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	03/26/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, homelike interior, and failed to ensure that bath linens were in good condition on two of two nursing units observed (first and second floor). Findings include: Observations made on March 26, 2025, at the noted times revealed the following: - 10:38 AM - The metal ring around the pipe coming out of the top of Resident 1's toilet was rusted and disintegrating. The towel/safety bars near the toilet were noted to have corrosion. The top of the heater unit under the sink had multiple rusty areas. - 10:40 AM - The wall outside of Resident 1's room had multiple dried liquid stains. - 10:40 AM - a washcloth in the first floor linen closet was observed to have visible brownish stains, and the corner of another was tattered. The towels in the linen closet were grayish-white in color. - 10:49 AM - The frame of the raised toilet seat in Resident 2's room was soiled and rusty. The paint on the post next to the shower and on the ceiling near the post was bubbled up and peeling in multiple areas. The towel and safety bars near the toilet were noted to have corrosion. The plate to the call bell cord next to the toilet was rusty. The heater next to the toilet had dried liquid streaks and chipped paint. - 11:10 AM - The frame of the raised toilet seat in Resident 4's bathroom was soiled, and an accumulation of dust and debris was present on the heater unit next to the toilet. - 11:12 AM - The threshold of Resident 5's bathroom was missing several tiles. Two large tiles were missing on the wall behind the toilet, the safety/towel bars were noted to have corrosion, and the heater unit next to the toilet had an accumulation of dried debris and dust. - 11:20 AM - towels and washcloths in the second floor linen closet were noted to be grayish-white in color. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11:21 AM - the toilet paper holder in Resident 6's bathroom was noted to be crooked on the wall. It did not appear to be in use as the toilet paper was mounted on another holder. The metal bars mounted on the wall were noted to have corrosion. - 11:25 AM - The wall next to Resident 7's bed had numerous dried brown spots. The floor at the base of the wall had areas of dried liquid. The heater next to the toilet in Resident 7's bathroom was badly rusted and the metal was disintegrating in some areas. Multiple tiles were missing from the floor next to the toilet. The safety/towel bars were noted to have corrosion, as did the leg of the sink counter. Dried brown spots were present on the floor coming out of the bathroom. A clear plastic bucket with a dried brown substance was sitting on the bathroom windowsill. During an interview with Resident 2 on March 26, 2025, at 10:49 AM, she expressed concern with the cleanliness of her room and bathroom. During a tour on March 26, 2025, at 12:00 PM, with the Director of Nursing, the aforementioned areas were observed, and she acknowledged the concerns. During an interview with the Nursing Home Administrator on March 26, 2025, at 12:39 PM, he confirmed that the was aware of the aforementioned concerns. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (e)(2.1) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on policy review, clinical record review, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide care and services in accordance with professional standards of practice to ensure the resident's highest level of well-being for one of four residents reviewed (Resident 11). Findings include: Review of facility policy, Medication Administration, undated, revealed, Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label .Residents are identified before medication is administered. Methods of identification include: a. Checking identification band, b. Checking photograph attached to medical record, c. If necessary, verifying resident identification with other facility personnel .Medications supplied for one resident are never administered to another resident. Review of Resident 11's clinical record revealed diagnoses that included Cauda Equina Syndrome (occurs when the bundle of the nerves at the lower end of the spinal cord are compressed causing pain, numbness, and incontinence) and infection of intervertebral disc (located between the vertebrae in the spine). Further review of Resident 11's clinical record revealed the following nursing progress note dated February 24, 2025, this writer was with orientation prepared resident medication. gave wrong resident the medication. notified supervisor, np [Nurse Practitioner], notified resident representative. [Nurse Practitioner] ordered vss q [Vital sign each] shift, monitoring bleeding x 3 days. Per email correspondence received from the Director of Nursing (DON) on March 26, 2025, at 11:35 AM, the following medications were provided in error to Resident 11 on February 24, 2025: Cholecalciferol Oral Tablet 50 MCG (vitamin supplement), cyanocobalamin Sublingual Tablet Sublingual 5000 mcg (vitamin B12), Iron 325 mg (supplement), Magnesium lactate 84 mg (mineral supplement), Mag ox 800 mg (supplement), Apixaban 2.5 mg (anticoagulant), Lasix 40 mg (diuretic), Keppra 500mg (anticonvulsant), Senna plus (laxative), and Metoprolol 25 mg (treats high blood pressure and other heart problems). Review of facility incident report and supporting documentation dated February 24, 2025, revealed that Employee 1 (Registered Nurse), who was being oriented by Employee 2 (Licensed Practical Nurse), prepared and administered the incorrect medications to Resident 11. Further review revealed that following the incident, Employee 1 and Employee 2 were re-educated by the DON and disciplinary action was taken. During an interview with the DON and Nursing Home Administrator on March 26, 2025, at approximately 12:45 PM, they were made aware of the concern with Resident 11's medication administration error. The DON revealed that an internal plan of correction was completed following this incident. Review of Resident 11's February 2025 Treatment Administration Record (TAR) revealed that following the incident, an order was written effective February 24, 2025, to monitor her vital signs each shift for three days. Further review of the TAR revealed that this was documented as being completed. No abnormal vital signs were recorded. It was also noted that Resident 11 was monitored for side effects, including bleeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following Resident 11's medication error, the facility reviewed incident reports for the two weeks preceding the error, and none were found. No medication error reports were present since the time of Resident 11's medication error on February 24, 2025. Review of an education sign-in sheet revealed that education was provided to licensed nursing staff on the Ten Rights of medication administration on March 10, 2025. A Medication Administration Test was administered to attendees on that date. Review of facility audits revealed that a medication administration competency checklist was completed during medication pass observation for two nurses during the weeks of February 24, 2025, and March 10, 2025, and four were completed during the week of March 19, 2025. Observations made and resident and staff interviews conducted during the onsite survey on March 26, 2025, failed to reveal any concerns with medication administration errors. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services