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	07/01/2026

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. Based on review of facility investigation, clinical record review, and staff interviews, it was determined that the facility displayed past noncompliance in its failure to ensure that abnormal test results were acted upon timely and in accordance with professional standards of practice for one of eight residents reviewed (Resident 6).Findings include: Review of Resident 6's clinical record revealed diagnoses that included fracture left hip, fracture right femur, fracture left femur, vascular dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), and history of falls. Further clinical record review documented Resident 6 sustained a fall on May 1, 2026; in-house x-rays of left and right hips and left and right femurs were obtained. Results of the x-rays revealed left hip fracture. The Resident was transferred to the hospital and underwent Internal Fixation (ORIF- surgical hardware [nails, screws] to stabilize a bone so it heals properly). Resident 6 sustained another fall on May 6, 2026, and no injuries were noted. Review of Resident 6's progress notes documented on May 7, 2026, during a follow-up Registered Nurse assessment post-fall that Resident 6 complained of lower left leg pain. At that time, an in-house x-ray of the left lower leg was completed. There was no evidence of fracture to the left tibia/fibula. On May 27, 2026, Resident 6 sustained another fall and no injury was noted. Further review of progress notes documented on June 5, 2026, revealed the Resident was noted to have blood in her urine. New orders were obtained for a urinalysis with culture and sensitivity and blood work. The facility attempted to obtain the urine sample via straight catheterization on June 6th, 7th, and 8th, 2026, and was unsuccessful. An abdominal x-ray obtained on June 8th, 2026, revealed a large round opacity (lacking transparency) emanating from the pelvis into the abdomen, moderate stool in the colon, mild degenerative disc disease (early age-related wear-and-tear of the spinal discs), ORIF left hip, and acute to subacute moderately displaced right intertrochanteric (top of the femur where the hip and leg meet) fracture. Employee 8 (CRNP-Certified Registered Nurse Practitioner) initialed the abdominal x-ray results on June 9th, 2026, and ordered MiraLAX and Dulcolax milk of magnesia; no acknowledgement/intervention for the right femur fracture. On June 9th, 2026, a STAT (immediate) order of an Ultrasound of the kidneys, ureters, and bladder was obtained and revealed left sided hydronephrosis and layering debris identified within the bladder with underlying mass not excluded. In response to the ultrasound, on June 9th, 2026, there was a new order for an urology consultation due to urinary retention and left-sided hydronephrosis. Review of the history and Physical completed by Employee 8, exam date June 9, 2026, read, in part, the Resident was seen and evaluated following retroperitoneal ultrasound results. Resident and nursing notes deny acute distress. Ultrasound reviewed showing left-sided hydronephrosis, significant bladder distention and layering bladder debris with underlying bladder mass not excluded. Plan discussed with nursing was to obtain a urology consultation for further evaluation, monitor for urinary output and assess for retention symptoms, consider bladder scan protocol and catheterization per facility protocol if clinically indicated, monitor for urinary tract infection, and consider CAT scan of the abdomen/pelvis and bladder as recommended by radiology, and to repeat labs (BMP/CMP) and monitor renal function on Friday. Summary of plan also included: ordered labs for Friday, check vitals if she allows, continue Physical and Occupational Therapy for precautions, neuro checks status post-fall, left hip fracture (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol as per orthopedic with follow up in two weeks, continue aspirin, left lower extremity weight bearing as tolerated, neuro checks initiate today after a fall no significant new injury. History and Physical was signed on June 11, 2026, and failed to acknowledge the right intertrochanteric fracture. Progress note, dated June 14, 2026, documented Resident 6 was noted to have vaginal bleeding with blood clots during care. Resident was transferred to the hospital at that time. Further review of progress notes documented the Resident returned to the facility on June 24th, 2026, and underwent ORIF to repair the right intertrochanteric fracture. Interview with Employee 9 (Regional Registered Nurse Coordinator) on July 1, 2026, at 1:30 PM, revealed that the CNRP initialed the abdominal x-ray, wrote orders and didn't address the right intertrochanteric fracture. Interview with Employee 8 on July 1, 2026, at 2:25 PM, it was revealed that her primary concern was Resident 6's bowel function, that is why the bowel meds were ordered. The Resident was on pain medication due to a hip fracture, with no increase to administration of as needed pain medication. Once the Resident had routine bowel movements and her bladder was emptied, Resident was feeling better and did acknowledge less pain. Resident wasn't getting out of bed at the time due to discomfort and her preference. It was also revealed that she should've been more concise in her note. Interview with Employee 9 on July 1, 2026, at 3:30 PM, revealed Employee 8 