STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395247	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Gettysburg, The	741 Chambersburg Road Gettysburg, PA 17325

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for four of 23 residents reviewed (Residents 14, 52, 56, and 69). Findings include: Review of Resident 14's clinical record revealed diagnoses that included chronic embolism and thrombosis of deep veins of left lower extremity (blockage in blood vessel, usually by a blood clot) and peripheral vascular disease (circulation disorder that affects blood vessels outside of the heart and brain, often those that supply the arms and legs). Review of Resident 14's May 2024 MAR (Medication Administration Record - form used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Xarelto (anticoagulant) every evening, effective April 9, 2024. Further review of the MAR revealed that it was documented that this medication was administered each day in May 2024. Review of Resident 14's May 7, 2024, quarterly MDS assessment (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) revealed that it was coded to indicate that Resident 14 did not receive an anticoagulant medication during the seven day look back period prior to the assessment date. During an interview with the Nursing Home Administrator (NHA) on June 26, 2024, at 1:05 PM, she confirmed that Resident 14's MDS was coded in error. Review of Resident 52's clinical record revealed diagnoses that included frontotemporal neurocognitive disorder (a group of disorders that cause damage to the frontal and temporal lobes of the brain, leading to changes in thinking and behavior) and dementia (overall decline in memory and other cognitive skills that reduce the ability to perform everyday activities). Review of Resident 52's quarterly MDS dated [DATE], revealed it was coded to indicate Resident 52 had no behaviors of wandering during the look back period. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 52's progress notes revealed a note dated April 15, 2024 at 6:45 AM, that stated, Resident awake at approximately 0345 this morning. Resident wandering halls, walking on tips of toes and unsteady. Resident wearing helmet throughout shift but not compliant with walker. Resident attempting to take items off of linen cart while morning rounds are being done, wandering in and out of bedrooms, and slamming doors. Behaviors redirected but continued. Snacks and fluids given and incontinence care provided Review of progress note dated April 16, 2024, at 6:47 AM, that stated, Resident appears back to baseline behaviors, wandering halls and following staff around. Pleasant mood and able to have small conversation with staff. During a staff interview on June 27, 2024 at 12:37 PM, with the NHA, it was revealed that Resident 52's quarterly MDS dated [DATE], was coded incorrectly. The NHA stated that it was the facility's expectation that MDS assessments be accurate. Review of Resident 56's clinical record revealed diagnoses that included unspecified dementia severe with agitation (overall decline in memory and other cognitive skills that reduce the ability to perform everyday activities) and muscle weakness (decreased strength in the muscles). Review of Resident 56's physician orders revealed an order for Aripiprazole (antipsychotic medication) oral solution 7.5 milligrams daily, with a start date of November 13, 2023. Review of Resident 56's medication administration sheets for February 2024 and March 2024 revealed Resident 56 received Aripiprazole daily as ordered. Review of Resident 56's quarterly MDS dated [DATE], revealed it was coded to indicate Resident 56 had not received antipsychotic medication during the look back period. Further review of Resident 56's quarterly MDS dated [DATE], revealed Resident 56 was coded to indicate Resident 56 sustained a fall with major injury during the look back period. Further review of Resident 56's clinical record failed to reveal Resident 56 sustained a fall with major injury during the look back period. During a staff interview on June 27, 2024 at 11:35 AM, with the NHA, it was revealed that Resident 56's aforementioned MDS assessments had been coded incorrectly. The NHA stated it was the facility's expectation that MDS assessment be accurate. Review of Resident 69's clinical record revealed diagnoses that included dysphagia (difficulty swallowing) and gastrostomy status (creation of an artificial external opening into the stomach for nurtritional support). Review of Resident 69's June 2024 MAR revealed an order for daily enteral feeding (a way of delivering nutrition directly to the stomach or small intestine through a tube), effective January 20, 2024. Further review of the MAR revealed that it was documented that Resident 69 received enteral feeding daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 69's June 22, 2024, quarterly MDS revealed that it was coded to indicate that Resident 69 did not receive nutrition via a feeding tube during the seven day look back period prior to the assessment date. During an interview with the NHA on June 27, 2024 at 12:39 PM, she confirmed that Resident 69's MDS was coded in error. