM, she on the 25, 2022, a nurse overslept and came in late, resulting in a missed medication of that she was sick and quarantining at home on the date in question. Enview with Employee 1 (Licensed Practical Nurse) on January 11, 2023, at 11:45 AM, was scheduled to come into the facility at 3:00 PM on December 25, 2022, but was arly since coverage was needed. She revealed that the scheduled nurse on the ACU, Practical Nurse), had been quarantined due to COVID-19, was permitted to return on at did not return on that date and did not notify anyone before the scheduled shift. | | |
| | she revealed that she was schedul called into the facility early since co Employee 4 (Licensed Practical Nu | | | |
| | Review of employee time card reve | ealed that Employee 1 punched in at 11 | 1:46 AM on December 25, 2022. | |
| | Employee 1 stated that she reporter from Employee 2 (Registered Nursthe ACU. Employee 1 revealed that noon medication passes were not contacted the Medical Director via OK. Employee 1 revealed that she records at that time. Employee 1 re | aployee 1 confirmed that this was the tile of to the 1300 unit at that time. She there is Supervisor) sometime after lunch to a to when she arrived on the ACU unit, she completed. She stated that around apparet to inform him of the missed medical began notification of responsible participated that she did not notify administration that they became aware of the concertification. | en revealed that she received a call assist with passing medications on the discovered that morning and roximately 1:30 PM - 2:00 PM she ations. She stated that his reply was as and documentation in resident reation of the missed medications on | |
| | (continued on next page) | | | |
| | | | | |

| | | | NO. 0936-0391 | |
|---|---|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 | |
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | 770 Poplar Church Road | STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road | |
| | | Camp Hill, PA 17011 | | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | on) | |
| Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | 4 was scheduled for dayshift on the been quarantined, was due to com to return on that date. DON stated Employee 4 had not shown for her stated that she then called Employing feeling up to it. DON stated that, sin contact with Employee 1. DON stated AM, at which time Employee 1 told enroute at that time. DON revealed she figured they were covered. DO until it was discussed at morning must be figured that she was scheduled to she was assigned as house supervexially 2 revealed that she contacted the Eshift on the ACU. Employee 2 states ince she had a medication pass the followed-up with the DON via text at that Employee 1 reported to work as when she arrived and began to pass when Employee 2 stated that she request the ACU, Employee 2 revealed unaware of what the physician's renotifying the responsible parties an of missed morning medications on missed medications since she was administered. The Nursing Home Administrator (I immediate jeopardy template on Jathat time. On January 10, 2023, at 6:24 PM, 10. - The facility is maintaining sufficier additional shifts and incentives, util treatments, and ensuring these medications on the survey of the | the DON on January 12, 2023, at 8:35 at ACU on December 25, 2022. She alse back on that date, and hadn't notified that she spoke with Employee 2 around shift. DON stated that she advised Emee 4 who stated she did not come to whose Employee 2 was busy passing medies she finally reached Employee 1 son DON she was on her way. DON stated I that, after she found out Employee 1 of Norecaled that she did not realize medieting on Tuesday, December 27, 2022 (Registered Nurse Supervisor) on Jaco work from 7:00 AM to 7:00 PM on Devisor and was also assigned a medication DON at 7 something to inform her that I and that DON informed her that she wou. Employee 2 stated she did not wait are needed to be completed on another at 8:30 AM to see if she was able to real around 12:00 PM. She stated that Employes I look through missed medications at the Employee 1's assistance on the AC around 12:00 PM. She stated the physical sponse was. Employee 2 stated they find documenting in resident records. Employee 1 suggested they just let the physical sponse was. Employee 2 stated they the ACU, and had not contacted the physical sponse was. Employee 2 stated they the ACU, and had not contacted the physical sponse was. Employee 2 stated they the Indiana provide in the ACU, and had not contacted the physical sponse was and the Indiana provide nursing calculations are administered time. The facility's immediate action plan was and licensed nursing staff onsite during a sizing agency staff to provide nursing calculations and treatments are administered time ewed to determine any negative effects and treatments are administered time ewed to determine any negative effects. | o revealed that Employee 4 had anyone that she was not planning d 8:30 AM - 8:45 AM to discuss that ployee 2 to call Employee 1. DON ork because she was not yet dications, she attempted to get in newhere between 8:30 AM - 9:30 d did not know if she was actually was coming in, she dropped it since dications were not administered 2. anuary 12, 2023, at 10:46 AM, she cember 25, 2022. She revealed on cart on the 1300 unit. Employee Employee 4 did not show for her and attempt to contact Employee 1 ound to see if Employee 4 showed, and the she can be provided that she had been been as a she was on the ACU to see what could still be given. CU. When Employee 1 arrived on ician know medications weren't can. Employee 2 stated she was nen split the responsibility of propose 2 revealed she was aware any sician earlier to notify of these to see what could be still be come and were provided with the liate action plan was requested at accepted, which included: Il nursing shifts by offering are including medications and nely as per physician orders. | |

