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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Gettysburg, The	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 28 residents reviewed (Residents 48, 83, 85, and 90). Findings Include: Review of Resident 48's clinical record revealed diagnoses that included diabetes (a disease characterized by high blood glucose) and muscle weakness (when your full effort doesn't produce a normal muscle contraction or movement). Observation of Resident 48 on May 12, 2025, at 12:41 PM, revealed Resident 48 lying in bed. Beside Resident 48 on his bedside stand was a CPAP (continuous positive airway pressure) machine with the mask lying on top of it. The mask was not in a bag or put away. Observation of Resident 48 on May 13, 2025, at 12:04 PM, revealed Resident 48 lying in bed. Beside Resident 48 on his bedside stand was a CPAP machine with the mask lying on top of it. The mask was not in a bag or put away. Review of Resident 48's care plan revealed a care plan with a focus are of: The Resident has altered respiratory status, with a revision date of January 31, 2025. The care plan failed to mention any preference of Resident 48 to have his CPAP mask available to him and not placed into a bag throughout the day. Interview with the Director of Nursing (DON) on May 13, 2025, at 10:40 AM, revealed Resident 48's CPAP mask was lying out because that is his preference, and Resident preferences should be on the care plan. Review of Resident 83's clinical record revealed diagnoses that included diabetes (a disease characterized by high blood glucose) and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). Observation of Resident 83 on Tuesday May 12, 2025, at 1:25 PM, revealed Resident 83 lying in bed. Resident 83 was wearing bilateral pressure offloading boots to relieve pressure on his heels. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 83's care plan revealed a care plan with a focus are of: The resident has potential for pressure ulcer development, with a revision date of August 2, 2024, and did not include pressure offloading boots. Interview with the DON on May 15, 2025, at 10:30 AM, revealed Resident 83 required the use of a device to relieve pressure on his heels and it should be on his care plan. Review of Resident 85's clinical record revealed he was admitted to the facility on [DATE]. Diagnoses included dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), depression (feelings of severe despondency and dejection), and atrial fibrillation (an irregular often rapid heart rate commonly causes poor blood flow). Resident 85's physician orders included Apixaban 2.5 mg two times a day for atrial fibrillation, start date March 11, 2025. Resident 85's care plan failed to include use of an anticoagulant (Apixaban - blood thinner). During an interview with the DON on May 15, 2025, at 10:29 AM, it was revealed that the anticoagulant was added to the care plan. Review of Resident 90's clinical record revealed diagnoses that included cerebral infarction (ischemic stroke, a condition where blood flow to the brain is interrupted,causing brain tissue damage) and hypertension (elevated blood pressure). Observation of Resident 90 on Monday May 11, 2025, at approximately 11:30 AM, and on Tuesday May 12, 2025, at 10:45 AM, revealed Resident 90 out of bed in a wheelchair wearing a sling on his left arm. Review of Resident 90's care plan dated May 2025, failed to reveal a care plan for a sling. During an interview with the Nursing Home Administrator (NHA) on May 12, 2025, at approximately 1:30 PM, the NHA said that the care plan should have been revised to include the use of the sling. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming for resident's dependent on staff for assistance with activities of daily living for one of 28 residents reviewed (Residents 91). Findings include: Review of Resident 91's clinical record revealed he was admitted to the facility on [DATE]. Diagnoses included dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory, and abstract thinking). Review of facility grievance log documented March 21, 2025, Resident 91's son was concerned that a haircut was paid for that his father didn't receive, and his wishes were made known for nursing to keep his father shaved. Resident 91 received a haircut on March 25, 2025. Review of Resident 91's care plan included a focus area for chronic/progressive decline in intellectual functioning characterized by; deficit in memory, judgment, decision making and thought process related to dementia; scored 6/15 on Brief Interview For Mental Status (BIMS- a screening tool used in Nursing Homes to assess cognition; 0-7= sever cognitive impairment, 8-12=moderate impairment, 13-15=intact cognitive response); presents with severe cognitive deficits in daily decision making, date initiated March 21,2025. Interventions included to cue and prompt Resident with simple direct verbal cures and reminders, and demonstrate tasks, date-initiated March 21,2025. Review of Resident 91's admission Minimum Data Set (MDS- periodic assessment of resident needs), dated March 21, 2025, revealed that Resident 91 BIMs score was 6, required supervision or touch assistance for shower/bathing, and partial to moderate assistance with personal hygiene (shaving washing hands and face). During an interview with Resident 91 on May 13, 2025, at 12:10 PM, he stated he hasn't had a shower. Surveyor observed a brown substance under Resident 91's fingernails and the Resident wasn't shaved, he had facial stubble. Resident 91 stated his nails needed to be cleaned and he wanted a shower; but doesn't mind some facial hair. Review of Resident 91's bathing documentation for the previous 30 days revealed: showers were provided April 18th, 20252, and May 3rd, 2025; and bed baths were provided April 15th, 16th, 20th, 26th, 27th, 28th, 29th, and 30th, 2025, and May 2nd, 5th, 6th, 8th, 9th, and 13th, 2025. Additional observation on May 14, 2025, at 11:40 AM, and an observation and interview with the Nursing Home Administrator (NHA) on May 14, 2025, at 11:55 AM, in main dining room, revealed Resident 91's fingernails were trimmed, however, two fingernails on his left hand contained a brown substance underneath, and the Resident wasn't shaved. The NHA stated that the Resident is fairly independent with care, and that his nails are trimmed and acknowledged that the two fingernails could be cleaned. It was also stated that she would have staff clean his nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident 91 on May 15, 2025, at 9:36 AM, revealed the Resident stated that his fingernails were cleaned yesterday, and it was observed the two fingernails on his left hand were better, minimal brown substance remained under his fingernails. During an interview with the NHA on May 15, 2025, at 10:40 AM, it was revealed that Resident 91's fingernails were cleaned yesterday. It was also revealed that Resident 91 is continent and utilizes the restroom himself, and that he was educated on hand hygiene. 28 Pa code 211.12.(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34631 Based on observation, policy review, and resident and staff interviews, it was determined that the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for one of three residents reviewed for respiratory care (Resident 55). Findings Include: Review of the facility's policy, titled Oxygen Therapy, with no review date, revealed in the section, Oxygen Concentrators, staff are to connect one end of the cannula tubing to the concentrator and place the other end into the resident's nostrils. The policy does not address the addition of a humidification bottle. Review of Resident 55's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause persistent and progressive airflow obstruction and breathing problems) and difficulty in walking. An observation of Resident 55's oxygen concentrator on May 12, 2025, at 10:24 AM, revealed the tubing disconnected and not attached from the concentrator to the humidification bottle. The humidification bottle is used to produce and disperse water vapor, adding moisture to oxygen and restoring healthy levels of humidity. An immediate interview with Resident 55 revealed that, although she had the tubing inserted into her nostrils, she was not receiving any oxygen flow. An interview the Licensed Practical Nurse (Employee 4) on May 12, 2025, at 10:25 AM, confirmed the tubing to be unattached and was immediately reattached by Employee 4. An interview with the Nursing Home Administrator (NHA) on May 13, 2025, at 1:38 PM, revealed Resident 55 to be up and down and disconnects the tubing at times while using the restroom. Also, any nurse would be responsible for ensuring the appropriate care of the equipment for residents receiving oxygen therapy. An interview with Resident 55 on May 15, 2025, at 9:24 AM, revealed she does not remove the tubing from the concentrator to the humidification bottle. 28 Pa. Code 211.12 (b) (5) Nursing services