| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395223 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gardens at West Shore, The | 770 Poplar Church Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on facility policy review, clinical record review, review of select facility documents, and staff interviews, it was determined that the facility failed to ensure each resident the right to be free from neglect, which resulted in actual harm as evidenced by superficial incontinence associated dermatitis for one out of three residents reviewed (Resident 2). Findings include:Review of facility policy, titled Abuse Policy read, in part, The resident has the right to be free from neglect. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of Resident 2's clinical record revealed diagnoses that included major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and hypertension (high blood pressure).Review of Resident 2's comprehensive care plan revealed a focus area of at risk for skin breakdown and pressure injury development related to incontinence, mobility deficit, last revised September 1, 2022, with an intervention for assist with AM/PM care as needed and report abnormal skin observations, initiated on May 25, 2022.Review of select documents detailed an incident on January 29, 2026, that read [Employee 3] (Nurse Aide) was just starting her evening shift when resident, [Resident 2], rang her call bell. [Employee 3] went to room to answer call bell. [Resident 2] stated, ‘could you change my brief? I have not been changed since this morning.' Resident was found to be incontinent of both urine and bowel movement. Incontinence cares provided. RN notified. RN assessment revealed the presence of superficial incontinence associated dermatitis [a form of skin irritation caused by prolonged contact with urine or feces, leading to redness, swelling, and potential skin breakdown]. Zinc oxide order obtained and applied. Statements/interviews gathered. MD and resident representative notified. Nurse aide who was assigned day shift was [Employee 1], she has been suspended pending investigation. February 2, 2026, follow-up RN assessment to buttocks and peri-area reveals no open areas and decreased redness.Review of statement written by Employee 4 (Registered Nurse [RN]) revealed [Employee 3] summoned me to patient's room to report the condition of patient. Patient's bed was soaked from side to side; the brief was so soaked that it dripped. Diarrhea was caked from upper groin all the way to both thighs. Bilateral buttocks were bright red. Patient stated that she hadn't been touched since night shift. Patient stated that she is fearful of retaliation from this aide because she believes this aide will think she reported her.Review of statement written by Employee 2 (RN Supervisor) on behalf of Resident 2 read, [I] didn't receive care all day. Resident states she put her light on ‘before noon' and an aide answered it. She told the aide she'd had a bowel movement and needed changed. She said aide said, ‘I'll tell your aide.' She turned the light off and left the room. She further stated, ‘I don't even know who my aide is. She then described the aide to Employee 2. Review of statement from Employee 1 revealed<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview with [Employee 1], dated January 30, 2026, at 1:10 PM, [Employee 1] was called with union representative present. [Employee 1] was told there is an allegation of neglect from yesterday dayshift. [Employee 1] was asked about the cares she gave to [Resident 2]. She stated that Resident 2 was not in her [work assignment]. She did not give her any cares. The document was signed by the Director of Nursing. Included with the statement document was a nurse aide assignment sheet noting Resident 2 was part of Employee 1's work assignment for day shift on January 29, 2026. During an interview with the Nursing Home Administrator (NHA) on February 9, 2026, at 12:48 PM, he revealed the nurse aide assignments are created by licensed nursing staff and stored at the nursing stations. He further revealed it is the responsibility of nurse aides to review and understand their assignments prior to the start of their shift. Review of Resident 2's nurse aide task documentation failed to reveal nurse aide incontinence care was provided for her on dayshift on January 29, 2026. Employee 2 retrieved statements from all other residents in Employee 1's work assignment on January 29, 2026, and no other issues were identified. The facility substantiated neglect and Employee 1 was terminated following the investigation.Review of nursing progress note from January 29, 2026, at 4:33 PM, revealed, At change of shift today, resident was noted to have several areas of reddened, non-blanchable skin to her right buttock & right gluteal fold as well and her left buttock. The area was cleansed and zinc oxide applied. The resident does complain of mild pain in the area. She is offered Tylenol for comfort. Will continue to monitor areas and refer to the wound team if indicated. The provider and POA are aware.Review of nursing progress note from January 30, 2026, at 11:55 AM, revealed, RN assessment reveals skin to be intact with blanching redness to buttocks and rectal area. Resident at baseline is incontinent of bowel and bladder. Reviewed with provider, magic mix treatment order in place.Review of Resident 2's physician orders revealed an active order for Silver Sulfadiazine Cream 1 %, Apply to Buttocks/rectum topically every shift for Wound Care, dated January 30, 2026. Review of Resident 2's skin and wound note from February 3, 2026, revealed The patient was noted to have moisture trapped in her peri area and some redness. Recommend washing area with soap and water and pat dry thoroughly. Keep