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	07/09/2025

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure the resident has a right to personal privacy and confidentiality, including the right to privacy in his or her oral communications, for one of 20 Residents reviewed (Resident 13). Findings include: Review of facility policy, titled Quality of Life- Dignity last reviewed June 5, 2025, read, in part, Residents private space and property shall be respected at all times. Staff will knock and request permission before entering residents' rooms. Staff shall promote, maintain, and protect resident privacy. During an interview with Resident 13 on July 7, 2025, at 9:51 AM, in her room, Employee 1 (Nurse Aide) came to her doorway, entered the room without permission, and proceeded to attempt to make her bed. Resident 13 looked over at Employee 1 and stated Honey, I am trying to talk to [the surveyor]. Employee 1 then exited the room and closed the door behind him. Further into interview with Resident 13 on July 7, 2025, at 9:54 AM, in her room, her door was swung completely open by Employee 2 (Nurse Aide), without knocking, peeking in or asking permission, Employee 2 replied I am so sorry and proceeded to drop an activity calendar off on the bedside table by the door and left. Resident 13 then stated, she does that because she wants to hear everything. During an interview with the Director of Nursing (DON) on July 8, 2025, at 11:31 AM, the surveyor revealed the concern with lack of privacy for Resident 13. The DON revealed her expectation that staff would treat all residents with respect, dignity, and privacy. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1) Nursing services

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 - Few	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 observations as well as resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like interior on one of two nursing units (second floor). Findings include: Interview with Resident 67 on July 7, 2025, at 7:11 AM, it was revealed that he utilizes the shower and the bathroom in his room and feel it should be cleaner. Observation in Resident 67's bathroom on July 7, 2025, at 7:11 AM, revealed there was a black substance on the floor at the base of the three walls in the shower, the shower chair had a black substance on the mesh material that attached to the arms and seat base, and the towel hanging on the toilet seat had a faded light brown stain. The wall vent to the left of the toilet contained a dried brown substance and a dark grey fuzzy substance, and the pipes at the ceiling and ceiling vent contained a dark grey fuzzy substance. Observation and interview with Director of Nursing (DON) on July 8, 2025, at 1:40 PM, in Resident 67's bathroom revealed it was in the same condition as documented above. The DON revealed that the aforementioned areas should be clean, and the towel should be changed out daily. Interview with the DON on July 8, 2025, at 2:10 PM, it was revealed that resident bathrooms should be cleaned daily. Observation on July 7, 2025, at 6:42 AM, and July 9, 2025, at 11:00 AM, with the DON in the 2nd floor dining room, revealed the blinds on two of the six windows were broken (slats missing or broken). Also, the wall unit air conditioner under the window on the left wall, as you enter the room, had half of an orange foam pool noodle filling the gap above the unit and a piece of crumpled paper filing the space to the right of the foam. The window above the air unit contained multiple cobwebs, dried grass, and bug nests. Interview with the DON on July 9, 2025, at 11:00 AM, revealed the blinds should be replaced and the window on the left wall as you enter the dining room should be cleaned. 28 Pa. Code 201.18 (e)(1)(2.1) Management

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on clinical record review and staff interview, it was determined that the facility failed to complete a significant change assessment after a significant change in health status was identified in one of 20 residents reviewed (Resident 80). Findings include: Review of Resident 80's clinical record revealed diagnoses that included congestive heart failure (decreased ability of the heart to pump blood effectively throughout the body) and hypertension (elevated/high blood pressure). Review of Resident 80's completed Minimum Data Sets (MDS - standardized assessment tool utilized to identify a resident's physical, mental, and psychosocial health needs) revealed the most recently completed MDS was a Quarterly MDS with an assessment reference date of May 6, 2025. Review of the Quarterly MDS revealed Resident 80 was not coded as having either significant weight loss (Section K), nor a pressure injury (Section M). After May 6, 2025, Clinical record review revealed Resident 80 was diagnosed with a stage III pressure ulcer (injury of the skin that extends below the layers of the skin) on May 13, 2025. On June 3, 2025, Resident 80 was identified as having a significant weight loss over the previous 30-day period (weight loss of 5% or more). At the time that the significant change in Resident 80's weight was identified, Resident 80 was still receiving treatment for an active stage III pressure ulcer. Review of Resident 80's MDS history revealed that the facility failed to initiate a Significant Change MDS within 14 days of identifying two significant changes in Resident 80's health status, which would be captured under section K and section M of the MDS. During a staff interview on July 9, 2025, at approximately 12:30 PM, Director of Nursing confirmed that no Significant Change MDS was completed for Resident 80. 