

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395575	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Gardens at Stevens, The		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Lancaster Avenue Stevens, PA 17578	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on review of policies, clinical records and investigative reports, as well as staff interviews, it was determined that the facility failed to complete thorough investigations of incidents to rule out that neglect and/or abuse were involved for two of eight residents reviewed (Resident 1 and Resident 8).</p> <p>Findings include:</p> <p>Review of the facility Abuse Policy, dated February 18, 2025, section labeled investigation and Reporting allegation of Abuse guidelines. States All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local state and federal agencies and thoroughly investigated by the administrator and or designee.</p> <p>A Quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 5, 2025, indicated that the resident was cognitively impaired, was sometimes able to understand and sometimes understood by others, required moderate assistance from staff for her care, and had diagnoses that included Alzheimer's Disease and dementia.</p> <p>A grievance for Resident 1, dated April 24, 2025, revealed that the daughter for Resident 1 was concerned that a male resident was found in the resident's bed thinking it was his room. He was only removed after the roommate for Resident 1 yelled for staff for several minutes.</p> <p>There was no documented evidence in the resident's medical records of the incident, and there was no documented evidence of an investigation completed by the facility.</p> <p>A significant change MDS assessment for Resident 8, dated February 10, 2025, indicated that the resident was cognitively intact, was usually understood and usually understood others, was dependent on staff for daily care needs and had anemia (a medical condition blood has a lower-than-normal number of red blood cells).</p> <p>An incident report log revealed Resident 8 was involved in an incident on May 20, 2025.</p> <p>A nursing note for Resident 8 dated May 20, 2025 revealed that he received a skin tear.</p> <p>Witness statement from DON dated May 20, 2025 revealed she heard a bang and questioned the resident if he needed help, and the resident stated he was ok.</p> <p>(continued on next page)</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence of an investigation completed by the facility to rule out neglect or abuse.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on June 4, 2025. at 1:45 p.m. revealed that they do not do a paper investigation and confirmed that she did not specifically ask staff or residents involved for written statements to complete a facility investigation to rule out neglect or abuse.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of Pennsylvania's Nursing Practice Act, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an assessment was completed by a registered nurse (RN) after an incident occurred where a male resident was found in her bed for one of 8 residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>The facility's risk management guide for incident and accidents, dated February 18, 2025, indicated that there should be an RN assessment after the incident in the clinical record.</p> <p>A Quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 5, 2025, indicated that the resident was cognitively impaired, was sometimes able to understand and sometimes understood by others, required moderate assistance from staff for her care, and had diagnoses that included Alzheimer's Disease and dementia.</p> <p>A grievance for Resident 1, dated April 24, 2025, revealed that the daughter for Resident 1 was concerned that a male resident was found in the resident's bed thinking it was his room. He was only removed after the roommate for Resident 1 yelled for staff for several minutes.</p> <p>There was no documented evidence in the clinical record for Resident 1 that there was a RN assessment completed after a male resident was found in the bed of Resident 1.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator at 1:45 p.m. revealed that there was no RN assessment completed of Resident 1 at the time when a male resident was found in her bed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, as well as family and staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for six of 8 residents reviewed (Resident 1,4, 5,6,7,8).</p> <p>Findings include:</p> <p>An annual Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 1, dated May 5, 2025, revealed that the resident was cognitively impaired and required moderate assistance from staff for personal care needs. Resident 1's shower schedule revealed that the resident preferred showering two times per week on Tuesday and Friday evening shift.</p> <p>Review of Resident 1's bathing records for May and June 2025 revealed that the resident received a bed bath on May 6, 16, 27, and June 3, 2025.</p> <p>There was no documented evidence Resident 1 was offered a shower on May 2,13,20,23, and 30, 2025.</p> <p>An admission diagnosis for Resident 4 revealed the resident was admitted to the facility on [DATE], with diabetes mellitus. Resident 4's shower schedule revealed that the resident preferred showering two times per week on Wednesday and Saturday morning shift.</p> <p>Review of Resident 4's bathing records for May and June 2025 revealed that the resident received a bed bath on May 31, 2025. There was no documented evidence that Resident 4 was offered a shower on May 21, 28, and June 4.</p> <p>Interview of Resident 4 on June 4, 2024, at 11:41 a. m. revealed that she was unaware of when her shower days are and would prefer having a shower instead of a bed bath. Observations of Resident 4 on June 4, 2024, at 11:41 revealed the resident was in bed in a hospital gown her hair was greasy and had large white flakes throughout. Her fingers were dirty and unkempt.