areas clean and dry and prevent skin to skin contact. Prevent excessive moisture and apply barrier protection as needed.Interview with the NHA on February 9, 2026, at 1:33 PM, revealed he would expect nurse aides to care for their assigned residents and residents to be free from neglect.The facility failed to ensure each resident the right to be free from neglect, which resulted in actual harm for Resident 2 as evidenced by superficial incontinence associated dermatitis.28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.29 (a) Resident rights |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility displayed past non-compliance by failing to provide adequate supervision to prevent an elopement of a resident identified as being at risk for elopement (Resident 3). Resident 3 was found in the street approximately 0.3 miles away from the facility. This failure placed a total of eight additional residents in an Immediate Jeopardy situation who were identified as at risk for elopement and not on a locked unit (Residents 6, 7, 8, 9, 10, 11, 12 and 13). Findings Include:Review of facility policy, titled Elopement, revised June 2023, revealed, It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement. Residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the premises of the facility without the knowledge and supervision of facility staff.Review of Resident 3's clinical record revealed diagnoses that included alcoholic cirrhosis of the liver (advanced, irreversible scarring of the liver caused by long-term heavy alcohol consumption, often resulting in liver failure), hepatic encephalopathy (a serious condition that occurs when the liver is unable to filter toxins from the blood. A buildup of toxins affects the brain's ability to function), and gastroesophageal reflux disease (GERD-when stomach acid flows back up into the esophagus and causes heartburn). Review of Resident 3's physician orders revealed an order, dated December 13, 2025, and discontinued February 5, 2026, for a wander guard to the right ankle (a bracelet that alerts staff by an alarm if they go beyond a specified area), check placement every shift and check functioning every night shift. Review of Resident 3's current physician orders revealed an order, dated February 5, 2026, for a wander guard to the left ankle, check placement every shift and check functioning every night shift. Review of Resident 3's care plan revealed an elopement care plan dated November 3, 2025, with a focus of Potential for elopement and associated injury related to exit seeking behavior. The resident is an elopement risk/wanderer AEB [as evidenced by] mood risk r/t [related to] expresses desire to go home. Review of the interventions revealed: assist in reorientation to room and facility using verbal cues and reminders; encourage group activity and attempt to keep occupied; provide diversional activities when exit seeking; redirect from exits as needed based on behavior; and wander guard device- check placement and function each shift.Further review of Resident 3's care plan revealed an intervention, dated February 27, 2025, Resident evaluated for safe outside. Requires direct supervision while outdoors, and an intervention dated January 23, 2026, for ambulation- one assist with walker.Review of Resident 3's elopement/wander risk evaluation, dated November 1, 2025, revealed a score of 9, meaning Resident 3 is a moderate risk. Review of Resident 3's incident report, dated February 4, 2026, at 8:45 PM, revealed that at 8:45 PM, Employee 2 (Registered Nurse [RN]) was made aware that Resident 3 could not be located on the unit. When Employee 2 arrived to the unit, a search was already underway. Staff also began searching the entire facility for the resident, to no avail. Resident had not signed out on the sign out sheet. At 8:55 PM, Employee 2 called Resident 3's cell phone, which went directly to voicemail. At 8:56 PM, Employee 2 called Resident 3's Responsible Party, who stated she did not know the whereabouts of Resident 3.Further review of the incident report revealed that, at that time, staff searched the outside perimeter of the building and Employee 4 (RN) drove to the local [NAME] store to search for Resident 3. Employee 4 called Employee 2 to notify her he had spoken to Resident 3's Responsible Party, who stated she spoke with Resident 3 and he said he was at [NAME], but was walking back to the facility. Employee 4 did not see Resident 3 between the<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | facility and [NAME]. Employee 4 drove in the opposite direction and at 9:10 PM, Employee 4 located Resident 3 in the street in the opposite direction, approximately 0.3 miles north of the facility and [NAME]. Resident 3 got into Employee 4's car without issues and Resident 3 was returned to the facility. The incident report further stated that upon returning to the facility, Resident 3 was noted to be warmly dressed in a long sleeve heavy T-shirt, flannel shirt and a winter coat, as well as a sweater hat and thick gloves. Resident 3 was also observed to be wearing thick trousers, socks and shoes. Resident 3 reported that he was going to [NAME] to buy something and to get some money out of the machine.Outside temperatures on February 4, 2026, for the facility's location, per online historical data, was high of 28 degrees F and a low of 16 F. It was also dark, and Resident 3 walked across a heavily trafficked roadway. Review of resident's clinical record revealed a nursing progress note, dated February 4, 2026, at 11:21 PM, stating Resident 3 was assessed by the RN. Resident 3 denied pain or discomfort, circulation and sensation are intact to all extremities. All skin was noted to be intact with no redness noted. Vital signs were within normal limits. Wander