

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  02/22/2024
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47966</p> <p>Based on clinical record review, review of facility documentation, policies and procedures, as well as resident and staff interviews, it was determined that the facility failed to ensure residents were free from neglect for one of four residents reviewed (Resident 4).</p> <p>Findings include:</p> <p>Review of facility policy, titled Abuse Policy last reviewed September 23, 2023, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . as well as, The resident has a right to be treated with respect and dignity .</p> <p>Review of the clinical record for Resident 4 revealed diagnoses that included hypertension (high blood pressure) and anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities)</p> <p>Review of Resident 4's clinical record revealed a progress note created on February 10, 2024, at 4:30 PM, by Employee 1 (Registered Nurse) that said the following: Resident was last changed 13:00 [1:00 PM]. While giving meds at 16:30 [4:30 PM] she asked to be changed. Explained to the resident that we only have 2 CNAs [nursing assistants] for the entire 800 and 900 hall.</p> <p>Review of staffing information from February 10, 2024, revealed that there were actually 4 Nurse Aids working on the 800/900 hall.</p> <p>Review of Resident 4's bowel and bladder continence task documentation revealed that on February 10, 2024, it was documented that Resident 4 was provided incontinent care for bladder at 9:33 PM and incontinent for bowel at 9:34 PM.</p> <p>During an interview with Resident 4 on February 22, 2024, at 2:20 PM, she confirmed that she did not get changed in a timely manner and was left sitting in wet briefs for hours until someone came and changed her.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on February 22, 2024, at 2:36 PM, they confirmed they will be doing education with Employee 1, and that the DON checked Resident 4's bottom today and had no concerns. The DON and NHA revealed they would expect Resident 4 to have had incontinence care provided in a timely manner, and would expect staff to document in the Resident's clinical record under the tasks section any time incontinence care is provided to a resident.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(c) Nursing services.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>33879</p> <p>Based on clinical record review, document review, observations, resident and staff interviews, and facility policy review, it was determined that the facility failed to provide suprapubic catheter care and monitoring, which resulted in actual harm, as evidenced by an active infection requiring antibiotic treatment. The facility also failed to promptly initiate urology specialist recommendations for treatment of the infection for one of two residents reviewed for catheter use (Resident 2).</p> <p>Findings include:</p> <p>Review of current facility policy, titled Catheter Care, Urinary, last revised September 2014, revealed the policy purpose was to, .prevent catheter-associated urinary tract infections.</p> <p>Review of policy's subsection, titled Complications, revealed it included, If the resident indicates that his or her bladder is full or that he or she needs to void (urinate), notify the physician or supervisor.</p> <p>Review of the policy's Documentation section revealed the steps of documentation included, The following information should be recorded in the resident's medical record .The date and time that catheter care was given .The name and title of the individual(s) giving the catheter care .All assessment data obtained when giving catheter care .Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor .Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain .Any problems or complaints made by the resident related to the procedure .How the resident tolerated the procedure .If the resident refused the procedure, the reason(s) why and the intervention taken .The signature and title of the person recording the data.</p> <p>Review of Resident 2's clinical record revealed diagnoses that included neuromuscular dysfunction of the bladder (loss of bladder control due to brain, spinal cord or nerve problems) and hypertension (elevated/high blood pressure).</p> <p>Further review of Resident 2's clinical record revealed that, upon admission on October 27, 2023, Resident 2 had a suprapubic catheter (catheter inserted into the bladder through an incision in the abdomen used to drain the bladder of urine).</p> <p>Review of Resident 2's physician orders revealed an order for catheter care dated October 27, 2023. The order included instructions to cleanse the suprapubic catheter site with normal saline and to apply a dry dressing every shift. However, review of Resident 2's Treatment Administration Record (TAR - record of administered treatments that prompts staff to perform and document treatments) revealed that the order for cleansing and applying a dry dressing was not on the TAR. Further review of the clinical record revealed no evidence that Resident 2's suprapubic catheter was being cleansed and a new dressing applied per physician order.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee 2 (Licensed Practical Nurse - LPN) on February 22, 2024, at approximately 2:10 PM, Employee 2 displayed the TAR orders that were prompted for staff to perform for Resident 2. It was observed that the ordered catheter care for Resident 2 was not present in Resident 2's TAR.