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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, record review, and staff interviews, it was determined that the facility failed to ensure the environment meets the individual needs of each resident by ensuring the call system is within reach of the resident for one of 35 residents reviewed (Resident 155).Findings include: Review of the facility policy, titled Answering the Call Light, last reviewed August 21, 2024, revealed to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. Review of Resident 155's clinical record revealed diagnoses that included type 2 diabetes mellitus (a chronic metabolic disorder characterized by the body's inability to properly use insulin, leading to high blood glucose levels) and hypertension (high blood pressure). Observation of Resident 155 on August 4, 2025, at 9:57 AM, revealed the Resident lying in bed, with their call bell on the floor on a fall mat to the left side of their bed, out of reach for the Resident. Observation conducted of Resident 155 on August 4, 2025, at 11:26 AM, revealed the Resident lying in bed, with their call bell on the floor on a fall mat to the left side of their bed, out of reach for the Resident. Observation conducted of Resident 155 on August 4, 2025, at 1:22 PM, revealed the Resident lying in bed, with their call bell on the floor on a fall mat to the left side of their bed, out of reach for the Resident. Review of Resident 155's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated May 30, 2025, revealed that Section B. Hearing, Speech, and Vision B0700. Makes Self Understood, Ability to express ideas and wants, consider both verbal and non-verbal expression, is marked 0. Understands; as well as section B0800 Ability to Understand Others, Understanding verbal content, however able, was marked 0. Understands. During an interview with the Director of Nursing (DON) on August 5, 2025, at 3:54 PM, it was revealed that per the unit nursing manager, Resident 155 is able to use their call bell. During an interview conducted with the DON on August 6, 2025, at 11:29 AM, she revealed that she would have expected Resident 155's call bell to have been within reach. Pa. Code 211.12(d)(1) Nursing Services

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	08/07/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a resident's medication regimen was free from unnecessary psychotropic medications for one of seven residents reviewed for unnecessary medications (Resident 8).Findings include: Review of facility policy, titled Psychotropic Medication Use, with a last revised date of February 2025, revealed in section titled PRN Medication that 3. PRN [as needed] orders for psychotropic medications are limited to 14 days. a. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order. Review of Resident 8's clinical record revealed diagnoses that included post-traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions) and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 8's physician orders revealed an on order for Klonopin (clonazepam) [a psychoactive medication used to treat anxiety] 0.5 mg (milligrams) give 0.25 mg every 12 hours as need for anxiety, dated June 30, 2025. The order failed to include a 14 day stop date. Review of Resident 8's Medication Administration Record's for June 2025, July 2025, and August 2025 revealed that he had not received any doses of the Klonopin. Email communication received from the Director of Nursing on August 6, 2025, at 2:59 PM, indicated that Resident 8's as needed Klonopin order had been discontinued. During a staff interview with the Nursing Home Administrator and Employee 2 (Regional Director of Clinical Services) on August 7, 2025, at 11:05 AM, Employee 2 indicated that the facility electronic health record program does not identify clonazepam as a benzodiazepine (a psychoactive medication), but rather an anticonvulsant 9 (antiseizure medication) so the order would not have flagged as needing a 14-day stop date. She indicated that a 14-day stop date should have been included in the order given that it was being utilized to treat anxiety. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.2(d)(3) Medical director28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211. 12(d)(1)(2)(3)(5) Nursing services

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	395223	A. Building B. Wing	08/07/2025

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Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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	395223	A. Building B. Wing	08/07/2025