| STATEMENT OF DEFICIENCIES | | | |
|---|---|--|---|
| AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIE | <u> </u> | STREET ADDRESS CITY STATE 71 | ID CODE |
| | :K | STREET ADDRESS, CITY, STATE, ZI 770 Poplar Church Road | PCODE |
| Gardens at West Shore, The | | Camp Hill, PA 17011 | |
| For information on the nursing home's | plan to correct this deficiency, please con | tact the nursing home or the state survey | agency. |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by formation of the company | | CIENCIES full regulatory or LSC identifying informati | ion) |
| F 0760 Level of Harm - Immediate jeopardy to resident health or safety | 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. | | |
| Residents Affected - Some | | e appropriate number of nursing staff a d and the on-call system will be impler | |
| | 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) Manager | ment | |
| | 28 Pa. Code 211.9(d) Pharmacy se | ervices | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | No. 0938-0391 |
|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIE | FR | STREET ADDRESS, CITY, STATE, Z | IP CODE |
| Gardens at West Shore, The | | | 6652 |
| For information on the nursing home's | plan to correct this deficiency, please con | tact 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) | | ion) |
| F 0835 | Administer the facility in a manner | that enables it to use its resources effe | ectively and efficiently. |
| Level of Harm - Minimal harm or potential for actual harm | 37116 | | |
| Residents Affected - Some | 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. | | |
| | and January 8, 2023, revealed that administered, 190 medications were ordered as a result of no daytime nevealed that on January 8, 2023, | view of missed medication administratics on December 25, 2022, 17 nutritional renot administered, and 4 nursing assignates being available to pass medication 17 nutritional supplements and 77 med Dunit, and ACU due to insufficient nursing the control of the con | supplements were not essments were not completed as ons on the ACU. Further review lications were not administered to |
| | revealed that on December 25, 202 | or of Nursing (DON) on January 10, 20 22, a scheduled nurse overslept and ca d that she was sick and quarantining a | ame in late, resulting in missed |
| | she revealed that she was schedul called into the facility early since of Employee 4 (Licensed Practical Nu | Employee 1 (Licensed Practical Nurse) ed to come into the facility at 3:00 PM overage was needed. She revealed that urse), had been quarantined due to CO curn on that date and did not notify any | on December 25, 2022, but was at the scheduled nurse on the ACU, VID-19, was permitted to return on |
| | (continued on next page) | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

