

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 12/03/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on staff and resident interviews, it was determined that the facility failed to ensure residents were assisted out of bed in a timely manner to attend scheduled Sunday religious services. Findings include: An interview conducted with the Activities Director on October 29, 2025, at approximately 12:30 p.m. revealed that some residents are unable to attend Sunday services because nursing staff do not get them out of bed in time. The Activities Director stated that this occurs every weekend. An interview conducted with the Activities Assistant on October 29, 2025, at approximately 12:40 p.m. revealed similar concerns. The Activities Assistant reported that 1-2 residents are unable to attend Sunday services weekly due to nursing staff not assisting them out of bed in time. She further stated that this issue occurs every weekend and that she reports it to nursing staff when it happens. Both the Activities Director and Activities Assistant reported that they did not inform the Nursing Home Administrator (NHA) of the issue because they did not think about it during the week. An interview conducted with Resident R1 on October 29, 2025, at approximately 1:30 p.m. revealed that she missed Sunday service on October 26, 2025, because nursing staff did not get her out of bed in time. Resident R1 stated that staff are aware in advance that she needs to be up before 9:30 a.m. to attend Sunday service. An interview conducted with the NHA on October 29, 2025, at approximately 3:00 p.m. confirmed the above. S 211.12(e) Nursing Services S 201.14(b) Responsibility of licensee</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, staff interviews, and review of facility records and policies, it was determined that the facility failed to implement contact precautions for a resident diagnosed with scabies (Resident R3). Findings include: Review of Resident R3's clinical record on October 29, 2025, revealed a diagnosis of scabies (a skin infestation caused by microscopic parasites that results in intense itching) with a start date of October 28, 2025. Review of the facility policy titled Scabies Identification, Treatment and Environmental Cleaning, revised August 2016, indicated: Affected residents should remain on Contact Precautions until twenty-four (24) hours after treatment. Further review of the clinical record failed to reveal any physician orders for contact precautions. Review of Resident R3's physician orders revealed an order for Permethrin 5% cream (a topical medication used to treat scabies) with a start date of October 28, 2025, and with a note to hold treatment until after a dermatology appointment scheduled for October 30, 2025. Observations conducted of Resident R3's room revealed no signage indicating that the resident was on contact precautions. An interview conducted with the Assistant Director of Nursing (ADON) on October 29, 2025, at approximately 1:45 p.m. revealed that she had not been informed of Resident R3's recent scabies diagnosis. The ADON stated that if she had been made aware of the diagnosis, she would have immediately implemented contact precautions and educated staff on appropriate procedures. The ADON further reported that Resident R3's dermatology appointments in July and August 2025 indicated that the resident did not have scabies at that time. Resident R3 was unavailable for interview due to cognitive impairment. A follow-up interview with the ADON at approximately 2:00 p.m. confirmed that Resident R3 should have been placed on contact precautions upon diagnosis. S 211.2(d)(5) Medical Director S 211.12(d)(5) Nursing Services</p>