STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 37013 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of four residents reviewed (Resident 4). Findings include: Review of Resident 4's clinical record revealed diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and Nontraumatic Intracerebral hemorrhage (a type of stroke in which a ruptured blood vessel causes bleeding inside the brain). Further review of Resident 4's clinical record revealed that she had a fall on May 13, 2024, at 9:00 PM. Review of Resident 4's nursing progress note on May 14, 2024, at 11:00 AM revealed that Resident 4 was complaining of some tenderness to the right side of her forehead on palpation, with skin slightly raised in the area. Physician was notified with orders received for a head CT (computed tomography- a medical imaging technique used to obtain detailed internal images of the body). Review of Resident 4's nursing progress note dated May 14, 2024, at 3:35 PM revealed that the unit manager and provider rounded on the resident. Resident was at neurological baseline, Strength more evident in right side verses left side but per clinicals on admission, she favors the right side. Transport for CT sent. Orders for alert charting x 3 days placed for changes to mental status. Review of Resident 4's physician orders revealed an order, dated May 15, 2024, for a CT scan of the head, related to her fall on May 13. Review of Resident 4's clinical record on May 21, 2024, revealed no evidence that the CT scan had been completed. In an email correspondence from the Nursing Home Administator (NHA) on May 21, 2024, at 3:55 PM, he provided documentation that Resident 4's CT scan appointment was made on May 15, 2024 and it wasn't scheduled until June 21, 2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the NHA on May 22, 2024, at 9:39 AM, the surveyor questioned why the CT scan, which was ordered after Resident 4's fall, wasn't scheduled until June 21, 2024, over one month after the fall occurred. The NHA stated that the CT scan was not ordered stat. The surveyor also questioned if the physician was made aware that the CT scan was not scheduled to be done until June 21, 2024. The NHA stated he would need to follow up. Review of Resident 4's clinical record revealed no evidence that the physician was made aware that the CT scan was not scheduled to be done until June 21, 2024. Review of Resident 4's clinical record on May 22, 2024, at 12:19 PM, revealed an order, dated May 22, 2024, for a stat CT scan of the head. During an interview with the NHA on May 23, 2024, at 10:01 AM, he stated that Resident 4's CT scan order was changed to stat and the CT scan was done on May 22, 2024, which was negative. He stated there may have been some breakdown in communication which caused the delay in obtaining the CT scan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37013 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that residents received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection of a pressure ulcer for one of four residents reviewed (Resident 1). Findings Include: Review of Resident 1's clinical record revealed diagnoses that included unstageable pressure ulcer of the sacral region (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device; unstageable- full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured), hypertension (elevated blood pressure), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Further review of Resident 1's clinical record revealed that she went to an outpatient appointment with the wound clinic on April 30, 2024. Review of the wound clinic consult discharge instructions revealed recommendations for a wound vac (a type of treatment that helps a wound heal by applying a vacuum through a special sealed dressing) to the sacral wound, using Aquacel non-silver (a type of wound dressing), change every Monday, Wednesday and Friday. Review of Resident 1's physician orders revealed an order, dated May 1, 2024, if wound vac supplies unavailable, complete the following treatment: Cleanse wound with normal saline solution (NSS), apply NSS wet to dry dressing, secure with ABD pad (gauze pad) and tape. Review of Resident 1's corresponding eMAR notes for the wound vac revealed the following: May 1 at 1:11 PM- wound vac not available May 1 at 9:49 PM- awaiting supplies May 1 at 11:21 PM- wound vac not on at this time, awaiting supplies May 2 at 10:53 AM- awaiting on wound vac and supplies. Review of Resident 1's nursing progress notes revealed a note, dated May 2, 2024, at 2:41 PM, stating that the pharmacy was unable to get Aquacel without adhesive. The facility notified the wound clinic who stated to use calcium alginate without silver. Review of Resident 1's physician orders revealed an order, dated May 3, 2024, to cleanse wound with NSS, apply calcium alginate non-silver (a type of dressing used for wounds) to area with bone exposed and black foam in base of wound, change Mondays, Wednesdays and Fridays. Review of Resident 1's Treatment Administration Record (TAR), dated May 2024, revealed that Resident 1's wound vac was not applied until May 6, 2024, at 5:18 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's corresponding eMAR notes for the wound vac revealed the following: May 3 at 10:18 AM- wound vac supply on order May 3 at 11:36 PM- wound vac not on at this time; awaiting supplies May 4 at 3:40 PM- awaiting supplies May 4 at 10:27 PM- awaiting supplies May 5 at 7:31 PM- wound vac not on at this time May 6 at 5:18 AM- wound vac applied. During an interview with the Nursing Home Administrator (NHA) and Employee 1, on May 20, 2024, at 1:32 PM, they stated that they had difficulty obtaining the wound vac supplies from central supply and the pharmacy so they had to reach out to a different wound care team who then supplied the required wound vac supplies. On May 20, 2024 at 1:35 PM, May 21, 2024 at 11:12 AM, and May 22, 2024, at 9:39 AM, surveyor requested evidence showing the attempts to get the wound vac supplies between May 1 and May 6, evidence that pharmacy and central supply did not have the wound vac supplies available, and evidence showing the eventual receipt of the wound vac supplies and where they came from. In a follow up interview with the NHA and Employee 1, on May 23, 2024, at 10:01 AM, they stated that the unit manager who was attempting to get the wound vac supplies is no longer employed at the facility and they were unable to provide evidence showing the facility's attempts to get the supplies. They stated that the wound vac supplies were eventually supplied by the wound care team who was coming into the facility to assess Resident 1's wound. At this time, they acknowledged that the wound vac wasn't placed until May 6, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.