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49123 Based on clinical record review, facility policy review, observation, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for one of 20 residents reviewed (Resident 56). Finding include: Review of the facility policy, titled Care Plans, Comprehensive Person-Centered, last revised September 2022, read, in part, 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of Resident 56's clinical record revealed diagnoses that included unspecified dementia severe with agitation (overall decline in memory and other cognitive skills that reduce the ability to perform everyday activities) and muscle weakness (decreased strength in the muscles). An observation was made on June 12, 2024, at 11:44 AM, of Resident 56's mattress on the floor without a bed frame. Further review of Resident 56's clinical record revealed Resident 56 suffered a fall with major injury on June 5, 2024. Review of Resident 56's comprehensive care revealed a focus area for fall risk. Review of Resident 56's interventions failed reveal an intervention for Resident 56's mattress being placed on the floor. During a staff interview with the Nursing Home Administrator (NHA) on June 26, 2024, at 11:26 AM, it was revealed Resident 56's mattress was placed on the floor as a safety intervention due to Resident 56 having multiple falls and other fall interventions not being effective. During an addition staff interview with the NHA on June 26, 2024 at 1:09 PM, she revealed Resident 56's comprehensive plan of care should have been updated to include an intervention for the mattress being placed on the floor. The NHA stated it was the facility's expectation that care plan revisions be made timely. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116 Based on clinical record review and staff interview, it was determined that the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections and complications related to the use of a foley catheter (small, flexible tube that can be inserted through the urethra and into the bladder, allowing urine to drain) for one of five residents reviewed for use of a catheter (Resident 92). Findings Include: Review of Resident 92's clinical record revealed diagnoses that included obstructive and reflux uropathy (structural or functional hindrance of normal urine flow) and hemiplegia and hemiparesis following cerebral infarction (one-sided weakness or inability to move following stroke). Further review of Resident 92's clinical record revealed he was admitted to the facility on [DATE]. Review of an admission nursing evaluation completed on May 8, 2024, revealed that Resident 92 had a foley catheter that was present when he arrived. Review of Resident 92's May 2024 MAR and TAR (Medication/Treatment Administration Records - forms used to document physician orders as well as when and how medications/treatments are administered to a resident) failed to reveal any orders related to the presence, indication for use, or care of his foley catheter until May 14, 2024 (six days following admission). Further review of Resident 92's clinical record failed to reveal any additional documentation of the daily care or maintenance of his foley catheter during the period of May 8 through 14, 2024. During an interview with the Nursing Home Administrator on June 27, 2024, she confirmed that the orders/documentation for catheter use and care were not timely. She revealed that the orders were entered into the electronic record at admission, but were pending confirmation, so they did not appear on the MAR and TAR until this issue was discovered and corrected. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116 Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure timely practitioner services following discovery of a skin integrity concern for two of three residents reviewed for pressure injuries (Residents 26 and 92). Findings include: Review of facility policy, titled Skin and Wound Management System, revised September 2022, revealed, Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Review of Resident 26's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking, and behavior) and peripheral vascular disease (circulation disorder that affects blood vessels outside of the heart and brain, often those that supply the arms and legs). Review of Resident 26's nursing progress note dated May 7, 2024, revealed, Resident noted to have dark area of discoloration on left outer ankle. Would benefit from wound team to assess. Review of Resident 26's nursing progress note dated May 14, 2024, revealed, Discolored area remains on left outer ankle. Review of wound assessment report completed on May 16, 2024, revealed that Resident 26 was evaluated by the nurse practitioner on that date and was determined to have a pressure injury (occurs when pressure reduces or cuts off blood flow to the skin) to his left lateral ankle. Review of Resident 26's May 2024 MAR/TAR (Medication/Treatment Administration Records - form used to document physician orders as well as when and how medications/treatments are administered to a resident) revealed an order for skin prep wipes (applies a protective barrier) to the left lateral ankle, effective May 16, 2024. Further review of Resident 26's clinical record failed to reveal any evidence that the physician or practitioner was notified of his change in skin integrity, that a practitioner evaluated the wound, or that treatment was prescribed for his wound between the time it was discovered on May 7, 2024, and when Resident 26 was evaluated by the wound consultant on May 16, 2024. During an interview with the Nursing Home Administrator (NHA) on June 26, 2024, at 1:05 PM, she confirmed that she did not have evidence that the practitioner was notified of or evaluated Resident 26's new skin integrity concern between May 7 and 16, 2024. Review of Resident 92's clinical record revealed diagnoses that included pressure ulcer of sacral region (area at base of the back, above the buttocks) and hemiplegia and hemiparesis following cerebral infarction (one-sided weakness or inability to move following stroke). Further review revealed that Resident 92 was admitted to the facility on [DATE]. