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	08/02/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on clinical record review, facility policy review, and facility document review, it was determined that the facility failed to adhere to acceptable standards of nursing practice related to medication administration for one of two residents reviewed (Resident 1). Findings include: Review of facility policy, Medication Administration, revised March 2022, revealed medications are to be administered by licensed nursing personnel. The policy further states that the nurse is to remain with the Resident to ensure the medication is swallowed after administering the medication. Review of Resident 1's medical record revealed the Resident was admitted on [DATE], with diagnoses that include Schizoaffective Disorder, Bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident 1's physician orders revealed an order for Depakote extended release 500 mg, three tablets at bedtime related to epilepsy, with a start date of May 28, 2022; and an order for Zyprexa 5 MG, one tablet at bedtime related to schizoaffective disorder, with a start date of June 9, 2022. Review of Resident 1's progress note dated July 27, 2022, at 4:16 PM, states Residents family presented 4 pills found in bed of resident. 3 Depakote and 1 Zyprexa. Review of Resident 1's Medication Error Report completed July 27, 2022, revealed the one Zyprexa tablet and three Depakote tablets were found in bed with the Resident. The report further revealed it was unsure of the staff member that had administered the medication to the resident or what day the medication was given. Review of Resident 1's Medication Administration Record for July 2022, revealed the ordered dose of Zyprexa and Depakote was documented as administered for the prior five days prior to finding the medications in the resident's bed. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on clinical record review, observations, facility document and policy review, and staff interviews, it was determined that the facility failed to ensure that the physician orders were followed for two out of four residents reviewed (Resident 1 and 3), and failed to consistently monitor and assess resident's clinical status to promptly identify individual resident care needs for one of two residents reviewed for falls (Resident 5). Findings include: Review of Resident 1's medical record revealed the Resident was admitted on [DATE], with diagnoses that include Schizoaffective Disorder, Bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident 1's physician orders revealed an order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/ACT inhaler, with directions to inhale one puff orally two times a day for Asthma related to chronic obstructive pulmonary disease, with a start date of July 19, 2022. Review of Resident 1's Medication Treatment Administration record for July 2022, failed to reveal any evidence the ordered Advair Diskus inhaler was administered to the Resident on July 19, 2022, July 20, 2022, and July 21, 2022. Review of Resident 3's medical record revealed the Resident was admitted to the facility on [DATE], with diagnoses that include malignant neoplasm of colon (cancer of the colon) and hypertension (high pressure in the arteries, which are the vessels that carry blood from the heart to the rest of the body). Further review revealed the Resident has a Mediport (an implantable device, placed under the skin, used to give therapy or withdraw blood) related to cancer therapy. Review of Resident 3's physician orders revealed an order for a Heparin Lock Flush of 10 UNIT/ML, to be instilled using one HUBER 22 GA-3/4 needle in the Resident's Mediport every 30 days for port maintenance, with a start date of July 6, 2022. Review of Resident 3's Medication Administration Record, for July 2022, revealed the ordered Heparin Lock flush of the Resident's Mediport using the Huber 23 GA-3/4 needle was not completed as ordered for the month of July. Review of the facility document titled Fall Policy dated January 1, 2022, revealed in the event of an incident that is classified as a fall, there is specific action in order to facilitate a positive outcome. The policy states that, if a fall occurs, the nurse will document a narrative note and complete an incident/accident report; and if the Resident has an unwitnessed fall or hits their head, neurology checks will be initiated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's medical record revealed the Resident was admitted on [DATE], with diagnoses that include Hemiplegia (paralysis of one side on the body) and Hemiparesis (paralysis or weakness of one side of the body) following non-traumatic subarachnoid Hemorrhage (bleeding in the area between the brain and the tissue covering the brain), affecting right dominant