28 Pa code 211.12(d)(1)(5) Nursing services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of Centers for Medicare and Medicaid RAI manual, and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 20 resident records reviewed (Residents 19 and 86). Findings include: Review of Resident 19's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), hyperlipidemia (high cholesterol), and dysphagia (difficulty swallowing). Review of Resident 19's clinical record revealed he had facility acquired pressure ulcers (wound that occurs when the skin and tissue are damaged by prolonged pressure), had a fall without injury on February 17, 2025, had a fall with an injury on February 27, 2025, and was receiving hospice services (end of life care). Further review of Resident 19's clinical record revealed he did not have any significant weight changes around the time of May 9, 2025. Review of Resident 19's Quarterly MDS (Minimum Data Set- an assessment tool to review all care areas specific to the resident such as a resident's physical mental or psychosocial needs) with ARD (assessment reference date- last day of the reference period) of May 9, 2025, revealed Resident 19 was coded for a significant weight gain, no for receiving hospice care, no for having any falls since the previous assessment, and was coded for having community acquired pressure ulcers. During an interview with Employee 4 (MDS Coordinator) on July 9, 2025, at 10:31 AM, she revealed Resident 19's MDS assessment with ARD of May 9, 2025, was coded inaccurately for his falls, pressure ulcers, hospice care, and weight gain, and she has since modified the assessment to revise the errors. Interview with the Director of Nursing (DON) on July 9, 2025, at 11:14 AM, revealed she would expect MDS assessments to be coded accurately. Centers for Medicare and Medicaid RAI manual (Resident Assessment Instrument- a standardized process is the basis for the accurate assessment of each nursing home resident) version 3.0, October 2024, chapter 3, page 42 read, in part, discharged status documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Review of Resident 86's clinical record revealed diagnoses that included dehiscence (split open) of closure of surgical wound, COPD, diabetes mellitus (chronic metabolic disease where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to high blood sugar levels) with polyneuropathy (damage to peripheral nerves on both sides of the body causing numbness, weakness and pain), artificial hip joint, history of falling, chronic kidney disease, and muscle weakness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 86 was admitted to the facility on [DATE], and billing was topped on June 7, 2025. Review of Resident 86's discharge MDS dated [DATE], documented a planned discharge return not anticipated to short-term general hospital (acute hospital). Further review of Resident 86's clinical record it was documented that she discharged home, in the community. Interview with the DON on July 9, 2025, at 11:10 AM, revealed the discharge MDS was coded incorrectly and it should've been coded for discharged to the community. 28 Pa. Code 211.5 Medical records

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, it was determined that the facility failed to ensure one of two medication storage areas observed were secure and access was limited to authorized personnel via a key (Second floor medication storage room). Findings include: During multiple observations on July 7, 2025, between 7:00 AM and 11:30 AM, it was observed that the door to the second story medication room was ajar. Further observation of the door revealed the door was prevented from fully closing due to the door catching on the door frame at the top. During the observations, staff were observed entering the second story medication room without the use of a key. On July 8, 2025,at approximately 10:05 AM, observation of the second story medication storage room revealed that the door was left ajar. At that time it was observed that no staff were present within line of sight of the medication room. At that time, the surveyor was able to access the medication storage room without a key. Observation of the medication room at that time revealed it stored multiple-dose containers of medications, injection supplies such as needles and syringes, and treatment supplies such as bandages and scissors. During an observation on July 8, 2025, at approximately 10:20 AM, while accompanied by the Director of Nursing (DON), Employee 5 was observed opening the second floor medication room door with out a key. During the observation, the DON confirmed that the facility was aware that the door did not fully close and lock as intended. During a staff interview on July 8, 2025, at approximately 11:45 AM, the DON revealed there was no outstanding work order to address the second story medication room door not closing and locking as intended. 28 Pa code 205.28(c)(3) Nurses' station