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of admission nursing evaluation dated May 8, 2024, revealed that, when Resident 92 was admitted , he had a sacral skin alteration that was covered by a dressing. The evaluation also indicated that Resident 92 would be seen by the wound consultant the following day. Review of history and physical form completed by Resident 92's physician on May 9, 2024, noted a stage III pressure injury (full thickness skin loss) under his primary medical history. Further review revealed the physician noted wound care following due to pressure. The history and physical included no ongoing plan for treatment of Resident 92's pressure injury. Review of Resident 92's clinical record revealed that he was seen for the first time and his wound was evaluated by the wound consultant on May 16, 2024. He was determined to have a stage II pressure injury (partial thickness wound, shallow open ulcer) to his sacrum. Treatment recommendations were made at that time. Review of Resident 92's May 2024 MAR revealed no orders for treatment or care of his sacral wound until May 20, 2024. During an interview with the NHA on June 27, 2024, at 11:29 AM, she revealed that the wound consultant was scheduled to come the day after Resident 92's admission. The facility wound care nurse forgot about the wound consultant's visit on the following day and did not arrive at work early to meet the wound consultant; therefore, the wound consultant was not aware of the need to see Resident 92 or evaluate his wound. The NHA revealed that the facility has since altered their process for notifying the wound consultant. The NHA confirmed that Resident 92's wound was not evaluated by a practitioner until eight days following admission. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46253 Based on observations, facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure clinical records were complete and accurately documented for one of three residents reviewed for oxygen use (Resident 30). Findings include: Review of facility policy, titled Oxygen Administration, with a last revised date of October 2010, revealed in section titled Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1) The date and time that the procedure was performed; 2) The name and title of the individual who performed the procedure; 3) The rate of oxygen flow, route, and rationale; 4) The frequency and duration of the treatment; 5) The reason for p.r.n.[as needed] administration; 6) All assessment data obtained before, during, and after the procedure; and 7) How the resident tolerated the procedure. Review of Resident 30's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations) and anoxic brain damage (brain damage caused from a lack of oxygen to the brain). Review of Resident 30's physician orders revealed an order for Oxygen at 2 liters per minute per nasal cannula as needed for shortness of breath, dated March 17, 2024. Observations of Resident 30 on June 24, 2024, at 10:44 AM; June 25, 2024, at 9:44 AM; and June 25, 2024, at 1:20 PM, revealed that the Resident was receiving oxygen at 2 liters per minute via a nasal cannula. The oxygen tubing was noted to be dated 6/24. Review of Resident 30's clinical record progress notes on June 25, 2023, at 1:21 PM, revealed that the last nurse's note present in their clinical record was dated June 20, 2024, at 2:09 PM, which indicated that Resident 30 was not receiving any oxygen. Review of Resident 30's June Treatment Administration Record (TAR) revealed that the oxygen administration was discontinued on June 3, 2024. During an interview with the Nursing Home Administrator (NHA) on June 25, 2024, at 1:35 PM, all the aforementioned observations and documentation concerns were shared. The NHA indicated that she would look into the concern and confirmed that Resident 30's oxygen administration should be documented. Further review of Resident 30's progress notes, revealed a nurse's note dated June 25, 2024, at 1:41 PM, indicated Resident 30 was short of breath, oxygen applied as ordered, and that the oxygen order was updated in the electronic health record. In addition, there was a nurse's note dated June 25, 2024, at 1:46 PM, that indicated it was a late entry note for June 24, 2024, and that Resident 30 was experiencing shortness of breath and that oxygen was applied per their physician orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up review of Resident 30's June TAR on June 26, 2024, at 10:18 AM, revealed that their oxygen order was now present. During an interview with the NHA on June 26, 2024, at 11:22 AM, the NHA indicated that there was an error made when staff entered Resident 30's oxygen order, and that was why it was not populating on their TAR for staff to sign for the oxygen administration. 28 Pa. Code 211.5(f)(viii) Medical Records 28 Pa. Code 211.10(c) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services