guard was applied to Resident 3's left ankle. The facility provided the surveyor with a picture of Resident 3 exiting the main entrance door of the facility, dated February 4, 2026, and timed 5:33 PM. In addition to the Resident in the picture, a second person can be seen around the corner, further up ahead of the Resident, on the sidewalk going towards the parking lot. That person was identified by the facility as Employee 5 (Assistant Housekeeping Director).Review of facility's investigation revealed an interview with Employee 5, conducted by the Nursing Home Administrator (NHA), undated. The interview revealed Employee 5 was asked if she observed Resident 3 standing in the lobby prior to exiting. Employee 5 stated that she observed some people/residents sitting in the lobby chairs but stated she did not observe anyone who resembled Resident 3. Review of Employee 4's witness statement, dated February 4, 2026, revealed that the Resident was last seen at dinner time. Nurse aide reported that the Resident had not been seen lately. Employee 4 stated that after searching the building, he drove to [NAME]. During the drive, Employee 4 spoke with Resident 3's Responsible Party, who had been in contact with Resident 3. The witness statement further stated that Resident 3 was lost and could not describe location. Employee 4 stated he found Resident 3 two blocks north of [NAME], walking on the street. Resident 3 got into Employee 4's vehicle and was returned to the facility. The witness statement further stated that Resident 3 stated that he was withdrawing money at [NAME] and that Resident 3 was wearing device on ankle. Review of Employee 6's (Nurse Aide) witness statement, dated February 4, 2026, revealed the Resident was last seen in his room at dinner time. Employee 6's statement further stated that she answered a call light for Resident 3's roommate, Resident 14. She stated that when assisting Resident 14, she asked him where his roommate, Resident 3, was. Resident 14 replied Don't know he's been gone a long time. Employee 6 stated she then went to the nurse's station to see if anyone else had seen Resident 3 and they said no.Review of Employee 2's witness statement, dated February 4, 2026, revealed she last saw Resident 3 at 5:30 PM when she was in his room interviewing him for another issue. She stated Resident 3 had eaten his dinner and staff were collecting trays. Employee 2 stated that Resident 3 was standing at the foot of his bed, using his walker and was noted to be fully clothed. Review of facility's telephone interview with Employee 7 (Receptionist) on February 6, 2026, at 2:39 PM, revealed that Employee 7 stated she did not notice anyone by the door, did not see Resident 3 go out the door, and did not take a break. During an interview with the NHA on February 9, 2026, at 10:15 AM, he stated that based on the facility investigation, it was determined there was an issue with the wander guard system at the door, and the door did not alarm when the Resident exited, even though he was wearing a wander guard. He stated that the door is to alarm when someone<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | with a wander guard gets close to it, but they determined that the door was only alarming intermittently. He further stated that the door has a delay when closing so after the code is put in for the door to open, if someone else approaches the door prior to it closing, it will open again, without the code. He stated that it is not confirmed, but possible that Resident 3 could have gotten out the door because of that delay. During the interview, the NHA also stated that the door company has ordered parts to fix the door and until it is fixed, a staff member is assigned to sit at the door 24/7 to monitor anyone entering and exiting. The facility has also disabled the button at the receptionist desk that opens the door; therefore, the receptionist needs to go to the door and physically enter the code every time someone enters or exits the building. The NHA stated that they have also added signs to the door to remind staff and visitors to be mindful of anyone behind you when exiting, to ensure a resident is not following behind. Information provided by the facility indicated that there are eight additional residents identified as elopement risks that reside on the unlocked units (Residents 6, 7, 8, 9, 10, 11, 12 and 13). Review of the clinical records for Residents 6-13 revealed orders for a wander guard and to check placement every shift and function every night shift. The facility failed to provide adequate supervision to prevent an elopement. Camera footage confirmed that Resident 3 left the building on February 4, 2026, at 5:33 PM but was not noticed to be missing until approximately 8:45 PM. Resident 3 was found in the street approximately 0.3 miles away from the facility, approximately three hours and 40 minutes after exiting the facility.The NHA was provided the immediate jeopardy template on February 9, 2026, at 1:29 PM, and an immediate action plan was requested.The facility initiated immediate interventions on February 4, 2026, after the incident. Documents and actions provided by the facility to address the Immediate Jeopardy included: -Resident 3 had wander guard device replaced and an updated elopement evaluation. -Residents with active orders for wander guards had devices checked for function. House wide elopement scores were reviewed for accuracy and care plans in place as indicated. Elopement binder reviewed to include residents with wander guards. Door system was evaluated for function. -Door company scheduled to inspect door system function. Over-ride button behind reception to be taken out of operation until door function validated. Camera to be placed in lobby to capture area