side and need for assistance with personal care. Review of Resident 5's progress notes on July 27, 2022, revealed the Resident has had multiple falls since admission to the facility on [DATE]. On June 4, 2022, at 5:49 AM, the Resident was found on the floor by staff, laying on her left side next to her bed; on June 14, 2022, at 8:30 PM, the Resident was found on the floor, the Resident stated she vomited after falling out of her wheelchair; on July 16, 2022, at 1:47 AM, the Resident was found on the floor next to her wheelchair in the dining room; on July 19, 2022, at 10:15 PM, staff were called to the Resident's room, where she was found lying on the floor parallel to her bed; and on July 22, 2022, at 3:03 PM, the Resident was noted to have slid to the floor by staff. Review of Resident 5's Neurological Check Flow Sheet documentation revealed staff should document a blood pressure, pulse, respiration rate, pupil size, pupil reactivity, eye opening response, best motor response, best verbal response, and hand grip strength. This assessment should be completed every 15 minutes for the first hour following a fall, then every half hour for two hours, then every hour for five hours, every four hours for 16 hours, and then every eight hours for the next 48 hours. Review of the June 4, 2022, documentation revealed three missing checks; review of the June 14, 2022, documentation revealed the form was missing the last five checks that were required every eight hours; review of the July 22, 2022, documentation revealed the form was missing 21 of the 24 checks required. The facility was unable to provide any neuro check documentation for the unwitnessed fall that occurred on July 19, 2022. Observations of Resident 5, on July 27, 2022, at 10:40 AM, revealed a Physical Therapy Employee (PT1) in the room talking with the Resident and asking about the bruising located on her arm. Upon inspection, bruising was observed on her right elbow, and a small lump was identified under the elbow. The Resident states she is unsure when the bruising occurred, and stated it happened from a fall she had. At approximately 10:45 AM, PT1 notified Nurse 1 about the Resident's elbow. At 10:50 AM, Nurse 1 assessed Resident 5. An interview with Nurse 1 on July 27, 2022, at 10:55 AM, revealed she was unaware of the Resident's bruising. Nurse 1 looked in the Resident's medical record and stated her last documented fall was on July 22, 2022. The Nurse also stated there were no skin assessments in her record to see if the bruising had been identified yet. Further, the Nurse stated the skin assessments should be completed weekly, and that this Resident did not have any since admission to the facility on [DATE]. During an interview with the Director of Nursing on July 27, 2022, at 3:00 PM, it was revealed that Residents should have skin assessments completed weekly on their shower day. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa Code 211.5(f) Clinical records

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on review of medical records, observations, and staff and resident interviews, it was determined that the facility failed to ensure residents received proper care of indwelling catheters for two of two residents reviewed (Resident 2 and 7), and failed to provide appropriate interventions to promote continence in one of ten residents reviewed (Resident 8). Findings include: Review of Resident 2's medical record revealed the Resident was admitted on [DATE], with diagnoses that include malignant neoplasm of the prostate (cancer of the prostate) and retention of urine requiring a foley catheter. Review of Resident 2's physician orders revealed an order for Foley Catheter, 16 French with 10 CC balloon silicone catheter for urinary retention, neurogenic bladder, and/or wound healing secondary to incontinence, with a start date of July 7, 2022; an order to irrigate the catheter with 200 CC of sterile water every shift, with a start date of July 10, 2022; and an order for foley catheter care every shift, with a start date of July 6, 2022. During an interview with Resident 2 on July 28, 2022, at 1:15 PM, the Resident stated that they do not empty his catheter bag often enough. The Resident further stated that, on one occasion, the bag was so full it burst, and the contents spilled all over the floor. Review of Resident 2's Treatment Administration Report for July 2022, revealed the Resident was missing the ordered foley catheter care on July 8, 2022, July 16, 2022, and July 20, 2022. Further review revealed the Resident is missing the ordered sterile water irrigation on July 13, 2022, July 16, 2022, July 20, 2022, and July 21, 2022. Review of Resident 7's medical record revealed the Resident was admitted on [DATE], with diagnoses that include Multiple Sclerosis (a disease that affects central nervous