should've acknowledged the right intertrochanteric fracture in the physical. It was also revealed that nursing should've discussed the right intertrochanteric fracture with Employee 8. Prior to the survey the facility failed to acknowledge and address all aspects of an x-ray report. Resident 6 was noted to have a fractured right intertrochanter on June 9th, 2026, that wasn't addressed until she was sent to the hospital, due to rectal bleeding, on June 14th, 2026. Five days passed between initial diagnosis at the facility and Resident diagnosis and treatment at the hospital. On June 24, 2026, Resident 6 returned to the facility post-hospital admission for a rectal prolapse. Work up revealed an acute, displaced angulated right femoral neck fracture, and ORIF was completed. In an effort to prevent future incidents, the facility initiated a new procedure for all x-ray results to be reviewed at clinical meetings Monday through Friday, and x-ray results are to be communicated by the licensed staff to the Physician/CRNP immediately. Initiated June 22, 2026. Residents who had x-rays in the past 30 days were audited to ensure results were communicated to the physician/CRNP and Responsible Party, and to ensure no incidental findings of fractures. If a fracture is identified, it will be reviewed with the provider for any appropriate orders. No incidental fracture sere identified. Completed June 17, 2026. Licensed nursing staff were educated on review of x-ray results, communication to provider related to acute findings, and having report reviewed by clinical team in clinical meeting. Completed June 17, 2026.Audits of completed x-rays weekly, for three months, to ensure results reviewed by provider and in clinical meeting. Initiated June 20, 2026. During the onsite survey, a review of audits, staff education, and initiated procedures regarding x-ray results were reviewed and failed to reveal continued or additional concerns regarding x-ray results.Date of compliance June 22, 2026. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, observations, facility document review, staff interviews, and facility policy review, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement and exhibiting exit seeking behaviors (Resident 1). This failure resulted in an immediate jeopardy situation.Review of facility policy, titled Elopement, revised June 2023, read, in part, 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 by the State of Pennsylvania as a resident leaving a safe area of the facility without authorization. Federal guidance for elopement, as described in F689, is a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. Review of Resident 1's clinical record revealed diagnoses that included dementia (cognitive and memory changes that disrupt everyday function) and major depressive disorder (a serious, common mood disorder characterized by persistent sadness, loss of interest, and fatigue, lasting at least two weeks and impairing daily life). Review of Resident 1's plan of care revealed a focus area of: Resident has the potential for elopement and associated injury related to exit seeking behavior, with an intervention of: door alarms on at all times, and answer alarms promptly; with a date initiated of March 24, 2026; redirect from exits as needed based on behavior, initiated March 24, 2026; and wander guard device to right wrist-check placement and function every night shift, revised May 17, 2026. Review of Resident 1's physician orders revealed an order dated March 24, 2026, for wander guard to right wrist, check placement every shift and check functioning every night shift. Review of facility provided document, Elopement/Wander Risk Evaluation-V3, dated March 23, 2026, revealed that Resident 1 was a high risk for elopement. Further review of the additional comments section revealed, resident attempting to open the hallway door to leave, redirected he went to the elevator, pressed in the code and got in. Review of facility provided document, Nursing Evaluation-(Admit/Readmit/Quarterly/COC)- V16, dated May 12, 2026, in the section labeled, Section 2. Elopement/Wander Risk Evaluation, revealed Resident 1 was at high risk for wandering or elopement. Review of facility provided incident report dated June 25, 2026, at 4:20 PM, revealed that on June 24, 2026, at 10:50 PM, police came to the facility to inquire if a resident may have left the building because a confused person was found at a convenience store several blocks away and someone had called the police and ambulance. At that time, a full house count was completed and Resident 1 was unable to be located. Facility staff had verified wander guard placement on June 24, 2026, at 7:51 PM. Further review of the incident report revealed Resident 1 returned from the hospital on June 25, 2026, at 2:25 AM, with no injuries and no change from his baseline. At that time, his wander guard device was replaced on his left ankle and he was placed on 1:1 supervision. The Resident reported that after the staff checked his wander guard placement, he had cut the device off and threw it across the room. He was then able to take the elevator to the first floor where he was able to push the door open and exit the building. Review of a motion detection camera located in the lobby revealed that Resident 1 exited the building between 8:02 PM and 8:07 PM. Review of a witness statement from Employee 1 (Licensed Practical Nurse [LPN]), without date, revealed that Resident 1 was last seen by staff when he inquired about if the therapy gym was still open after the evening meal (no time stated). Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 30, 2026, at 11:30 AM, revealed that on June 24, 2026, after Resident 1 had his wander guard placement checked at 7:51 PM, he cut it off. After that, he propelled in his wheelchair down the hallway towards the elevator and when stopped by a nurse, told her that he was going to the therapy gym located across the hallway from the elevator. He then got on the elevator and went to the first-floor lobby, where the receptionist had just left for (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the night at 8:00 PM. Resident 1 was able to slide the front door open because of the fire release feature (when the door is forced open with this feature, an alarm sounds but only until the door is closed). The facility investigation revealed that no staff heard this alarm and, thus, did not respond. Resident 1 left his wheelchair at the front door when he exited the building. A motion detector camera in the lobby revealed that Resident 1 entered the lobby in his wheelchair at 8:02 PM, and the next photo showed his empty wheelchair sitting beside the entrance door at 8:07 PM. At that time, facility staff failed to respond to the door alarm and Resident 1 exited the facility and was found walking along the road. The facility failed to ensure adequate supervision to prevent elopement which placed Resident 1 in immediate jeopardy situation. The NHA was provided with the immediate jeopardy template on July 1, 2026, at 10:07 AM, and an immediate action plan was requested. On July 1, 2026, at 1:09 PM, the facility's immediate action plan was accepted, which included: On 6/25/26, Resident 1 was returned to facility post Emergency Department evaluation with no negative outcome. Wander guard device was reapplied to Resident's ankle, and he was placed on frequent monitoring at 1:1 level. A new elopement evaluation was completed, and wander guard function was verified. Completed upon resident's return on 6/25/26. Residents with wander guard devices were audited for placement and function of their devices. Audible door alarms were tested for detectability. Completed 6/24/26. Wander guards were audited for appropriate bands and replaced with heavy rubber/vinyl bands to decrease removability. Completed 6/27/26. Facility staff continuously monitored front door until door company arrived onsite 6/29/26 and adjusted front door to ensure it cannot be slid open manually. Director of Maintenance adjusted the 8/9 unit secondary audible alarm speaker which has enhanced detectability. Audible alarm now sounds when door is manually pushed open forward as part of its emergency safety feature, alarm remains sounding until sensors are reengaged when door is set back on track. Facility staff were re-educated on elopement policy; Maintenance staff were re-educated on door alarm testing including detectability. Completed 6/27/26. DON or designee will audit residents with wander guards to ensure placement 3x per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. Director of Maintenance or designee will audit audible door alarms including front door and 8/9 unit secondary alarm 3x per week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. Results to QAPI. Date of Compliance June 27, 2026 During an interview with the NHA on July 1, 2026, at 1:15 PM, the NHA stated that on June 26, 2026, when Resident 1 returned from the hospital, his wander guard device was reapplied to his ankle and he was placed on 1:1 supervision. Another elopement evaluation was also completed at that time, and the wander guard function was verified. Further interview revealed that all residents with wander guard devices were audited for placement and function of their devices. All door alarms were also checked for function and detectability. Facility staff were monitoring the lobby door from the time of the incident until the door was able to be adjusted by the door company on June 29, 2026, to increase the difficulty to reset the door and turn off the alarm. Observations made during a tour of the facility on July 1, 2026, revealed that the door in the front lobby was locked unless you entered a code for it to open. To override the fire safety feature, you could no longer slide the door to the side to open it. Instead, it required pushing the door off track, which set off an audible alarm at the door and at the 800/900 nurses' station. Pushing the door off track increased the difficulty and time needed to put it back on track, thereby increasing the time the alarm is alerting staff. All residents who used a wander guard were observed to have a functional wander guard in place at that time with the new higher durability wander guard bands. Facility staff were interviewed during the onsite survey regarding the facility's Immediate Action Plan and demonstrated knowledge of education regarding the facility elopement policy and their responsibility to immediately respond to door alarms. The Immediate Jeopardy was lifted on July 1, 2026, at 1:59 PM, after ensuring that the immediate action plan had been implemented. The facility failed to implement interventions, supervision, and effective safety measures to prevent Resident 1 from eloping from the facility. This failure placed Resident 1 in an Immediate Jeopardy situation. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management