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility meal assessment form, completion of one meal test tray, and resident and staff interviews, it was determined that the facility failed to provide food and a beverage that were at a palatable and appealing temperatures at one of one meal observed. Findings include: Review of facility document, titled Nutrition Service Test Meal, revealed hot entrée, starch and vegetable should have a temperature of 135 degrees Fahrenheit (F- unit of measure) or above at the time of service, and cold beverages should be 40 degrees F or below at the time of service. Interview with Resident 67 on July 7, 2025, at 7:03 AM, he revealed his dislike for the food served at the facility, including the temperature, and that at times the steam table is not always functional. Interview with Resident 24 on July 7, 2025, at 7:59 AM, the Resident revealed that the hot food is not served hot. Interview with Resident 13 on July 7, 2025, at 9:50 AM, revealed her food is served cold sometimes at her meals. A test tray was completed on July 8, 2025, at 12:48 PM, upon the completion of lunch meal service on the 2nd floor with Employee 3 (Kitchen Supervisor). The tray came directly from the steam table on the unit and was tested within 2 minutes from service. The test tray consisted of Sliced Ham, Mashed Sweet Potatoes, [NAME] Beans, Coffee, and Milk. Employee 3 took the temperature of the food and beverages on the cart. The temperature of the ham was 107 degrees F, the temperature of the green beans was 109 degrees F, the temperature of the mashed sweet potatoes was 130 degrees F, and the temperature of the milk was 50 degrees F. Therefore, the food on the tray as well as the milk were not at appetizing temperatures. Interview with Employee 3 on July 8, 2025, at 12:51 PM, revealed the way the pans were arranged on the steam table created empty space in between the pans, which allowed for more heat to escape, and she planned to educate staff to ensure pans were arranged on the steam table properly. Interview with the Nursing Home Administrator on July 8, 2025, at 1:22 PM, the surveyor revealed the concern with the test tray evaluation. No further information was provided. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observations, and staff interview, it was determined that the facility failed to store food and beverages and utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of facility policy, titled Policy: Storage Areas last reviewed June 5, 2025, read, in part, The kitchen manager will retain temperature logs for 12 months. Plastic containers with tight-fitting covers must be used for storing cereals, flour, and broken lots of bulk food. All containers must be legible and accurately labeled and dated. Scoops are not to be stored in food or ice containers but are kept covered in a protected area near the containers. Observation in the main kitchen on July 7, 2025, at 6:38 AM, revealed a container of bran flake cereal labeled use by May 21, 2025. Observation in the four-door reach in refrigerator on July 7, 2025, at 6:40 AM, revealed seven beverage containers with various color beverages not labeled or dated. Further observation in the four-door reach in refrigerator on July 7, 2025, at 6:41 AM, revealed a pan of individual chocolate pudding not properly covered, and the pudding appeared to be dry on the top. Observation in the two-door reach in refrigerator on July 7, 2025, at 6:43 AM, revealed two containers of a brown beverage appearing not be iced tea, not labeled and date with a use by date of June 27, 2025. Further observation in the four-door reach in refrigerator on July 7, 2025, at 6:44 AM, revealed four containers of orange juice not labeled or dated. Observation in the walk-in freezer on July 7, 2025, at 6:45 AM, revealed a frozen water bottle and frozen energy drink belonging to kitchen staff, and a bag of frozen green beans not dated and appeared to be freezer burned. Observation in the main kitchen on July 7, 2025, at 6:48 AM, revealed a container of thickener with a scoop stored inside, one container of flour, open, not sealed properly and not dated, and one bag of open milk powder not dated. Review of temperature logs for the kitchen equipment dating back to October 2024, revealed the facility was unable to locate temperature logs for the dish machine from November 2024; the three pot sink from November 2024-March 2025; the two-door reach in refrigerator from November 2024-February 2025; the four-door reach in refrigerator from November 2024-February 2025; the walk-in refrigerator from November 2024-February 2025; the walk-in freezer from November 2024-February 2025; and the stockroom from October 2024-February 2025. