STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395660	A. Building B. Wing	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Nursing & Rehabilitation Center	1000 Claremont Road Carlisle, PA 17013

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on observation, clinical record review, review of facility policies, and staff interviews, it was determined that the facility failed to secure the stairway and elevators and failed to provide adequate supervision and interventions to prevent accident hazards for wandering residents on two of four nursing units (Floors 1 and 2). This failure placed the facility in an Immediate Jeopardy situation. Findings include: Review of the facility policy titled, Elopement Policy/Procedure last revised October 2020, outlines the following: defines wandering as aimless moving about without a desire to leave the facility; defines exit seeking behavior as the process of a resident endeavoring to leave the facility without authorization; and defines elopement as a resident who has left the facility unauthorized or unwitnessed, or an unauthorized absence of a resident. The policy further states that residents who have risk for elopement will be monitored for safety as part of their plan of care and placed on the elopement list. The interdisciplinary team will assess and develop appropriate interventions and approaches to prevent the resident from eloping. Residents at risk for elopement will have an elopement risk care plan that will include the interventions in place for prevention of elopement. Observations on June 9, 2022, at 10:24 AM on the first-floor nursing care unit, revealed a door that opened to a stairwell. The door was unlocked and freely accessible, with a push bar that opens the door into the stairwell. The stairwell went down to the ground floor and went up to the second and third floors. Further observation revealed two elevators present that provide access to the third, second, and ground floors. The third floor is currently vacant, and the ground floor stairwell has an alarmed emergency door located inside the stairwell. Observations on June 9, 2022, at 10:30 AM on the second-floor nursing care unit, revealed a door that opened to a stairwell. The door was unlocked and freely accessible with a push bar that opens the door into the stairwell. The stairwell went down to the first and ground floors and went up to the third floor. Further observation revealed two elevators located in the center of the unit in front of the nurse's station. The elevators give access to the third, first, and ground floors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident's clinical records revealed 43 residents residing on the first floor, of those 43 residents, 21 residents are capable of ambulating independently by walking without assistive devices, walking with a cane or walker, or using a wheelchair, and 4 of those also has a diagnosis of Dementia. Further review revealed 13 residents residing on the second floor, of those 13 residents, 6 residents are capable of ambulating independently by walking without assistive devices, walking with a walker, or moving independently while in a wheelchair, and 1 of those also has a diagnosis of dementia. Observation on June 9, 2022, at 10:35 AM, revealed Resident 1 walking back and forth with a walker in the halls and in front of the elevators. Interview with Employee 1 on June 9, 2022, at 10:38 AM, revealed Resident 1 has been wandering while residing on that unit. Employee 1 stated Resident 1 should have a Wanderguard (a security bracelet / anklet that prevents the elevator from departing the unit and activates an alarm) present to prevent him from getting on the elevators. The Employee checked the Resident's ankle to see if a Wanderguard was present and identified he did not have one. Review of Resident 1's medical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that include schizophrenia (a mental disorder with cognitive symptoms that may include problems in attention, concentration, and memory, and psychotic symptoms that may include hallucinations, delusions, thought disorders, and movement disorders) and Parkinson's Disease (a chronic and progressive a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Resident 1 was admitted to the facility following knee surgery. Review of Resident 1's progress notes revealed a note dated June 6, 2022, at 12:51 AM, stating Resident 1 wandered out of his room and was speaking to himself in the hallway most of the shift. An additional note dated June 6, 2022, at 12:25 PM, revealed Resident walking in and out of bedroom and walking through hallway naked. Resident attempted to use elevator multiple times. Review of Resident 1's admission assessment dated [DATE], revealed resident is independently ambulatory and walks frequently and is a current smoker. The assessment further revealed the resident does not have normal gait/balance, has