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Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident assessment accurately reflected the resident status for three of 35 residents reviewed (Residents 5, 51, and 85). Findings include:Review of Resident 5's clinical record revealed diagnoses that included anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 5's physician orders revealed an order for a soft padded helmet on at all times, as Resident allows, and release every two hours, dated September 5, 2024. During a staff interview with Employee 7 on August 4, 2025, at 10:22 AM, Employee 7 indicated that Resident 5 removes his helmet frequently because he does not like it . At the time of interview, Employee 7 was reapplying Resident 5's helmet. The helmet was noted to be a soft padded helmet with no securing device, which would prevent Resident 5 from removing the helmet as he desired. Review of Resident 5's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of November 28, 2024, indicated in Section P. Restraints and Alarms revealed he was coded as having an other restraint utilized when in chair or out of bed on a daily basis during the assessment period. Review of Resident 5's Quarterly MDS with the assessment reference date of February 26, 2025, indicated in Section P. Restraints and Alarms revealed he was coded as having an other restraint utilized when in chair or out of bed on a daily basis during the assessment period. Review of Resident 5's Quarterly MDS with the assessment reference date of May 28, 2025, indicated in Section P. Restraints and Alarms revealed he was coded as having an other restraint utilized when in chair or out of bed on a daily basis during the assessment period. Review of Resident 5's Quarterly MDS with the assessment reference date of June 17, 2025, indicated in Section P. Restraints and Alarms revealed he was coded as having an other restraint utilized when in bed on a daily basis during the assessment period. Email communication received from the Director of Nursing (DON) on August 7, 2025, at 9:58 AM, indicated that Resident 5's helmet was being used at the preference of the family and hospice for injury prevention. During a staff interview with the Nursing Home Administrator (NHA) and Employee 2 (Regional Director of Clinical Services) on August 7, 2025, at 11:20 AM, Employee 2 further indicated that the family and hospice wanted the helmet to be used to prevent head trauma if he were to fall. Employee 2 confirmed that Resident 5 can and does remove it as he desires. Employee 2 confirmed Resident 5's helmet should not have been coded as a restraint on his MDS assessments since it did not meet the definition of a restraint.Review of Resident 51's clinical record revealed diagnoses that included depressive disorder (persistent sadness, loss of interest, and difficulty functioning in daily life) and hypertension (elevated/high blood pressure).Review of Resident 51's physician orders revealed an order for zolpidem (a psychotropic hypnotic) 5 mg at bedtime, dated July 18, 2024.Review of Resident 51's most recent annual MDS with an assessment reference date of May 2, 2025; and most recent quarterly MDS with an assessment reference date of April 10, 2025, revealed that section N Medications, was not coded to include the use of a hypnotic medication.In an electronic communication on August 6, 2025, at 2:10 PM, the DON confirmed that Resident 51's annual and quarterly MDS's were coded incorrectly for the use of a hypnotic medication.Review of Resident 85's clinical record revealed diagnoses that included dementia and schizoaffective disorder (a mental health condition marked by symptoms that include hallucinations and delusions). Review of Resident 85's physician orders revealed an active order for Haloperidol Lactate Concentrate 2 mg/ml (antipsychotic medication), give 1 ml by mouth one time a day related to schizoaffective disorder, with a start date of October 25, 2024. Review of Resident 85's Quarterly MDS with assessment reference date of June 18, 2025, under section N0450. Antipsychotic Medication Review A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent? Resident 85 was marked No- antipsychotics were not received.Review of Resident 85's June MAR (Medication Administration Record- documentation for treatments/medication administered or monitored) revealed she was marked as having received the haloperidol antipsychotic medication on all days of that month. During an interview with the NHA on August 7, 2025, at 11:39 AM, he confirmed Resident 85's aforementioned MDS assessment was marked in error, and he would expect MDS assessments to be coded accurately. 28 Pa. Code 211.5(f) Medical records

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	08/07/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the resident plan of care for one of 35 residents reviewed (Resident 8).Findings include: Review of facility policy, titled Care Plans, Comprehensive Person-Centered, with a last revision date of March 2022, and a last review date of August 24, 2024, revealed Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of Resident 8's clinical record revealed diagnoses that included type II diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin), post-traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions), and pressure ulcers. Review of Resident 8's current physician orders revealed the following orders: do not resuscitate dated May 20, 2025; and wound care to left lateral malleolus (ankle) pressure ulcer cleans with normal saline, apply betadine to base of wound, and leave open to air twice a day and as needed, dated July 31, 2025. Review of Resident 8's care plan revealed a care plan focus for Resident has an advanced directive of full code, with an initiated date of May 6, 2025. Email communication received from the Director of Nursing (DON) on August 6, 2025, at 12:35 PM, indicated that Resident 8's care plan had been changed to do not