

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

October 9, 2025

AMY WAGAMAN, LEGAL ENTITY
COUNTRY MEADOWS OF WEST SHORE LLC

RE: COUNTRY MEADOWS OF WEST
SHORE
4905 EAST TRINDLE ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33353

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/26/2025, 08/27/2025, 08/28/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: COUNTRY MEADOWS OF WEST SHORE License #: 33353 License Expiration: 08/31/2026
 Address: 4905 EAST TRINDLE ROAD, MECHANICSBURG, PA 17050
 County: CUMBERLAND Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: COUNTRY MEADOWS OF WEST SHORE LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 11/19/2022 Issued By: Department of Labor and Industry

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 146 Waking Staff: 110

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 08/28/2025

Inspection Dates and Department Representative

08/26/2025 - On-Site: [REDACTED]
 08/27/2025 - On-Site: [REDACTED]
 08/28/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 180 Residents Served: 104

Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:

Hospice
 Current Residents: 4

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 103
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 42 Have Physical Disability: 0

Inspections / Reviews

08/26/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/22/2025

Inspections / Reviews (*continued*)

09/24/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/03/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/01/2025

09/30/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/03/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/10/2025

10/09/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/03/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

19 - Review Waiver

1. Requirements

2600.

19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On 12/6/24, 12/16/24, 12/17/24, 1/30/25, 4/16/25, and 7/22/25, the home received waivers for staff education. However, none of these waivers were posted in the home.

Plan of Correction

Accept ([redacted] - 09/30/2025)

Associate ED placed the waivers immediately upon discovery on 8/28/25.

The Associate Executive Director will complete a training with the business office managers and the employment specialists that assist with receiving waivers of 55 Pa. Code Ch. 2600.54a. The purpose is to educate them that waivers need to be posted in a conspicuous and public place within the home. This training will be completed by 9/26/25.

The Associate ED or designee will monitor for the next 3 months beginning on or before October 3, 2025 that copies of any waivers are being placed in the shadow box upon receipt.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented ([redacted] - 10/09/2025)

81a - Accommodation

2. Requirements

2600.

81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home received a physician's order for a beside mobility device for resident #1 on 7/30/25. However, on 8/27/25, this device was not installed on the resident's bed.

Plan of Correction

Accept ([redacted] - 09/30/2025)

A new mattress was obtained that complied with bed enabler safety protocols. The bed enabler was re-attached to the bed with the new mattress on 8/30/25 by the maintenance associate.

Maintenance Team, Shift Managers, and Restorative Coordinator will complete training on proper installation of bed enablers when a doctor's order is obtained. In this training, we will educate them to ensure bed enablers are installed on a 12" mattress, with a properly fitted cover when a doctors order is obtained to prevent them from being removed. Our Shift Manager or designee will complete an audit of all residents that have an order for a bed enabler, to ensure their bed enablers are properly fitted to their beds and are meeting the requirements to safely use them. This will be completed by 9/26/25.

81a - Accomodation (continued)

Bed enablers will be checked monthly the Shift Manager or designee for the next 3 months beginning on or before October 3, 2025 to ensure compliance to the process.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented (█) - 10/09/2025)

132c - Fire Drill Records

3. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home does not include the total number of residents evacuated during fire drills but counts only residents evacuated from the area where the simulated fire occurs. These drills include those conducted on:

- On 7/11/25 at 5:44 AM, there were 101 residents present in the home. However, it was documented as only 35 residents evacuated.
- On 6/9/25 at 9:08 AM, there were 98 residents present in the home. However, it was documented as only 35 residents evacuated.
- On 5/13/25 at 6:12 AM, there were 103 residents present in the home. However, it was documented as only 23 residents evacuated.
- On 4/17/25 at 4:01 PM, there were 105 residents present in the home. However, it was documented as only 38 residents evacuated.

Plan of Correction

Accept (█) - 09/30/2025)

The team discussed expectations with the inspector on 8/28/2025.