problems balancing when standing, has problems balancing while walking, and requires use of assistance device (cane, walker, wheelchair, furniture). Review of the facility assessment titled, Wandering Risk Scale revealed resident are scored on abilities in multiple categories to identify their risk of wandering. If a resident scores 0-8 points they are considered low risk, 9-10 points is considered at risk to wander, and 11-and above is considered high risk to wander. Review of Resident 1's wandering risk assessment dated [DATE], revealed the resident is identified as a high risk to wander. The assessment revealed the resident was marked as can move without assistance while in a wheelchair (1 point), the resident was not marked for ambulatory (3 Points). The resident is also marked for having a history of wandering (2 points), has medical diagnosis of dementia/cognitive impairment, diagnosis impacting gait/mobility or strength (5 points), has history of wandering (2 points), has wandered within the home without leaving the grounds (1 point), has wandered in the past month (1 point), can follow instructions (1 point). The Resident was given a score of 12 which categorizes as a high risk to wander. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Director of Nursing (DON) on June 10, at 10:40 am, revealed that the wandering risk assessment for Resident 1, dated June 6, 2022, was coded incorrectly. The DON revealed the resident was marked for having a medical diagnosis of dementia/cognitive impairment, diagnosis impacting gait/mobility or strength and should not have been. The DON stated this change would change the resident to a low risk to wander. Review of Resident 1's updated wandering risk assessment submitted on June 10, 2022, revealed the resident was marked as can move without assistance while in a wheelchair (1 point) and not marked as ambulatory (3 points), has a history of wandering (2 points), has wandered within the home without leaving the grounds (1 point), has wandered in the past month (2 points), and can follow instructions (1 point). The assessment was updated to show resident does not have a medical diagnosis of dementia/cognitive impairment, diagnosis impacting gait/mobility or strength, The resident was given a score of 7 which categorizes as a low risk to wander. Observation on June 9, 2022, at 1:40 PM on the second-floor nursing care unit, revealed no staff present at the nurse's station or in view of elevators or stairwell door. Review of Resident 2's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses that include adjustment disorder with disturbance of conduct and conversion disorder with seizures or convulsions (a mental condition in which a person experiences blindness, paralysis, or other nervous system [neurologic] symptoms that cannot be explained by illness or injury). Interview with Employee 2 on June 9, 2022, at approximately 4:00 PM, revealed Resident 2 was admitted the day prior and has been upset due to being in a new environment. The Employee confirmed that Resident 2 could get to the stairs. Review of Resident 2's Functional Abilities and Goals assessment completed on June 9, 2022, revealed the resident is able to walk. Review of Resident 2's wandering risk assessment dated [DATE], revealed the resident was marked as able to move without assistance while in a wheelchair (1 point), and was not marked for ambulatory (3 points), however documentation in the clinical record shows Resident 2 walks. The assessment further revealed the resident can follow instructions (1 point). The resident was given a score of 2 which categorizes as a low risk to wander. Review of Resident 3's medical record revealed resident was admitted to the facility on [DATE], with diagnoses that include schizoaffective disorder bipolar type (symptoms of schizophrenia-like delusions and paranoia, while also having periods of mania) and epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors). Review or Resident 3's Minimum Data Set, dated dated [DATE], revealed under the functional status section that resident ambulates using a walker and a wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 3's wandering risk assessment dated [DATE], revealed the resident was not marked for the section regarding movement, the options are: can move without assistance while in a wheelchair (1 point) or ambulatory (3 points), an additional 1-3 points would be added to score if completed. The assessment revealed the resident can follow instructions (1 point) and has a medical diagnosis of dementia/cognitive impairment, diagnosis impacting gait/mobility or strength (5 points). The resident was given a score of 6 which categorizes as a low risk to wander. An Immediate Jeopardy situation was identified, and the immediate Jeopardy template was provided to the Nursing Home Administrator on June 9, 2022, at 4:20 PM, for failing to ensure adequate supervision and