resuscitate. She further indicated that he changed his code status after admission and that his care plan was not updated at that time. Email communication received from the DON on August 6, 2025, at 6:37 PM, indicated that she would expect Resident 8's care plan to have been updated when his code status changed. Review of Resident 8's care plan failed to revealed that his pressure ulcer to his left lateral malleolus was included on his current care plan. Further review of Resident 8's care plan revealed a care plan focus for Resident has PICC line (peripherally inserted central catheter, is a long, flexible tube inserted into a vein in the upper arm, used for long-term intravenous access to deliver medications, fluids, or draw blood) related to infectious process, with an initiated date of May 29, 2025. Review of Resident 8's clinical record revealed that his PICC line was discontinued on June 9, 2025. Email communication received from the DON on August 6, 2025, at 3:39 PM, indicated that Resident 8's care plan had been updated to include his new pressure ulcer and that the PICC line was resolved from his care plan. During a final interview with Employee 2 and the Nursing Home Administrator and Employee 2 on August 7, 2025, at 11:05 AM, the NHA confirmed that he would expect Resident 8's care plan to have been revised when all the changes occurred. 42 CFR 483.21(b)(2) Comprehensive Care Plans28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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	395223	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	395223	A. Building B. Wing	08/07/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, clinical record reviews, observations, and resident 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 four of 35 residents reviewed (Residents 43, 82, 128, and 141). Findings include:Review of facility policy, titled Catheter Insertion and Care Midline Dressing Changes, with an effective date of July 2017, and a last review date of August 24, 2024, revealed Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. Review of facility policy, titled IIA2: Medication Administration-General Guidelines, undated with a last review date of August 24, 2024, revealed, in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 11. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. 15. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate. Review of Resident 43's clinical record revealed diagnoses that included bacterial pneumonia, urinary tract infection, and hypertension (high blood pressure). During a resident interview with Resident 43 on August 4, 2025, at 11:32 AM, Resident 43 was observed to have a dressing in place on her right inner elbow (antecubital space) covering a midline intravenous catheter, dated July 23, 2025. Review of Resident 43's Treatment Administration Record for July 2025 revealed that she was documented as having received a dressing change to this site on July 30, 2025. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on August 6, 2025, at 11:38 AM, the DON confirmed that the midline intravenous dressing should have been changed on July 30, 2025, as per order and facility policy. The DON indicated that she could not speak as to why the nurse signed as completing the dressing change but did not do so.Review of Resident 82's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning) and anxiety (a feeling of worry, nervousness, or unease). Review of Resident 82's physician orders revealed the following active orders: May go on LOA (leave of absence- signed out of the facility) supervised without medications May go on LOA supervised with medications,During an email correspondence with the DON on August 5, 2025, at 1:03 PM, the surveyor questioned Resident 82's conflicting physician orders. Return email correspondence from the DON on August 6, 2025, at 10:15 AM, she wrote May go LOA supervised without medications is the correct order. The other has been discontinued. The order was confirmed with the Certified Registered Nurse Practitioner. During an interview with the NHA on August 7, 2025, at 11:39 AM, he revealed his expectation that residents would not have conflicting physician orders.Review of Resident 128's clinical record revealed diagnoses that included dementia and moderate calorie protein malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it gets).Review of Resident 128's physician orders revealed an active order for Enhanced Barrier Precautions (EBP- an infection control intervention) related to open wound. Observation of Resident 128 in her room on August 4, 2025, at 2:32 PM; August 5, 2025, at 1:19 PM; and August 6, 2025, at 11:04 AM; failed to reveal EBP materials or a sign on her door; and during the observations on August 4 and 5, 2025, staff were observed in her room not following EBP. Review of Resident 128's clinical record revealed she had a history of a wound that resolved in April of 2025.During an interview with the DON on August 6, 2025, at 11:49 AM, the surveyor questioned the EBP order for Resident 128. Interview with the NHA on August 7, 2025, at 11:39 AM, revealed he would expect orders to be discontinued if no longer indicated.Review of Resident 141's clinical record revealed diagnoses that included Hodgkin's lymphoma (a cancer of