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	11/17/2022

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37013 Based on facility policy review, clinical record review, review of the American Heart Association (AHA) information, and staff interviews, it was determined that the facility failed to immediately provide Cardiopulmonary Resuscitation (CPR - emergency life-saving procedure performed when the heart stops beating) as required for one of one residents reviewed who had requested that CPR be administered and was found unresponsive with no pulse (Resident 1) and 64 of 180 residents (Residents ,d+[DATE]) that had requested to have CPR administered if they became unresponsive and pulseless. Findings include: Review of facility policy, titled Emergency Procedure- Cardiopulmonary Resuscitation, revised [DATE], revealed If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS [Basic Life Support] shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. There are obvious signs of irreversible death (e.g., rigor mortis) (Rigor mortis is the stiffening of the joints and muscles of a body a few hours after death). According to the American Heart Association (AHA), immediate CPR can double or triple chances of survival after cardiac arrest. The AHA has established evidenced-based decision making guidelines for initiating CPR when cardiac or respiratory arrest occurs. The AHA urges all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer. If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order. Review of Resident 1's clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included asthma, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and dementia (a group of thinking and social symptoms that interferes with daily functioning). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's POLST (Pennsylvania Orders for Life-Sustaining Treatment) form, revealed that, in the event Resident 1 has no pulse and is not breathing, Resident 1 checked that he wanted CPR/Attempt Resuscitation. Resident 1 signed the POLST form on [DATE]. Review of Resident 1's physician order, dated [DATE], revealed Resident 1 was a Full Code (meaning that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). Review of Resident 1's care plan revealed a care plan in place for Full Code, initiated [DATE]. The goal stated In the event of cardiac arrest or unresponsive episode staff will honor the code status of FULL CODE and attempt resuscitation. Review of Resident 1's nursing progress note revealed a note written by Employee 3 (Registered Nurse), dated [DATE]. The note stated that the nurse entered Resident 1's room at approximately 8:10 PM to administer medications to Resident 1's Roommate. The nurse observed Resident 1 to be mottled (a bluish-red, lace-like pattern under the skin which happens when deoxygenated blood pools beneath the skin's surface) and without spontaneous respirations. There was no response to vigorous tactile stimuli and Resident 1 was noted with blue lips and fingertips, and Resident 1 did not have a carotid pulse. Skin remained warm and dry. POLST was confirmed that Resident 1 was a Full Code and a rapid response request was made overhead for all available licensed staff. The note further states that resuscitation efforts were initiated, AED (automated external defibrillator) was put into place and advised no shock. CPR continued and Resident 1's Responsible Party was notified of Resident 1's condition and the overt clinical signs of irreversible death. Resident 1's Responsible Party wished for efforts to cease as EMS arrived and took over CPR. The physician at the hospital was contacted and made aware of Resident 1's condition and the wishes of the Responsible Party. An order was received to cease all efforts and the Registered Nurse (RN) pronounced Resident 1 deceased at 8:34 PM. During an interview with Employee 1 (Registered Nurse) on [DATE], at 11:45 AM, she stated that Employee 3 (RN) told her to call 911, Resident 1 is dead. Employee 1 stated she went into Resident 1's room to assess him and noted that he was cyanotic (bluish or grayish color of the skin), mottled, pulseless, and had no rise and fall of his chest. Employee 1 stated she was made aware that Resident 1 was a Full Code but felt that he was too far gone based on her experience as a critical care nurse. Employee 1 stated she was told by another nurse that they needed to do CPR because Resident 1 was a Full Code. Employee 1 stated that Employee 2 (RN) was the one who started the chest compressions. Employee 1 was unable to say how much time had passed between Resident 1 being confirmed a Full Code and then starting CPR. Employee 1 also stated that the prior RN stated she was in Resident 1's room not long before Resident 1 was found unresponsive, and that Resident 1 had just finished dinner and his plate was pushed off to the side. Employee 1 stated Resident 1's pupils were not blown and she was unsure what happened for Resident 1 to go unresponsive and pulseless. During an interview with Employee 2, on [DATE], at 1:40 PM, she stated that she was working downstairs when she heard the code being called. She stated she came upstairs (via the elevator) and found Resident 1 with no pulse and no signs of life. Employee 2 initiated chest compressions. Employee 2 stated that Resident 1 still felt a little warm and Employee 2 stated that Resident 1 was not stiff. Employee 2 was unable to say exactly how long it took her to arrive upstairs after the code was called, but she stated it was barely five minutes. Employee 2 stated that she was the first person to do any chest compressions. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Employee 3 on [DATE], at 1:46 PM, she stated that, when she was giving medications to Resident 1's Roommate, Employee 3 saw Resident 1 was slumped over with mottled arms and did not appear to be breathing. Employee 3 approached Resident 1 and touched him. Employee 3 stated he felt warm. Employee 3 stated she looked in the computer for Resident 1's code status, which was listed as Full Code. Employee 3 then went to the nurses station, at the opposite end of the hallway, to obtain the chart and confirm the Full Code status with Resident 1's POLST. Employee 3 called the code overhead and Employee 3 stated she approached Employee 1 at the nurses' station and informed her that there was a code, that Resident 1 was a Full Code, and to go to Resident 1's room while she got the crash cart and AED. Employee 3 stated that Employee 1 went to Resident 1's room and stated that Employee 1 was the first RN in the room. Employee 3 called EMS and went downstairs to get the AED. Employee 3 stated that as she was going to get the AED, she passed Employee 2 getting off of the elevator. Employee 3 stated that Resident 1 had no signs of rigor mortis. During an interview with the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON) 1 and ADON 2 on [DATE], at 1:00 PM, they stated that the code was reviewed during morning meeting on Monday, [DATE], but they were not made aware of any issues. Review of facility provided document listing the current code status of current Residents, as well as review of the clinical records for Residents ,d+[DATE], revealed that Residents ,d+[DATE] were all listed as Full Codes (if their heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive) including CPR. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(a)(b)(1)(2)(3)(e)(1) Management 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services