| enters for Medicare & Medic | and Services | | No. 0938-0391 |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2023 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZI | P 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 conf | tact 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) | | on) |
| F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Employee 1 confirmed that this was to the 1300 unit at that time. She th Supervisor) sometime after lunch to when she arrived on the ACU unit, completed. She stated that around text to inform him of the missed me she began notification of responsible revealed that she did not notify admiconfirmed that they became aware. During an additional interview with 4 was scheduled for dayshift on the been quarantined, was due to come to return on that date. DON stated the Employee 4 had not shown for her stated that she then called Employe feeling up to it. DON stated that, sin contact with Employee 1. DON stated that, at which time Employee 1 told enroute at that time. DON revealed she figured they were covered. DO until it was discussed at morning m. During an interview with Employee revealed that she was scheduled to she was assigned as house superv 2 revealed that she contacted the Eshift on the ACU. Employee 2 state since she had a medication pass the followed-up with the DON via text at that Employee 1 reported to work a when she arrived and began to pass when Employee 2 stated that she requesithe ACU, Employee 2 stated Employee 2 revealed unaware of what the physician's responsible parties an of missed morning medications on the state of the state of the state of missed morning medications on the state of the state of the state of missed morning medications on the state of morning medications on the state of the s | aled that Employee 1 punched in at 11 sthe time she arrived at the facility. Emen revealed that she received a call from assist with passing medications on the she discovered that morning and noon approximately 1:30 PM - 2:00 PM she dications. She stated that his reply was be parties and documentation in resident innistration of the missed medications of the concern at the next morning medicate that she spoke with Employee 2 around shift. DON stated that she advised Ember 4, who stated she did not come to we have Employee 2 was busy passing medicated that she she finally reached Employee 1 son DON she was on her way. DON stated that after she found out Employee 1 son DON she was on her way. DON stated that after she found out Employee 1 won revealed that she did not realize medicating on Tuesday, December 27, 202 (Registered Nurse Supervisor) on Jacob work from 7:00 AM to 7:00 PM on Decisor and was also assigned a medication at needed to be completed on another that DON informed her that she woul Employee 2 stated she did not wait are at needed to be completed on another that 18:30 AM to see if she was able to real round 12:00 PM. She stated that Employee 1 suggested they just let the physic stated Employee 1's assistance on the AC byee 1 suggested they just let the physic that Employee 1 contacted the physic stated Employee 2 stated they the documenting in resident records. Employee 4 documenting in resident records. Employee 2 stated that orders that Employee 2 stated they the documenting in resident records. Employee 1 suggested they pust let the physic state Employee 2 stated they the documenting in resident records. Employee 1 suggested they pust let the physic state Employee 2 stated they by the documenting in resident records. Employee 2 stated they by the documenting in resident records. Employee 2 stated they by the publications that Employee 2 stated they by the documenting in resident records. Employee 2 stated they by the publications the ACU and had not contacted the physic stated they by the publi | aployee 1 stated that she reported om Employee 2 (Registered Nurse e ACU. Employee 1 revealed that medication passes were not contacted the Medical Director via so OK. Employee 1 revealed that introcords at that time. Employee 1 on December 25, 2022, but eting. AM, she confirmed that Employee 1 on revealed that Employee 4 had anyone that she was not planning the si30 AM - 8:45 AM to discuss that ployee 2 to call Employee 1. DON work because she was not yet dications, she attempted to get in newhere between 8:30 AM - 9:30 that did not know if she was actually was coming in, she dropped it since dications were not administered 2. Anuary 12, 2023, at 10:46 AM, she cember 25, 2022. She revealed on cart on the 1300 unit. Employee 1 ound to see if Employee 4 showed, unit. She stated that she ich Employee 1. Employee 2 stated oyee 1 reported to the 1300 unit revealed that she was on the ACU to see what could still be given. CU. When Employee 2 stated she was nen split the responsibility of ployee 2 revealed she was aware ysician earlier to notify of these |

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 395223

If continuation sheet Page 21 of 22

| | | 01/12/2023 |
|--|--|--|
| NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The | | PCODE |
| to correct this deficiency, please cont | | agency. |
| | | on) |
| uring an interview with the Assistanortage on January 8, 2023. She restructed them to administer cardial esidents who received either diabed dministered. uring a later interview with the DC 023, they did not have sufficient standard to the sufficient standard to | ant DON on January 10, 2023, at 12:52 revealed that the physician was notified at and diabetic medications. She reveal tic or cardiac medications, all of their of the order of the control of the contro | PM, she confirmed a staffing I of the situation, and that he led that this was done and, for the ther medications were also she revealed that on January 8, arts. She revealed that the to cover medication carts. She lON revealed that it was known |
| La Carrier Car | Jammary Statement of Defice ach deficiency must be preceded by the deficiency of the def | orcrect this deficiency, please contact the nursing home or the state survey and MMARY STATEMENT OF DEFICIENCIES and deficiency must be preceded by full regulatory or LSC identifying informatic uring an interview with the Assistant DON on January 10, 2023, at 12:52 ortage on January 8, 2023. She revealed that the physician was notified structed them to administer cardiac and diabetic medications, all of their of iministered. Juring a later interview with the DON on January 12, 2023, at 11:07 AM, s 123, they did not have sufficient staff scheduled to cover all medication c sistant DON, unit manager, and one other agency nurse were called in vealed that one of the nurses was assigned two medication carts. The D at medication administration was going to be late for some of the resider systician was notified of the situation. B Pa. Code 201.18(e)(1) Management B Pa. Code 201.18(b)(1)(3) Management B Pa. Code 211.12(d)(1)(5) Nursing services |