the immune system) and moderate protein-calorie malnutrition (the state of inadequate food intake) During a resident interview with Resident 141 on August 4, 2025, at 11:22 AM, there was a medication cup containing several pills noted on her overbed table. Resident 141 indicated that the nurse had left them there for her while she went to get a shower. Resident 141 indicated that she was going to take them and that the nurses normally do not leave them there. Resident 141 shared an incident where she had spilled her medications on the floor when she went to take them and that she put on her call light and a nurse aide came in to answer the light. Resident 141 said she asked the nurse aide what she should do like let the nurse know or what and Resident 141 said the nurse aide picked up all the pills on the floor

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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure a resident with limited range of motion and mobility received appropriate services, equipment, and assistance to maintain or improve range of motion or mobility for one of one residents reviewed (Resident 17).Findings include: Review of Resident 17's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left dominant side and hypertension (high blood pressure). During an interview with Resident 17 on August 4, 2025, at 10:38 AM, Resident 17 indicated she was supposed to be getting a brace for my left leg and it is taking forever. Review of Resident 17's clinical record revealed a CRNP (Certified Registered Nurse Practitioner) visit note dated July 10, 2025, that indicated PT [Physical Therapy] Consult Request: Please evaluate the patient for lower left extremity (LLE) brace qualification and/or necessity. Assess for any deficits in strength, joint stability, alignment, gait mechanics, or neurological function that may warrant orthotic support. Recommendations for appropriate bracing options and mobility assistance are appreciated. Further review of Resident 17's clinical record revealed that the CRNP notes for July 14, 16, 17, 21, 23, 24, 28, 30, and 31, 2025, and August 4, 2025, all indicated the same documentation about a PT consult. In addition, there was physician's note dated July 18, 2025, that also indicated the same documentation about a PT consult. Review of Resident 17's physician orders revealed an order for PT evaluation and treat as indicated as needed dated January 31, 2025, but orders failed to reveal any current PT treatment orders. Review of Resident 17's care plan revealed a care plan focus for limited physical mobility related to left sided weakness with a revision date of February 6, 2025, with interventions that included but were not limited to PT, OT [Occupational Therapy] referrals as ordered, PRN [as needed] with an initiated date of January 31, 2025. Email communication received from the Director of Nursing on August 5, 2025, at 2:59 PM, indicated Therapy will be evaluating for LLE brace. CRNP [Certified Registered Nurse Practitioner] be educated on ordering therapy evaluations. During a staff interview with the Nursing Home Administrator and Employee 2 (Regional Director of Clinical Services) on August 7, 2025, at 11:04 AM, Employee 2 indicated that the nurse practitioner did not put in the therapy request for a screen, which is what therapy reviews to know if have outstanding screens to complete. She said she would have expected there to be communication between the nurse practitioner and the nursing staff regarding the request since it was an ongoing request by the provider in the notes. She said the practitioner will be educated on the proper facility process to ensure services are provided timely. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(3)(5) Nursing services

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	395223	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at West Shore, The	770 Poplar Church Road Camp Hill, PA 17011

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure pharmacy recommendations were acted on appropriately for two of 35 residents reviewed (Residents 25 and 51). Findings include:Review of facility policy, titled Consultant Pharmacist Reports. IIIA1: Medication Regimen Review (Monthly Report), undated, revealed Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.Review of Resident 25's clinical record revealed diagnoses that included major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of Resident 25's December 2024 pharmacy review revealed a recommendation to consider a GDR (gradual dose reduction) for the medications Zolpidem (used to treat insomnia), Hydroxyzine (used to treat anxiety), and Haloperidol (antipsychotic medication used to treat resident's bipolar disorder). Review of Resident 25's clinical record failed to reveal evidence that the physician responded to the pharmacy recommendation. On August 7, 2025, at 12:19 PM, the Nursing Home Administrator (NHA) stated that they were unable to locate Resident 25's December 2024 pharmacy recommendation with physician response. Review of Resident 51's clinical record revealed diagnoses that included depressive disorder (persistent sadness, loss of interest, and difficulty functioning in daily life) and hypertension (elevated/high blood pressure).Review of Resident 51's