The Associate Executive Director will be completing a training form to go over all the expectations of what all needs documented on our fire drill records. Our maintenance team and executive directions will be completing this training to make sure everyone knows how to complete this form per state regulations which includes the amount of resident that are present during the time of the fire drills and the number of residents that have been evacuated. Both of these categories must be the same number. This training will be completed by 9/26/2025.

The Associate Executive Director or designee will be reviewing the form once it is completed after a fire drill for the next 3 months beginning on or before October 3, 2025 to make sure this information is correct moving forward.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented (█) - 10/06/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.

141b1 - Annual Medical Evaluation (continued)

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's current annual medical evaluation, dated [REDACTED], does not include height.

Resident #4's current annual medical evaluation, dated [REDACTED] does not include height.

Resident #5's current annual medical evaluation, dated [REDACTED], does not include height, health status and cognitive functioning

Resident #6's current annual medical evaluation, dated [REDACTED], does not include height.

Plan of Correction

Accept [REDACTED] - 09/30/2025)

An audit was completed of all DME's by the Assistant Director of Nursing in community and reviewed for omissions by September 24, 2025.

The physicians for residents #3, #4, and #6's will be faxed to request to add in the heights of the residents obtained on September 24th, 2025 to updated by the Assistant Director of Nursing or LPN designee. The physician for resident #5 will be faxed to add in the height, health status and cognitive functioning by September 24th, 2025 and will be added by the Assistant Director of Nursing or LPN designee.

The Assistant Director of Nursing will complete a training to ensure that the Wellness Secretary and LPN's understand that there should be no omission of information on a DME. This training will be completed by 9/26/25.

When a DME is received by the DON or ADON they will ensure to review the document within 72 hours to make sure there is no omission of information for the next 3 months beginning on or before October 3, 2025 to ensure the plan of correction is effective. Should an omission be found the clinical administration team will reach out to provider and obtain a verbal or written order for an addendum to the DME.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented [REDACTED] - 10/09/2025)

183b - Meds and Syringes Locked

5. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 8/28/25, at 10:00 AM, a Tube of Neosporin ointment was unlocked, unattended, and accessible in resident #7's room. Resident #7 is not assessed as being able to self-administer.

On 8/28/25, at 10:20 AM, and again on 8/28/25, at 12:37 PM, there was a tube of Balmex diaper rash cream that was unlocked, unattended and accessible on the bathroom vanity of resident #4's room. Resident #4 is not assessed as being able to self-administer medication.

183b - Meds and Syringes Locked (continued)

Plan of Correction

Accept (█) - 09/30/2025)

Medications were removed from both resident's apartments upon discovery on 8/28/25 by Assistant Director of Nursing.

The Assistance Director of Nursing will be completing a training form to review resident self-administrating and supporting medication safety. In this training, we will educate Direct Care Staff what to do if they discover medications or creams in a resident apartment who is not assessed as being able to self-administer their medication. Co-workers will treat all loose medications and creams as contraband and report immediately to the nurse for clarification. This training will be complete by 9/26/25.

Personal Care Associates, Nursing, or Medication Associates are assisting residents in their apartment, they will be mindful to check the apartment for medications or creams that may be brought in by family or purchased by the resident themselves for the next 3 months beginning on or before October 3, 2025 to ensure corrective action is affective.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented (█) - 10/06/2025)

183d - Prescription Current

6. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 8/27/25, Tramadol 50 ml prescribed for resident #8, was in the home's medication cart. However, this medication was discontinued on 5/13/25.

On 8/27/25, Insulin Aspart 100 U prescribed for resident #9, was in the home's medication cart. However, this medication was discontinued on 7/10/25.

On 8/28/25, at 10:00 AM, a tube of Neosporin ointment was unlocked, unattended, and accessible in resident #7's room. There was no current order for Neosporin ointment.

Plan of Correction

Accept (█) - 09/30/2025)

Medication was pulled from the medication cart on 8/27/25 by the Assistant Director of Nursing.

The Assistance Director of Nursing will be completing a training form to pull all medications that do not have current orders from the cart with the Medication Associates. This training will be complete by 9/26/25.

Medication associates will complete cart audits that include the review of medications and orders once weekly and turn into the DON and ADON for review. These will be reviewed for the next 3 months beginning on or before October 3, 2025 to ensure compliance is achieved.