interventions to prevent accident hazards for wandering / elopement risk residents. An immediate corrective action plan was requested on June 9, 2022, at 4:25 PM, to ensure the stairway and elevators were properly secured to prevent injury or elopement of residents. The facility provided an immediate corrective action plan on June 9, 2022, at 6:35 PM, which indicated: A Wanderguard transmitter was placed on Resident 1 upon discovery, which triggers an alarm on the elevator and renders in unable to run until overridden with a code. Resident 1's care plan was updated to incorporate the approach. A motion-censored local alarm was placed on the first and second floor stairwell. The facility reviewed elopement assessments of remaining residents and did not discover additional residents at risk for elopement. The facility initiated immediate education of second floor nursing staff regarding Resident 1's assessment, wandering risk, and care plan approaches, including the Wanderguard transmitter. Facility initiated immediate education of facility staff concerning local alarms on first and second floor stairwell doors. The facility engaged a contracted service company to provide a proposal to incorporate the two stairwell doors into an existing alarm notification annunciator at the nurse's station. The Immediate Jeopardy was removed on June 10, 2022, at 11:09 AM, following confirmation the corrective action plan was implemented. Free of Accident Hazards/Supervision/Devices CFR 483.25(d)(1)(2) 28 Pa. Code 210.14(a) Responsibility of licensee 28 Pa. Code 201.18(a)(b)(1)(3) Management 28 Pa. Code 207.2(a) Administrator's responsibility

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44805 Based on review of test tray results and resident and staff interviews, it was determined that the facility failed to serve foods at palatable temperatures as discerned by one of three residents sampled (Resident 4). Findings include: According to the federal regulation 483.60(i)-(2) Food safety requirements- the definition of Danger Zone temperatures of food is temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit. Temperatures outside the federal temperature standards could allow rapid growth of pathogenic microorganisms that can cause foodborne illness. Review of form titled Estimated Time of Meal Cart Delivery, revealed tray line service starts at 11:00 AM for lunch service. Two meal carts are used to deliver meals to residents on the C-wing. The first cart is scheduled to arrive at 11:50 AM, the second cart is scheduled to arrive at 12:20 PM. Observation of the lunch meal on June 9, 2022, on the C-wing revealed the last tray from the second delivered meal cart was served at 1:58 PM. The temperatures of the test tray food items revealed the following unpalatable food and beverage temperatures: Milk - 74.1 degrees Fahrenheit Pureed ground beef - 122 degrees Fahrenheit Pureed bread - 120 degrees Fahrenheit Mashed sweet potato -120 degrees Fahrenheit Interview with the Dietary Manager, the staff member who took the food and beverage temperatures, at 2:00 PM, revealed the milk was not a good temperature. Interview with Resident 4 at 3:20 PM, revealed the milk was not cold and the green beans were not hot when they arrived for lunch. The resident states the temperatures of her food being incorrect is normal for most meals. 28 Pa. Code 211.6(c) Dietary services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44805 Based on observations, document review, and interviews with residents and staff, it was determined that the facility failed to provide meals at scheduled times for one out of four nursing units (C-wing). Findings include: Review of form titled Estimated Time of Meal Cart Delivery, revealed tray line service starts at 11:00 AM for lunch service. Two meal carts are used to deliver meals to residents on the C-wing. The first cart is scheduled to arrive at 11:50 AM, the second cart is scheduled to arrive at 12:20 PM. Observation of lunch preparation in the kitchen revealed the first meal cart for C-wing left the kitchen at 12:59 PM, one hour and nine minutes after it should have arrived. Further observation at 1:38 PM revealed the second meal cart leaving the kitchen, one hour and 18 minutes after it should have arrived. The second meal cart was taken to C-wing at 1:39 PM and left at the end of the hallway where it was not visible to staff. At 1:43 PM, two staff members approached the meal cart and started to deliver lunch trays to residents. The last resident on C-wing was served at 1:58 PM. Interview with Resident 4 at 3:20 PM, revealed her lunch has been late very often, and usually does not arrive until 1:30 PM to 2:20 PM. The Resident states her dinner arrived at 8:30 PM the night before, and that caused her to stay up later than she likes. The Resident states when the food does get delivered it is usually cold. 28 Pa. Code 201.14(a) Responsibility of licensee