

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/01/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment on 5 nursing units, the 2nd floor and the main facility hallway. Findings include: Review of facility policy, titled Housekeeping Administration, effective date March 2015, read, in part, Policy Interpretation 1. Conducts rounds daily for identification of areas of improvement. 4. Develops and maintains a cleaning schedule for common areas (lobby, dayrooms, hallways, dining areas, activity rooms, outside areas, etc.). 6. Assures dining rooms will be cleaned after each meal and special functions. Tour of facility conducted on June 1, 2026, from 10:50 AM - 12:00 PM revealed the following concerns: Main hall of the facility revealed the following: Painters' tape was being used to hold part of the baseboard to the wall. Cracked/crumbling plaster noted under the windows. A strong urine smell was noted. Dirt buildup was noted in the door jams, along baseboards, and behind handrails. The ACU (100/200 halls, dining room and residents' lounge) revealed the following: Multiple broken and stained tiles in the hallway ceiling. Dirty walls, dirt build up in door jams, along baseboards, and behind handrails. Multiple rooms were missing the floor transition strip from the hallway into the resident room and the floor tiles were chipped. Multiple windows in Residents' rooms were dirty with a film on them. Dirty cabinets and dirt buildup was observed on the floors and under the sink in the dining room. Holes were in the wall plaster in the dining room. The walls were dirty with various marks, the door had black marks on it, and there were dirty tables with food debris in the dining room. Dirty walls with broken plaster was in the resident lounge. There was an electrical outlet with no cover in the dining room. There were stains on the ceiling tiles in corner of the dining room. The electric baseboard heater vent was rusted in the dining room. The AACU (300/400 halls, dining room and residents' lounge) revealed the following: Multiple hallway ceiling tiles had black/pink fuzzy staining. Multiple walls had cracked and broken plaster. Multiple broken and stained tiles in the hallway ceiling. There were bugs in the hallway light covers. Doors at the end of the hallways were dirty. The walls were dirty with various marks, there was dirt build up in door jams, along baseboards, and behind handrails. Multiple rooms were missing floor transition strips from the hallway and there were chipped floor tiles. Multiple windows in Resident's rooms were dirty. In room [ROOM NUMBER], the ceiling appeared to be patched but was cracked on top of the patchwork. The AACU lounge had broken, stained and sagging ceiling tiles. The AACU lounge had various markings on the walls, dirt buildup in door jams and along the baseboards. The AACU dining room had dirt on the walls and cracked plaster. The AACU dining room had multiple stained ceiling tiles. The baseboard electric heaters on left and right side of the AACU dining room was missing the front cover with coils exposed. The base board heater on the right side of the room had wires exposed. There were exposed wires on the corner of the wall on left side of the room in the AACU dining room. The AACU dining room had multiple holes in the wall plaster throughout the room. The AACU dining room kitchen cabinet had multiple doors and drawer fronts missing. The ceiling in the AACU dining room was cracked and crumbling and the wall plaster had brown staining in the back right corner by the window and bulkhead. The 500 Hall revealed the following: Multiple (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 - Many	management platform for managing maintenance) report from March 2026 through current revealed that one TELS had been entered on May 13, 2026 regarding a missing outlet plate cover in the ACU dining room. No additional TELS had been entered for any of the aforementioned concerns. The above concerns were shown to the Nursing Home Administrator (NHA) during a tour of the facility on June 1, 2026 at 1:22 PM. The NHA stated the staining on ceiling tiles appeared to be moisture, and that the pink/black fuzzy staining could be anything. He stated that he cannot confirm that the staining is mold but would have maintenance replace the tiles. The NHA stated that ceiling tiles are replaced as needed and as concerns are reported. NHA stated that the missing electric based board heater covers are unacceptable and will be replaced immediately. He also stated that the cracked and crumbling plaster in the AACU dining room appears to be water damage and that he will have maintenance follow up. When shown the missing outlet cover in the ACU dining room, the NHA stated he was not sure if it had previously been replaced but that he would check with maintenance. He also stated that the cover will be replaced immediately. NHA stated that the second floor is used for storage and confirmed that facility's emergency drinking water is stored on the second floor. He stated that the sink water is left running so that the pipes do not freeze and that, since summer is coming, they will be shutting off the water. Follow up interview with the NHA at approximately 2:27 PM, revealed that the aforementioned ceiling tiles with pink, black, and fuzzy staining had been replaced and that maintenance was working on the other repairs. The NHA also stated that the second floor is licensed for 60 beds but has not been used in over a decade. An interview on June 1, 2026, at 2:54 PM, with Employee 1 (Maintenance Director) revealed that the electric base board heaters in the AACU dining room are not currently in use and that the exposed coils and wires do not have electric current unless the thermostat is turned on. Employee 1 stated he did not know if the outlet cover in the ACU dining room had been replaced since the TELS was entered on May 13, 2026. Pa. Code 207.2(a) Administration responsibility		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff for one out of three floors (2nd floor unit). Findings include: Tour of the facility conducted on June 1, 2026, from 10:50 AM - 12:00 PM, revealed the following concerns on the second floor: Multiple rooms with sink water running at a steady flow. Dirt, trash and debris scattered on the floor in all rooms and hallways observed. Broken and stained ceiling tiles were observed in all rooms and hallways. Multiple rooms with broken/missing ceiling tiles and those broken ceiling tiles lying on the floor. Toilets in multiple rooms observed with a thick, dried brown substance and paper in the toilets. Multiple rooms/bathrooms with sheets and towels observed on bathroom floors and wrapped around toilet and sink bases. Several rooms marked with signage stating, emergency water source. Stacked boxes of water observed in the rooms. Some boxes were smashed with crushed water bottles inside. Dirt and debris scattered throughout the rooms. Several rooms were used for equipment storage for wheelchairs, mattresses, bedside commode, and positioning devices. Mattresses heaped on piles restricting access to the room. A box of resident records was being used to prop open the door. One room marked for storage of current residents' belongings. Unsanitary conditions observed on the second floor of the facility made the unit uninhabitable for residents. The facility has not housed residents on the second floor for several years despite having licensed beds on that unit. The above concerns were addressed to the Nursing Home Administrator (NHA) on June 1, 2026, at 1:22 PM. NHA stated that the second floor is used for storage and confirmed that facility's emergency drinking water is stored on the second floor. He stated that the sink water is left running so that the pipes do not freeze and that, since summer is coming, they will be shutting off the water. The NHA revealed that they use the second floor for storing extra resident mattresses and wheelchairs, and larger equipment, as well as over flow for resident belongings. Follow up interview with the NHA at approximately 2:27 PM, revealed that the second floor is licensed for 60 beds but has not been used in over a decade. Pa. Code 207.2(a) Administration responsibility		