</p> <p>An annual MDS for Resident 5 dated, May 2, 2025, revealed that the resident was cognitively impaired, was usually understood, and usually understood others. Resident 5's shower schedule revealed that the resident preferred showering two times per week on Tuesday and Friday morning shift.</p> <p>Review of Resident 5's bathing records for May and June 2025 revealed that the resident received a bed bath on May 6,13, and 20. There was no documented evidence Resident 5 was offered a shower on May 27, 30 and June 3.</p> <p>Interview of Resident 5 on June 4, 2024, at 9:11 a.m. revealed the resident didn't receive her showers like she prefers. Observations of Resident 5 on June 4, 2024, at 9:11 a.m. revealed that the resident was unkempt and dirty. Her hair was dirty and matted, and she was covered on her chest, arms, and back with an unknown rash. Resident stated that it felt like bugs crawling on her, and showers feel better.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS for Resident 6 dated, May 11, 2025, revealed the resident was cognitively intact and required moderate assistance from staff for daily care needs. Resident 6's shower schedule revealed that the resident preferred to shower on Wednesday and Saturday morning shift.</p> <p>Review of Resident 6's bathing records for May and June 2025 revealed that the resident received a bed bath on May 3,14,21, and 31. There was no documented evidence that the resident was offered a shower on May 10, 17, 24 and June 4, 2025.</p> <p>Interview with Resident 6 on June 4, 2024, 11:21 a.m. revealed that he did not receive showers like he should, and he would prefer a shower. He will get bed baths when they don't have enough staff to get him showers.</p> <p>A significant change MDS for Resident 7 dated February 10, 2025, revealed that the resident was cognitively intact and was dependent on staff for daily care. Resident 7's shower schedule revealed that the resident preferred to shower on Wednesday and Saturday evening shift.</p> <p>Review of Resident 7's bathing records for May 2025 revealed that the resident received a bed bath on May 3,10,17, and 24. There was no documented evidence that the resident was offered a shower on May 7,21, 28, and 31, 2025.</p> <p>A quarterly MDS for Resident 8 dated April 2, 2025, revealed that the resident was cognitively impaired and required moderate assistance with shower needs. Resident 8's shower schedule revealed that the resident preferred to shower on Mondays and Thursday day shift.</p> <p>Review of Resident 8's bathing records for May and June 2025 revealed that there was no documented evidence the resident was offered a shower on May 5, 29 and June 2, 5, 2025.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on June 4, 2025, at 2:39 p.m. confirmed that there was no documented evidence in the resident's medical records of the resident receiving showers on the above dates.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide showers as scheduled for six of 8 residents reviewed (Residents 1,4,5, 6,7).</p> <p>Findings include:</p> <p>The facility's policy regarding bathing/showering, dated February 18, 2025, indicated that all residents will be provided a shower at least one time weekly.</p> <p>An annual Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 1, dated May 5, 2025, revealed that the resident was cognitively impaired and required moderate assistance from staff for personal care needs. Resident 1's shower schedule revealed that the resident preferred showering two times per week on Tuesday and Friday evening shift.</p> <p>Review of Resident 1's bathing records for May and June 2025 revealed that the resident received one shower in the last 34 days. She had not refused any showers.</p> <p>An admission diagnosis for Resident 4 revealed the resident was admitted to the facility on [DATE], with diabetes mellitus. Resident 4's shower schedule revealed that the resident preferred showering two times per week on Wednesday and Saturday morning shift.</p> <p>Review of Resident 4's bathing records for May and June 2025 revealed that as of June 4, 2025, the resident has not received a shower since her admission on [DATE]. The resident has not refused any showers.</p> <p>Interview of Resident 4 on June 4, 2024, at 11:41a.m. revealed that she was unaware of when her shower days are and would prefer having a shower instead of a bed bath. Observations of Resident 4 on Jun 4, 2024, at 11:41 revealed the resident was in bed in a hospital gown her hair was greasy and had large white flakes throughout. Her fingers were dirty and unkempt. Resident revealed that she would prefer a shower, but was told they don't have enough staff to provide her a shower.</p> <p>An annual MDS for Resident 5 dated, May 2, 2025, revealed that the resident was cognitively impaired, was usually understood, and usually understood others. Resident 5's shower schedule revealed that the resident preferred showering two times per week on Tuesday and Friday morning shift.</p> <p>Review of Resident 5's bathing records for May and June 2025 revealed that as of June 4, 2025, the resident has not had a shower since May 15, 2025. The resident refused one shower in the last 39 days on May 9, 2025.</p> <p>Interview of Resident 5 on June 4, 2024, at 9:11 a.m. revealed the resident hasn't received a shower in a while, and it feels like bugs crawling on her. She was informed it was due to not having enough staff to get her a shower.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations of Resident 5 on June 4, 2024, at 9:11 a.m. revealed that the resident was unkempt and dirty. Her hair was dirty and matted, and she was covered on her chest, arms, and back with an unknown rash.</p> <p>A quarterly MDS for Resident 6 dated, May 11, 2025, revealed the resident was cognitively intact and required moderate assistance from staff for daily care needs. Resident 6's shower schedule revealed that the resident preferred to shower on Wednesday and Saturday morning shift.