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 22, 2024, at approximately 2:30 PM, they revealed that Resident 2's order for catheter care was incorrectly transcribed into the electronic health record and, therefore, did not carry over to the TAR.</p> <p>Review of Resident 2's clinical record revealed no evidence that Resident 2 was receiving catheter care as ordered since admission on October 27, 2023.</p> <p>Observation of Resident 2's catheter insertion site on February 22, 2024, in the presence of Employee 2, at approximately 2:25 PM, revealed Resident 2 had no dressing to the catheter insertion site. Observation revealed a moderate amount of yellow-white drainage at the catheter site and on Resident 2's brief.</p> <p>During the observation, Employee 2 confirmed that there was no dressing to Resident 2's catheter insertion site.</p> <p>Further review of Resident 2's clinical record revealed that on December 5, 2023, Resident 2 was sent to the hospital with catheter related complications. Further review of Resident 2's clinical record revealed that he was treated for a urinary tract infection.</p> <p>Review of Resident 2's comprehensive plan of care revealed that on December 6, 2023, a care plan was initiated with a focus of, [Resident 2] has a urinary tract infection related to catheter use. The care plan included the interventions of, Administer meds as ordered .encourage increased fluid consumption .evaluate residents response to treatment and meds .observe characteristics of urine, color, odor, sediment.</p> <p>Review of Resident 2's urology consultation report from December 14, 2023, revealed [Suprapubic] tube not draining for three weeks per patient report. He reports voiding out of urethra. Seen in [emergency room ] 12/5/23 and started on [ciprofloxacin] for pyelonephritis [infection of the kidneys] . The report also noted that Resident 2's suprapubic tube was blocked. Recommendations included a follow-up in one month for a catheter change.</p> <p>Review of Resident 2's urology consultation report from January 18, 2024, revealed no concerns, recommendations to follow-up in one month for a catheter change, and instructions to contact urology with any catheter concerns.</p> <p>Review of the clinical record revealed no evidence of a urology consultation report for the visit in February 2024.</p> <p>During an interview with the NHA and DON on February 22, 2024, at approximately 2:00 PM, a request was made for Resident 2's February 2024 urology report.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>At approximately 2:30 PM, DON provided a urology consultation report for Resident 2's February 15, 2024, urology appointment titled Urology Outpt Note *Final Report*. When provided, the NHA revealed that the facility sends a report of consultation form with a Resident to outside services, and typically receives the form back with information provided by the consultative service. The facility then receives a typed report from the office within 7 to 10 days. The NHA confirmed there was no report of consultation from the February 15, 2024, urology appointment for Resident 2 in his clinical record.</p> <p>Review of urology consult report dated February 15, 2024, revealed, Today [Resident 2] presents for monthly [suprapubic] tube catheter changes. Further, the February 15, 2024, urology report stated, Resident 2 voided a thick pus like drainage from his urethra. There has been no urinary drainage from his [suprapubic] tube for two weeks. He reports voiding into a urinal. Bladder scan in office showed 296 [milliliters][of urine in Resident 2's bladder] and, [suprapubic catheter] tube removed with large amounts of pus-like drainage mixed with yellow urine. A new suprapubic catheter was inserted and it was noted that Resident 2 has another 25 ml of clumpy drainage. Due to pus drainage will send a urine culture and start him on antibiotics . The report also included recommendations to start ciprofloxacin twice a day for seven days, to obtain a urine culture, and to increase the catheter change to every two weeks.</p> <p>Review of Resident 2's physician orders failed to reveal any orders for antibiotics, urine culture, or catheter change since the February 15, 2024, urology consultation.</p> <p>During a Resident interview on February 22, 2024, at approximately 2:17 PM, Resident 2 expressed that he sometimes voids through his urethra into a urinal. Further, Resident 2 stated that he had not received his antibiotics that he was supposed to receive.</p> <p>During an interview with the DON on February 22, 2024, at approximately 3:30 PM, DON revealed that the facility did not have a urology consultation report from Resident 2's February 15, 2024, urology consultation, prior to the surveyor requesting the consult.</p> <p>During the interview, NHA revealed that staff should follow-up with outside consultative services when a report is not provided upon a Resident's return to the facility.</p> <p>The facility failed to follow facility policy, care planned interventions, and physician orders for catheter care and monitoring which resulted in failure to identify signs of infection and complications with Resident 2's suprapubic catheter. Additionally, the facility failed to implement urology recommendations to include: administration of antibiotics to treat an identified infection, obtainment of lab work, and an increase in the frequency of catheter changes.</p> <p>28 Pa code 201.18(b)(1) Management</p> <p>28 Pa code 211.12(d)(1)(3)(5) Nursing services</p>		