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the dish machine temperature logs provided, dating back to October 2024, revealed wash and rinse temperatures failed to be recorded on January 31, 2025, at dinner; March 7, 2025, at lunch and dinner; and April 30, 2025, at dinner. Review of the two-door reach-in refrigerator temperature logs provided, dating back to October 2024, revealed temperatures failed to be recorded on October 25-31 in AM and PM; March 1-20, 22-24, and 26-31 in PM; and April 9-20 and 22-30 in PM. Review of the four-door reach-in refrigerator temperature logs provided, dating back to October 2024, revealed temperatures failed to be recorded on October 25-31 in AM and PM; and March 1-20, 22-24, and 26-31 in PM. Review of the walk-in refrigerator temperature logs provided, dating back to October 2024, revealed temperatures failed to be recorded on October 25-31 in AM and PM; March 1-20, 22, 23, and 26-31 in PM; and April 9-20 and 22-30 in PM. Review of the walk-in freezer temperature logs provided, dating back to October 2024, revealed temperatures failed to be recorded on October 25-31 in AM and PM; March 1-20, 22, 23, and 26-31 in PM; and April 9-20 and 22-30 in PM. Review of the stockroom temperature logs provided, revealed temperatures failed to be recorded on March 1-4, 2025; and May 29-31, 2025. Interview with the Nursing Home Administrator on July 8, 2025, at 11:25 AM, revealed it was the facility's expectation that food and beverages are labeled and dated per facility policy, and food items and kitchen equipment are stored, cleaned, and utilized in accordance with professional standards. 28 Pa. Code 211.6(f) Dietary services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and staff interview, it was determined that the facility failed to administer medications in a safe and sanitary manner for two of three residents observed during medication administration observation (Residents 7 and 24). Findings include: is there a policy? During medication administration observations conducted on July 8, 2025, at approximately 8:30 AM, Employee 5 was observed donning gloves. Employee 5 was then observed touching multiple services of the medication cart with gloved hands. Employee 5 was also observed retrieving a blood pressure cuff from the medication cart, entering the resident room and performing a blood pressure check on for Resident 7, which required touching Resident 7's skin. Employee 5 did not remove his soiled gloves after performing the blood pressure check on Resident 7. After exiting Resident 7's room, Employee 5 was observed preparing medications for Resident 7. During preparation of Resident 7's medication, Employee 5 was observed dispensing Vitamin D3 tablets from a multi-dose container into the lid of the multi-dose container. Then, using his soiled gloved hand, Employee 5 placed a finger on one of the Vitamin D3 tablets to prevent it from falling out while he poured one tablet into a medication cup. At approximately 8:39 AM, Employee 5 was observed administering the medications to Resident 7. After medication administration to Resident 7, Employee 5 was observed retrieving the blood pressure cuff from the medication cart and performing a blood pressure check on Resident 24, which required touching Resident 24's skin. At no time did Employee 5 change gloves or perform hand hygiene between residents. After Employee 5 obtained Resident 24's blood pressure, Employee 5 began preparing Resident 24's medication. During medication preparation, Employee 5 was observed dispensing Resident 24's medications into a medication cup. Employee 5 then informed the surveyor that Resident 24's medications would be crushed. Employee 5 was then observed retrieving a medication crushing packet. As Employee 5 was pouring Resident 24's medication tablets from the medication cup into the medication crushing packet, one round white tablet was observed to fall to the surface of the medication cart. Employee 5 was observed to use his soiled gloved hand to pick up the tablet and place it in the medication crushing packet. Employee 5 then proceeded to crush the medications. At approximately 8:52 AM, Employee 5 was observed administering the crushed medications to Resident 25. After which, Employee 5 then removed his gloves and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on July 8, 2025, at approximately 11:45 AM, Director of Nursing revealed that Employee 5 should not have handled Resident 7 and Resident 24's medications with gloves that had made contact with surfaces of the medication cart, the blood pressure cuff, or unclean surfaces. 28 Pa code 211.12(d)(1)(5) Nursing services