

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Gardens at Gettysburg, The		STREET ADDRESS, CITY, STATE, ZIP CODE 741 Chambersburg Road Gettysburg, PA 17325	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37116</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for one of 12 residents reviewed (Resident 2).</p> <p>Findings Include:</p> <p>Review of Resident 2's clinical record revealed diagnoses that included osteoporosis (condition where bone strength weakens and is susceptible to fracture) and osteoarthritis (joint degeneration resulting in pain).</p> <p>Review of Resident 2's February and May 2024 MARs (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed orders for Miacalcin Nasal Solution (medication that contains calcitonin, a hormone that helps prevent bone loss in postmenopausal women) daily for osteoporosis.</p> <p>Further review of the MARs revealed that Miacalcin was not administered on February 22-26, 2024, and on May 16, 2024.</p> <p>Review of corresponding nursing progress notes revealed the following: on February 22, 2024 - unavailable - pharmacy called - they will send in a new bottle; on February 23, 2024 - called [pharmacy] again - they had sent a supply earlier this month. they need DON [Director of Nursing] approval; on February 24 and 25, 2024 - On order; on February 26, 2024 - medication unavailable- awaiting pharmacy delivery; and on May 16, 2024 - unavailable - ordered from pharmacy.</p> <p>Further review of available clinical documentation failed to reveal that the physician was notified of the aforementioned missed doses of medication.</p> <p>During an interview with the Nursing Home Administrator on May 22, 2024, at 1:45 PM , she revealed that she was not able to provide evidence that the physician was notified of the aforementioned missed medication doses.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>37116</p> <p>Based on clinical record review and staff interview, 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 12 residents reviewed (Resident 1).</p> <p>Findings Include:</p> <p>Review of Resident 1's clinical record revealed diagnoses that included peripheral vascular disease (circulation disorder that affects blood vessels outside of the heart and brain, often those that supply the arms and legs) and congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues).</p> <p>Review of wound consultant wound assessment report, dated May 16, 2024, revealed that Resident 1 was evaluated on that date for a new stage II pressure injury (an open wound that affects both the top and bottom layers of the skin) to her left medial distal foot (refers to the inner edge of the foot, extending from the heel to the big toe).</p> <p>Further review of the wound assessment report revealed daily treatment recommendations that included: cleanse the area with wound cleanser, apply calcium alginate to the wound (provides a moist cover to prevent the wound from drying out, allowing the wound to heal more quickly), and secure with bordered gauze (has an adhesive border of non-woven cloth tape and a non-adherent absorptive gauze pad).</p> <p>Review of Resident 1's active physician orders revealed an order to cleanse the open area to left medial distal foot with wound cleanser, apply silver alginate to the wound base, and cover with bordered gauze dressing daily. This order was effective May 21, 2024.</p> <p>Further review of Resident 1's clinical record failed to reveal any orders for treatment of the wound between May 16, 2024 and May 21, 2024.</p> <p>During an interview with the Nursing Home Administrator on May 22, 2024, at 1:45 PM, she stated she would have expected treatment orders to be into place immediately following discovery of Resident 1's new skin concern.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>37116</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for one of 12 residents reviewed (Resident 2).</p> <p>Findings Include:</p> <p>Review of Resident 2's clinical record revealed diagnoses that included osteoporosis (condition where bone strength weakens and is susceptible to fracture) and osteoarthritis (joint degeneration resulting in pain).</p> <p>Review of Resident 2's February and May 2024 MARs (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Miacalcin Nasal Solution (medication that contains calcitonin, a hormone that helps prevent bone loss in postmenopausal women) daily for osteoporosis effective February 17, 2023.</p> <p>Further review of the MARs revealed that nursing staff documented that Miacalcin was not administered on February 22-26, 2024, and on May 16, 2024.</p> <p>Review of corresponding nursing progress notes revealed the following: on February 22, 2024 - unavailable - pharmacy called - they will send in a new bottle; on February 23, 2024 - called [pharmacy] again - they had sent a supply earlier this month. they need DON [Director of Nursing] approval; on February 24 and 25, 2024 - On order; on February 26, 2024 - medication unavailable- awaiting pharmacy delivery; and on May 16, 2024 - unavailable - ordered from pharmacy.</p> <p>During an interview with the Nursing Home Administrator (NHA) on May 22, 2024, at 1:45 PM she revealed that the Miacalcin was not administered to Resident 2 because the staff could not locate the medication, and when a replacement was requested from the pharmacy, the pharmacy had to request approval from the facility to fill it since it was a non-covered medication. The process took a couple of days. The NHA also revealed that she did not have any additional information regarding the missed dose on May 16, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		