STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395123	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Camp Hill, The	46 Erford Road Camp Hill, PA 17011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34631 Based on policy review, document review, and staff interviews, it was determined that the facility failed to protect the resident's right to be free from physical abuse by Employee 7 for one of six residents reviewed (Resident 4). Findings Include: A review of the facility's policy, titled Preventing Resident Abuse, revised November 28, 2016, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment that results in physical harm, pain or mental anguish. A review of Resident 4's clinical record revealed diagnoses that included schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder. Symptoms may occur at the same time or at different times. Cycles of severe symptoms are often followed by periods of improvement. Symptoms may include delusions, hallucinations, depressed episodes, and manic periods of high energy) and a history of a traumatic brain injury (Brain dysfunction caused by an outside force, usually a violent blow to the head). A review of the facility's Incident Report dated November 1, 2024, described an incident with Resident 4 and the Registered Nurse (Employee 7) in the following manner: Writer [Employee 4] witnessed aggression between staff member [Employee 7] and resident [Resident 4] came to nursing station in agitated mood and asking to see a doctor immediately, the nurse [Employee 7] sitting at nursing station started to have a verbal exchange with the resident and resident continued to get more escalated and agitated, at this point resident stood up and tried to push computer monitor off the nursing station where the nurse [Employee 7] was seated, nurse [Employee 7] was able to catch the monitor and prevented it from falling onto the floor, at this point the nurse [Employee 7] got up and walked around the nursing station and took a water pitcher off the medication cart and proceeded to pour the water over the resident, at this point writer [Employee 4] intervened and pulled resident away and took her back to her room, nursing staff assisted to change resident's clothes and cleaned her up. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Employee 7's witness statement dated November 1, 2024, read, [Resident 4] was very aggressive at the nursing station, [NAME] [threw] items on this nurse, resident stood up and pushed the desktop computer away on the floor. Redirection was not successful. I noticed that a shower helps her calm down, trying to take resident to shower was not successful, resident kept trowing [throwing] thing [s] from the nursing cart to this nurse. This nurse sprinkled water on resident to calm her down. Resident refused to get shower . An interview with the Registered Nurse (Employee 4) on November 12, 2024, at 10:26 PM, revealed he was present during the incident with Resident 4 and Employee 7 and described Employee 7 as agitated and involved in a back and forth with Resident 4. The interview also revealed Resident 4 does not take showers, prefers bed baths, and that he witnessed Employee 7 use the water pitcher and throw the water on the face of Resident 4. Employee 4 stated the water was thrown on the front side of Resident 4, resulting in the water hitting Resident 4's face and chest areas. Employee 4 also stated he and other nursing staff intervened and returned Resident 4 to her room. An interview with the Licensed Practical Nurse (Employee 8) on November 12, 2024, at 10:36 AM, revealed staff struggle to get Resident 4 to shower and that Resident 4 becomes agitated and staff have to reapproach. An interview with the nurse aide (Employee 5) on November 12, 2024, at 10:38 AM, revealed her presence during the incident with Resident 4 and Employee 7, and stated Employee 7 threw the water on Resident 4 and also agreed that Resident 4 does not usually take showers. Review of Resident 4's interdisciplinary plan of care revealed documentation of behaviors that included verbal and physical aggression. Staff interventions include please tell me what you are going to do before you begin. Also, speak to me unhurriedly and in a calm voice. Continued review of Resident 4's interdisciplinary plan of care revealed no interventions instructing staff to pour or throw water on Resident 4. Review of Resident 4's bathing documentation x 30 days revealed bed bath documentation only. There were no showers documented during those 30 days. An interview with the Director of Nursing on November 12, 2024, at 11:15 AM, confirmed Resident 4 is not care planned for water to be poured or thrown on her for deescalation and acknowledged Employee 7 would be responsible for the abuse of Resident 4. 28 Pa. Code 211.12 (d) (1) (2) (5) Nursing services

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34631 Based on document review and staff interviews, it was determined that the facility failed to ensure sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing related services to assure resident safety and care for residents with mental and psychosocial disorders and a history of trauma to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of six residents reviewed (Resident 4). Findings Include: Review of the facility's Registered Nurse Job Description dated December 11, 2023 and signed by Employee 7 read, Purpose of Your Job Description- Supervise day to day nursing activities of the facility. Such supervision must be in accordance with federal, state and local standard guidelines, and regulations that govern the facility, and may be required by the Director of Nursing Services, to ensure the highest quality care is maintained at all times. Also, Interact/communicate with residents, staff and visitors in a courteous manner. And Ensure that all residents are treated fairly, and with kindness, dignity and respect. A review of Resident 4's clinical record revealed diagnoses that included schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder. Symptoms may occur at the same time or at different times. Cycles of severe symptoms are often followed by periods of improvement. Symptoms may include delusions, hallucinations, depressed episodes, and manic periods of high energy) and a history of a traumatic brain injury (Brain dysfunction caused by an outside force, usually a violent blow to the head). Review of Resident 4's interdisciplinary plan of care revealed documentation of behaviors that included verbal and physical aggression. Staff interventions include please tell me what you are going to do before you begin. Also, speak to me unhurriedly and in a calm voice. A review of the facility's Incident Report dated November 1, 2024, described an incident with Resident 4 and the Registered Nurse [Employee 7] in the following manner: Writer [Employee 4] witnessed aggression between staff member [Employee 7] and resident [Resident 4] came to nursing station in agitated mood and asking to see a doctor immediately, the nurse [Employee 7] sitting at nursing station started to have a verbal exchange with the resident and resident continued to get more escalated and agitated, at this point resident stood up and tried to push computer monitor off the nursing station where the nurse [Employee 7] was seated, nurse [Employee 7] was able to catch the monitor and prevented it from falling onto the floor, at this point the nurse [Employee 7] got up and walked around the nursing station and took a water pitcher off the medication cart and proceeded to pour the water over the resident, at this point writer [Employee 4] intervened and pulled resident away and took her back to her room, nursing staff assisted to change resident's clothes and cleaned her up. (continued on next page)

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