physician orders revealed a physician order for Seroquel (antipsychotic medication) 12.5 milligrams (mg - metric unit of measure), twice a day, which was dated August 14, 2024; and zolpidem (a psychotropic hypnotic medication) 5 mg at bed time which was dated July 18, 2024.Review of pharmacy recommendation dated January 15, 2025, revealed a recommendation to attempt a GDR of the zolpidem 5 mg. Review of the physician response portion of the pharmacy recommendation revealed that the GDR recommendation was declined and a written rational of Followed by psych[iatric services] was included.Again on April 11, 2025, the pharmacist recommended a GDR of the zolpidem 5 mg. Review of the physician response revealed it was declined due to Resident 51 being, Followed by psych.The recommendation to GDR the zolpidem 5 mg was made a third time on July 9, 2025. The physician declined an attempt of the GDR with the rational of, Followed by psych. However, review of Resident 51's clinical record revealed the last psychiatric consultation was conducted on August 6, 2024, and was not actively being monitored or followed by psychiatric services during the aforementioned GDR recommendations made on January 15, 2025; April 11, 2025; and July 9, 2025.During a staff interview on August 7, 2025, at approximately 11:35 AM, Employee 2 (Regional Director of Clinical Services) confirmed that he facility was unable to locate any psychiatric consultation reports/visits completed for Resident 51 after August 6, 2024. During the interview, Employee 2 revealed that it was the facility's expectation that pharmacy recommendations that are declined have an appropriate clinical rational for declining the recommendation.28 Pa. Code 211.10(c) Resident care policies28 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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of safety data sheet, review of facility temperature logs, and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen.Findings include:Observation of the dish machine in the main kitchen on August 4, 2025, at 10:02 AM, revealed kitchen staff were washing dishes from breakfast and the rinse temperature on the machine read 93 degrees Fahrenheit (F-unit of measure). Interview with Employee 1 (Assistant Dietary Manager) on August 4, 2025, at 10:02 AM, revealed she was not sure why the dish machine was recording such a low rinse temperature, and she would contact maintenance to come look at the machine. Observation of the dish machine in the main kitchen on August 4, 2025, at 1:38 PM, revealed kitchen staff were washing dishes from lunch and the rinse temperature on the machine read 96 degrees F. Interview with Employee 6 (Dietary Employee) on August 4, 2025, at 1:38 PM, revealed no one from maintenance had come to the kitchen thus far to look at the dish machine. During an interview with Employee 1 and the Nursing Home Administrator (NHA) on August 4, 2025, at 2:58 PM, they revealed the dish machine is a high temperature dish machine with a minimum safe rinse temperature of 180 degrees F, but low temperature sanitizer solution is connected to the machine so it can run at a lower temperature. Review of safety data sheet document titled Low Temperature Machine Sanitizer under Directions for Use revealed The rinse water temperature should be between 120 and 140 degrees Fahrenheit.Review of the dish machine temperature logs utilized by the kitchen stated at the bottom of the document: The wash temperature must be at least 160 degrees and the final rinse temperature at least 180 degrees. If the temperature is not at the proper temperature, do not use the machine- notify your supervisor for instructions. Review of the August 2025 dish machine temperature log revealed rinse temperatures had been recorded below 120 degrees F during breakfast, lunch, and dinner on August 1-5, 2025. Further review failed to reveal any corrective action noted. Review of the July 2025 dish machine temperature log revealed wash and rinse temperatures failed to be recorded on July 1, 2, 6, 9, 12, 13, 15, 18, 23, 25, 26, 29, and 30 at breakfast and lunch; and failed to be recorded on July 1-3, 5-7, 9, 11-21, 23-27, 29, and 30 at dinner. Review of the June 2025 dish machine temperature log revealed wash and rinse temperatures failed to be recorded on June 1, 6, 8, 11, 15, 16, 20, 22, 25, and 29 at breakfast and lunch; and failed to be recorded on June 1 and 5-30 at dinner. Review of the May 2025 dish machine temperature log revealed wash and rinse temperatures failed to be recorded on May 5-31 at dinner. Review of the November 2024 kitchen equipment temperature logs revealed temperatures failed to be recorded on November 25-28 for Refrigerator #1, Refrigerator #2, and the Milk Cooler Refrigerator.Interview with the NHA on August 6, 2025, at 11:49 AM, he revealed his expectation that kitchen equipment is utilized in accordance with professional standards.During a follow-up interview with the NHA on August 7, 2025, at 11:44 AM, he revealed the facility was unable to locate any kitchen equipment temperature logs for the month of January 2025, including for Refrigerator #1-3, the Milk Cooler Refrigerator, the walk-in refrigerator and freezer, and the dish machine. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.6(f) Dietary services