STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395440	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camp Hill Skilled Nursing and Rehabilitation Ctr	1700 Market Street Camp Hill, PA 17011

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46253 Based on facility policy review, observations, clinical record review, staff interviews, and facility documentation review, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for four of 12 residents reviewed (Residents 4, 9, 10, and 12). Findings include: Review of facility policy, titled Medication Administration Section 7.1 General Guidelines, dated January 2024, revealed Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices; 1. Medications are administered in accordance with written orders of the prescriber .14. medications are administered within 60 minutes of scheduled time. Observation of third floor on July 25, 2024, at 11:30 AM, revealed that Employee 1 (Licensed Practical Nurse [LPN]) and Employee 2 (LPN) were administering medications to residents. During an interview with Employee 1 on July 25, 2024, at 11:31 AM, Employee 1 indicated that the LPN was still administering morning medications and that the they had two more residents (Residents 2 and 3) to administer medications to. Employee 1 further indicated that the they were a new employee at the facility and that the they were not sure of the timeframe in which the they had to pass medications, but thought the they had from 7 AM to 10 AM to pass the residents' morning medications. During an interview with Employee 2 on July 25, 2024, at 11:34 AM, Employee 2 indicated that they had just administered the last Resident their morning medications (Resident 4). Employee 2 indicated that they were not aware of a timeframe in which they had to administer medications, but indicated I try to get them done before lunch. Observation of Arcadia unit on July 25, 2024, at 11:36 AM, revealed that Employee 3 (Licensed Practical Nurse) was administering medications to residents. During an interview with Employee 3 on July 25, 2024, at 11:36 AM, Employee 3 indicated that they were still administering morning medications to residents. Employee 3 indicated that they still needed to administer medications to eight more residents (Residents 5, 6, 7, 8, 9, 10, 11, and 12). Employee 3 further stated that they were running behind. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's clinical record revealed diagnoses that included right above the knee amputation and diabetes mellitus type II (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin) with neuropathy (a group of diseases resulting from damaged or malfunctioning of nerves that causes weakness, numbness and pain in hands and feet). Review of Resident 4's physician orders revealed an order for gabapentin capsule 300 mg (milligrams) give 300 mg by mouth three times a day for neuropathy, dated March 6, 2023. Review of Resident 4's July Medication Administration Record (MAR) revealed that their gabapentin was scheduled to be administered at 9:00 AM, 1:00 PM, and 8:00 PM. Review of Resident 4's Medication Administration Audit Report provided by the facility from July 18-25, 2024, revealed that the Resident received their prescribed gabapentin doses as follows: 1) on July 19, 2024, received their 9:00 AM dose at 10:15 AM (1 hour and 15 minutes past the prescribed time); 2) on July 20, 2024, received their 9:00 AM dose at 10:28 AM (1 hour and 28 minutes past the prescribed time) and received their 1:00 PM dose at 2:15 PM (1 hour and 15 minutes past the prescribed time); 3) on July 24, 2024, received their 9:00 AM dose at 11:48 AM (2 hours and 48 minutes past the prescribed time) and received their 1:00 PM dose at 1:34 PM (only 1 hour and 46 minutes between doses had lapsed); and 4) on July 25, 2024, received their 9:00 AM dose at 11:25 AM (2 hours and 25 minutes past the prescribed time) and received their 1:00 PM dose at 12:57 PM (only 1 hour and 32 minutes between doses had lapsed). Review of Resident 9's clinical record revealed diagnoses that included hypertension (high blood pressure) and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 9's physician orders revealed an order for Coreg oral tablet 6.25 mg (Carvedilol) give 12. 5 mg by mouth every 12 hours for hypertension Hold for SBP (systolic blood pressure) less than 120, dated October 18, 2023. Review of Resident 9's July MAR revealed that their coreg was scheduled to be administered at 9:00 AM and 9:00 PM. Further review of Resident 9's July MAR revealed that the Resident was administered their prescribed coreg outside of the physician ordered parameters as follows: 1) July 1, 2024, at 9:00 AM, their BP was 115/52; 2) July 7, 2024, at 9:00 PM, their BP was 105/52; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) July 10, 2024, at 9:00 AM, their BP was 106/73; 4) July 11, 2024, at 9:00 PM, their BP was 112/79; 5) July 14, 2024, at 9:00 AM, their BP was 108/91; 6) July 18, 2024, at 9:00 AM, their BP was 119/60; and 7) July 19, 2024, at 9:00 AM, their BP was 108/53. Review of Resident 9's Medication Administration Audit Report provided by the facility from July 18-25, 2024, revealed that the Resident received their prescribed coreg doses as follows: 1) on July 18, 2024, received their 9:00 AM dose at 12:37 PM (3 hours and 37 minutes past the prescribed time) and their 9:00 PM dose at 8:52 PM (only 8 hours and 15 minutes between doses had lapsed); 2) on July 20, 2024, received their 9:00 AM dose at 12:54 PM (3 hours and 54 minutes past the prescribed time) and their 9:00 PM dose at 9:00 PM (only 8 hours and 6 minutes between doses had lapsed); 3) on July 22, 2024, received their 9:00 AM dose at 12:35 PM (3 hours and 35 minutes past the prescribed time) and their 9:00 PM dose at 8:30 PM (only 7 hours and 55 minutes between doses had lapsed); and 4) July 25, 2024, 2024, received their 9:00 AM dose at 12:20 PM (3 hours and 20 minutes past the prescribed time). Review of Resident 10's clinical record revealed diagnoses that included generalized osteoarthritis (degeneration of joint cartilage and the underlying bone, causing pain and stiffness especially in the hip, knee, and thumb joints) and vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults). Review of Resident 10's physician orders revealed an order for acetaminophen 325 mg give two tablets orally every 12 hours for pain, dated March 1, 2021. Review of Resident 10's July 2024 MAR revealed that their acetaminophen was scheduled to be administered at 9:00 AM and 9:00 PM. Review of Resident 10's Medication Administration Audit Report provided by the facility from July 18-25, 2024, revealed that the Resident received their prescribed acetaminophen doses as follows: 1) July 20, 2024, received their 9:00 AM dose at 11:57 AM (2 hours and 57 minutes past the prescribed time) and their 9:00 PM dose at 8:57 PM (only 9 hours between doses had lapsed); (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(c)(d)(1)(2)(5) Nursing Services