exiting through inside double doors. Signage placed on doors to check your surroundings. Door to be monitored 24 hours and will continue until door is repaired and function verified. -Education to staff on elopement policy. Education to reception staff on no over-ride button available and manual code must be entered to unlock the door. Education to staff that when entering code to open the door, monitor for residents attempting to exit before door fully closes. -Observational audits of lobby area to validate code entered and door monitored until fully closed. Door function to be checked weekly once door repaired. Wander guards to be checked for function every day on the 11-7 shift. The facility's plan, as noted above, was reviewed on February 9, 2026, during the onsite survey. On February 9, 2026, at 4:35 PM, the facility's immediate action plan was accepted, which included:-Resident 3 was returned to facility with no adverse outcome, a new wander guard was placed on resident, and a new updated elopement evaluation was completed on 2/5/26. -All facility residents with active orders for wander guards had devices checked for function. All facility resident elopement scores were reviewed for accuracy and that care plans were in place as indicated. Elopement binders were reviewed to include residents with wander guards. Completed on 2/5/26. -The over-ride button at the receptionist desk was disengaged until door/wander guard system is repaired. Service call placed to door company who arrived onsite 2/6/26, parts were ordered and repairs will be made by 2/13/26. A surveillance camera was installed in the lobby to continuously monitor lobby area. Signage was installed on lobby exiting doors to remind visitors/staff to check<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | surroundings when exiting facility. Building entrance door to be monitored continuously by receptionist/designee until repairs completed and door/system is fully operational. -Facility staff were re-educated on facility elopement policy. Facility reception staff were educated on the disabling of over-ride button until proper repairs are completed. Facility staff were educated on when exiting facility to be mindful of who is behind you when exiting. Completed on 2/6/26. -DON (Director of Nursing)/designee will conduct observational audits when door code is entered to ensure that door is monitored until fully closed three times per week for four weeks and then three times per month for two months. Maintenance Director/designee will conduct door/wander guard function audits weekly once door is repaired. Wander guard audits will be checked daily on 11-7 shift. Results to QAPI. -Date of Compliance February 6, 2026. Facility staff of different disciplines were interviewed during the onsite survey regarding the facility's Immediate Action Plan and demonstrated knowledge of education regarding the facility's elopement policy, that the over-ride button has been disabled, that staff are currently monitoring the main entrance door 24/7, and to be mindful of who is around when entering and exiting the facility. The Immediate Jeopardy was lifted on February 9, 2026, at 4:35 PM, after ensuring that the immediate action plan had been implemented. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on facility policy review, clinical record review, facility document review, and staff interviews, it was determined that the facility failed to maintain complete clinical records for one of 14 residents reviewed (Resident 3). Findings Include:Review of facility policy, titled Elopement, revised June 2023, revealed, Post Elopement/upon return to the facility, the Director of Nursing Services or Charge Nurse shall: complete and file an Incident Report; and Document the event in the resident's medical record.Review of Resident 3's clinical record revealed diagnoses that included alcoholic cirrhosis of the liver (advanced, irreversible scarring of the liver caused by long-term heavy alcohol consumption, often resulting in liver failure), hepatic encephalopathy (a serious condition that occurs when the liver is unable to filter toxins from the blood. A buildup of toxins affects the brain's ability to function), and gastroesophageal reflux disease (GERD-when stomach acid flows back up into the esophagus and causes heartburn). Review of facility reported incident revealed that on February 4, 2026, at approximately 8:45 PM, facility staff were unable to locate Resident 3. At approximately 9:10 PM, Resident 3 was found on the street approximately 0.3 miles away from the facility. Review of Resident 3's incident report, dated February 4, 2026, revealed a detailed description of Resident 3's elopement from the facility. Further review of the incident report revealed that at the bottom of the form, it read Privileged and Confidential-Not part of the Medical Record.Review of Resident 3's clinical record on February 9, 2026, at 9:48 AM, revealed no progress notes or any other documentation regarding Resident 3's elopement on February 4, 2026. During an interview with the Nursing Home Administrator (NHA) and Employee 13 (Regional Director of Clinical Services) on February 9, 2026, at 1:55 PM, Employee 13 stated she needed to confirm, but it is possible that when the nurse put the risk management note in the incident report, a button may not have been clicked for the note to populate into the clinical record. During a follow up interview with Employee 13 on February 9, 2026, at 2:21 PM, Employee 13 stated that the note on the incident report/risk management should have populated to the clinical record progress note but the button must not have been hit for the note to populate into the progress notes in the clinical record. 28 Pa Code 211.5(f)(ii)(iii) Medical records. |