</p> <p>Review of Resident 6's bathing records for May and June 2025 revealed the resident received 2 showers in the last 34 days, and did not refuse any showers.</p> <p>Interview with Resident 6 on June 4, 2024, 11:21 a.m. revealed that he did not receive showers like he should, and he would prefer a shower. He will get bed baths when they don't have enough staff to get him showers.</p> <p>A significant change MDS for Resident 7 dated February 10, 2025, revealed that the resident was cognitively intact and was dependent on staff for daily care. Resident 7's shower schedule revealed that the resident preferred to shower on Wednesday and Saturday evening shift.</p> <p>Review of Resident 7's bathing records for May and June 2025 revealed that the resident received 1 shower in the last 34 days, and did not refuse any showers.</p> <p>Interview with Nurse Aide 1 on June 4, 2025, at 12:39 p.m. revealed that there was not enough staff and they did not always have time to get showers done for residents they will cycle which resident's receive showers.</p> <p>Interview with Licensed Practical Nurse (LPN) 2, at 12:39 p.m. revealed that she will have to help the girls with toileting, and she is not able to get the resident's showers done, turning and repositioning is not always done, and the care is not quality care because staff are rushed.</p> <p>Interview with Nurse Aide 3 on June 4, 2025, at 11:37 a.m. revealed that they do not have enough staff to complete their daily tasks, showers are not done on all residents.</p> <p>Interview with Nurse Aide 4 on June 4, 2025, at 11:45 a.m. revealed that they do not have enough staff to shower all residents they will only have time to shower 1 out of the 5 scheduled on June 4, 2025.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on June 4 at 1:34 p.m. revealed that they do the best to schedule enough staff.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for six of 8 residents reviewed (Resident 1,4,5,6,7,8), and that documentation of incident was in the clinical records for one of 8 residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>An annual Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 1, dated May 5, 2025, revealed that the resident was cognitively impaired and required moderate assistance from staff for personal care needs.</p> <p>The shower record for Resident 1 for May and June 2025 revealed that on May 2,13,20,23, and 30, 2025 had no documentation.</p> <p>An admission diagnosis for Resident 4 revealed the resident was admitted to the facility on [DATE], with diabetes mellitus.</p> <p>The shower record for Resident 4 for May and June 2025 revealed that on May 21, 2025 NA was documented, and on May 24 and July 4, 2025, the shower record had no documentation.</p> <p>An annual MDS for Resident 5 dated, May 2, 2025, revealed that the resident was cognitively impaired, was usually understood, and usually understood others.</p> <p>The shower record for Resident 5 for May and June 2025 revealed that May 23, 27, 30, and June 3, 2025, had no documentation.</p> <p>A quarterly MDS for Resident 6 dated, May 11, 2025, revealed the resident was cognitively intact and required moderate assistance from staff for daily care needs.</p> <p>The shower record for Resident 6 for May and June 2025 revealed that May 10, 17, 24, and June 4, 2025, had no documentation.</p> <p>A significant change MDS for Resident 7 dated February 10, 2025, revealed that the resident was cognitively intact and was dependent on staff for daily care.</p> <p>The shower record for Resident 7 for May 2025 revealed May 7 and 28, 2025 had no documentation, May 21, 2025, was documented NA May 31, 2025.</p> <p>A quarterly MDS for Resident 8 dated April 2, 2025, revealed that the resident was cognitively impaired and required moderate assistance with shower needs.</p> <p>The shower record for Resident 8 for May and June 2025 revealed that May 5, 2025 was had no documentation and May 29 and June 2, 2025 was documented NA.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on June 4, 2025, at 1:45 p.m. confirmed that the documentation for the shower record should never be left blank and documenting NA is unacceptable.</p> <p>28 Pa Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure a system of surveillance was in place to identify, prevent, monitor, and report potential infectious skin conditions.</p> <p>Findings include:</p> <p>Observations of Resident 5 on June 4, 2025, at 9:21 a.m. revealed the resident had a rash on her upper arms, chest and back. An interview with the resident on June 4, 2025, at 9:21 a.m. revealed the resident has had this rash for a while, and it feels like bugs crawling on her.</p> <p>Observations of Resident 3 on June 4, 2025, at 9:15 a.m. revealed resident had a rash all over his arms, chest, and back. A review of the resident's clinical records revealed that the resident receives permethrin cream (a medication for the treatment of scabies) on June 3, 2025, at 6:00 p.m. Interview with Resident 3 on June 4, 2025, at 9:45 a.m. revealed that he wasn't itchy for the first time in months after the treatment.</p> <p>Interview with the Nurse Practitioner on June 4, 2025, at 12:04 p.m. revealed that it is the infection prevention nurse's job to track and trend skin conditions, and that Resident 3 was treated with permethrin cream because they tried different treatments, and nothing else had worked. The resident was not tested for scabies because the rash didn't present like typical scabies, and that he has an appointment with dermatology for follow-up testing.</p> <p>Interview with the Infection Prevention Nurse on June 4, 2025, at 9:45 a.m. revealed that she does not have a system in place to track and trend skin conditions. She believes that the Nurse Practitioner has that information.</p> <p>Interview with the Director of Nursing on June 4, 2025, at 1:52 p.m. revealed that they do not have a system in place to track and trend skin conditions.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>