Licensee's Proposed Overall Completion Date: 10/03/2025

183d - Prescription Current (continued)

Implemented () - 10/06/2025

184a - Resident's Meds Labeled

7. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #8 is prescribed Lantus Solostar insulin with orders to inject 43 units subcutaneously daily in the am". However, the pharmacy label states inject 38 units subcutaneously daily at lunch.

Repeated Violation - 8/13/24, et al

Plan of Correction

Accept () - 09/30/2025

Direction change label was placed on the medication upon finding on 8/27/25 by the Assistant Director of Nursing.

The Assistance Director of Nursing will be completing a training form to place direction change stickers on medications that have order changes with the medication associates. This training will be complete by 9/26/25.

Medication associates will complete cart audits that include the review of medications and orders once weekly and turn into clinical admin for review. These will be reviewed for the next 3 months beginning on or before October 3, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented () - 10/06/2025

227d - Support Plan Medical/Dental

8. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1's utilizes a bedside mobility device. However, the resident's current support plan, dated () does not include the specific need for the device, the intended use and risks associated with the use of this device, the resident's abilities to use the device safely for the purposes intended and the identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Resident #4's utilizes a bedside mobility device. However, the resident's current support plan, dated (), does not include the specific need for the device, the intended use and risks associated with the use of this device, the resident's

227d - Support Plan Medical/Dental (continued)

abilities to use the device safely for the purposes intended and the identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Resident #5's utilizes a bedside mobility device. However, the resident's current support plan, dated [REDACTED] does not include the specific need for the device, the intended use and risks associated with the use of this device, the resident's abilities to use the device safely for the purposes intended and the identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Resident #10's utilizes a bedside mobility device. However, the resident's current support plan, dated [REDACTED] does not include the specific need for the device, the intended use and risks associated with the use of this device, the resident's abilities to use the device safely for the purposes intended and the identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Resident #11's utilizes a bedside mobility device. However, the resident's current support plan, dated [REDACTED] does not include the specific need for the device, the intended use and risks associated with the use of this device, the resident's abilities to use the device safely for the purposes intended and the identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Plan of Correction

Accept [REDACTED] - 09/30/2025)

An audit was completed of all residents that have bed canes or halo devices to review what RASPs needed to be updated on 8-28-2025 by the Associate Executive Director.

The Associate Executive Director will be completing a training with LPN's, Assistance Director of Nursing, and Shift Managers that assist with completing the RASPs for our resident to educate the team on the following information that we will be documented in a resident's RASP if they are using a bed cane or Halo device. "(Resident Name) has difficulty moving in bed, repositions [REDACTED] and transferring in/out of bed. (Resident Name) requires bed enabler for safety and stability, bed mobility, repositioning, transferring in/out of bed. (Resident Name) has been assessed by [REDACTED] provider, PT and nursing and is deemed safe to use the FDA approved a (Halo Safety Ring or Bed Cane) with cover. Use of this device is in compliance with company policy. (Resident Name) and her POA have been informed of associated risks including but not limited to strangulation, suffocation, entrapment. Informed consent has been obtained and signed. DCS will ensure the (Halo Safety Ring or Bed Cane) is always in place, the (Halo Safety Ring or Bed Cane) cover is always in place, the (Halo Safety Ring or Bed Cane) is secure on the bed and mattress has not shifted."

This training will be completed by 9-26-2025.

The RASPs for residents #1, #3, #4, #5, #10 and #11's will be updated with an addendum for the bedside mobility language on or before September 26, 2025 by the Associate Executive Director and Restorative Coordinator.

Any other RASPs needing corrected as part of the audit will also have an addendum into their care plans stating the above information on or before the date of September 26, 2025.

The DON, ADON or designee will review initial and annual care plans for the next 3 months beginning on or before October 3, 2025 to ensure the documentation is correct for any bed enablers upon completion to ensure corrective

227d - Support Plan Medical/Dental (continued)

action has been effective.

Licensee's Proposed Overall Completion Date: 10/03/2025

Implemented ([REDACTED] - 10/06/2025)