system, making it difficult for the brain to send signals to rest of the body) and Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Review of Resident 7's physician orders revealed an order for Foley Catheter, 18 French with 10 CC balloon silicone catheter for urinary retention, neurogenic bladder, and/or wound healing secondary to incontinence, with a start date of May 31, 2022. Further review revealed the Resident is not ordered any foley catheter care to be completed. Review of Resident 7's Treatment Administration Report for July 2022, failed to reveal any evidence that the Resident has had foley catheter care or sterile water irrigation completed in the month. Review of Resident 8's medical record revealed the Resident was admitted [DATE], with diagnoses that include Hemiplegia (paralysis of one side) and Hemiparesis (paralysis or weakness of one side) following cerebral infarction, affecting left side and generalized muscle weakness. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	An observation on July 27, 2022, at 2:00 PM, revealed Resident 8 notifying Employee 3 that he needed his brief changed. Employee 3 then notified the Resident that they did not have the proper fitting briefs to use. Employee 3 then obtained supplies to change the Resident. During an interview with Resident 8, 2022, at 2:02 PM, it was revealed that he has not had the proper fitting brief for some time, and that he feels it isn't right. The Resident further stated that the briefs they use are very cheap and leak and tear very easily. During an interview with Employee 3, on July 27, 2022, at 2:05 PM, it was revealed that she does not have the Resident's proper size of brief available, and she has been using a bariatric brief on him because that is all she has to use. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44805 Based on clinical record review and interview with staff, it was determined that the facility failed to ensure assessments, care, and services were consistently provided for one resident reviewed that had significant weight loss (Resident 1). Findings include: Review of Resident 1's medical record revealed the Resident was admitted on [DATE], with diagnoses that include Schizoaffective Disorder, Bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident 1's physician orders revealed an order for Resident to be weighed weekly on Wednesdays, with a start date of June 1, 2022; and an order for Ensure Plus 8 oz to be given two times a day related to body mass index of 16.8 and Resident at risk for malnutrition . Review of Resident 1's comprehensive care plan dated June 4, 2022, revealed a focus showing, the Resident has nutritional problem or potential nutritional problem relate to low current body weight. The plan of care further states staff are to monitor, record, and report to the physician any signs or symptoms of malnutrition, emaciation, muscle wasting, and significant weight loss of three pounds in one week, >5% weight loss in one month, >7.5% in three months, or >10% in six months. Review of Resident 1's weights revealed the following recorded information: June 1, 2022 - 101.1 pounds June 8, 2022 - 100 pounds June 15, 2022 - 78 pounds June 22, 2022 - 97 pounds June 30, 2022 - 85 pounds July 19, 2022 - 100 pounds Further review of Resident 1's weights revealed the Resident was not weighed as ordered on July 6, 2022, and July 13, 2022. Review of Resident 1's medical record on July 28, 2022, failed to reveal any evidence the physician was notified regarding the significant weight variances recorded on June 15, 2022, or June 30, 2022. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's initial nutrition assessment, completed by the Registered Dietitian (RD) on June 4, 2022, revealed the Resident receives a regular diet and intake is between 26-100% of meals; the Resident has not experienced any weight changes; and the Resident's current body mass index was 16.8. The note further states the RD will suggest the Resident to start on Ensure supplement between meals twice a day. Further review of Resident 1's medical record on July 28, 2022, failed to reveal any additional notes or assessments completed by the RD. Review of Resident 1's Medication Administration Report for the June 2022, revealed the Ensure supplement was not administered as ordered on the following dates: June 4, 2022; June 5, 2022; June 6, 2022; June 7, 2022; June 8, 2022; June 9, 2022; June 10, 2022; June 11, 2022; and June 12, 2022. The Nursing Home Administrator (NHA) and Director of Nursing (DON) were notified of these findings on July 28, 2022 at approximately 3:00 PM. The NHA and DON were unable to provide any additional documentation showing the physician was notified or that the RD had addressed the weight variances for Resident 1. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services