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	04/11/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37013 Based on facility policy review, facility document review, clinical record review, and staff interviews, it was determined that the facility failed to report sexual abuse to the State Agency within the specified timeframes for two of two incident reports reviewed. Findings Include: Review of facility policy, titled Abuse, Neglect and Exploitation, dated 2022, revealed 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. Further review of the policy revealed: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies (e. g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Review of Resident 1's clinical record revealed diagnoses that included Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), COPD (chronic obstructive pulmonary disease - a group of lung diseases that block airflow and make it difficult to breathe), and hypertension (elevated blood pressure). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's modification of admission MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs), dated December 21, 2023, revealed a BIMS (brief interview for mental status) score of 3, meaning severe cognitive impairment. Review of Resident 10's clinical record revealed diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), delusional disorder (a type of psychotic disorder), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident 10's quarterly MDS dated [DATE], revealed a BIMS score of 99, meaning Resident 10 was unable to complete the interview and, therefore, a staff assessment was completed. Review of the staff assessment for mental status revealed that Resident 10's cognitive skills for decision making was moderately impaired. Review of Resident 1's clinical record revealed a progress note dated January 17, 2024, stating that Resident 1 was being sexually inappropriate with Resident 10 in the dining room. The note stated that Resident 1 pulled Resident 10's shirt up and had her breast in his mouth. Resident 10 was telling Resident 1 no. The note further stated that staff immediately intervened and removed both Residents. When attempting to educate Resident 1 about the inappropriate behavior, the Resident continued to repeat statements I like her. Where did she go? I want to sleep with her. Review of the incident report dated January 17, 2024, revealed a witness statement that as the staff member was walking past the day room, she noticed Resident 1 go up to Resident 10 in his wheelchair, pull up Resident 10's shirt and started sucking her breast. Resident 10 was pushing Resident 1 away from her as the staff member entered the room to remove Resident 1. Review of electronic report submission to the Pennsylvania Department of Health (State Agency responsible for receiving and reviewing allegations of abuse from Long Term Care facilities), revealed that the facility did not notify the State Agency of the incident involving Resident 1. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 10, 2024, at 1:40 PM, the NHA confirmed that the incident was not reported to the State Agency. In a follow-up interview with the NHA and DON on April 11, 2024, at 2:00 PM, the NHA stated that the incident has since been reported to the State Agency via the electronic event reporting system. Additional review of Resident 1's quarterly MDS dated [DATE], revealed a BIMS score of 9, meaning cognitive status is moderately impaired. Review of Resident 2's clinical record revealed diagnoses that included dementia, psychosis (a mental disorder characterized by a disconnection from reality), and depression. Review of Resident 2's quarterly MDS assessment dated [DATE], revealed a BIMS score of 99. Review of the staff assessment for mental status revealed that Resident 2's cognitive skills for decision making were moderately impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility investigation revealed that on April 5, 2024, Resident 1 and 2 were found in bed together. Review of Employee 1's witness statement dated April 5, 2024, revealed that she entered Resident 1's room to find Resident 2 lying on her back with her legs wide open, wearing a button-down shirt and no pants. Resident 1 was naked, with his brief by his ankles and was lying on top of Resident 2 and they were having what appeared to be sexual relations. I did not see his penis inside of her vaginal vault. I assumed sexual intercourse was happening because [Resident 2] was holding onto [Resident 1's] hips. Residents were separated, [Resident 2] was taken to her room .[Resident 1] stayed in his room and went to bed. Review of Employee 2's witness statement dated April 5, 2024, revealed she entered Resident 1's room and observed Resident 2 lying on the bed, on her back, with a shirt on and no bottoms. Resident 1 was lying on top of [Resident 2] naked with his brief around his ankles. He was humping her; his penis was near her pelvic area. We tried to separate them but [Resident 2] would not let go, she was holding on. We were finally able to separate them. The statement further stated that Resident 2 was then taken to her room and provided care and Resident 1 remained in his room. Review of electronic report submission to the Pennsylvania Department of Health revealed that the facility did not notify the State Agency of the incident involving Residents 1 and 2. During an interview with the NHA and DON on April 10, 2024, at 1:40 PM, the NHA confirmed that the incident was not reported to the State Agency. In a follow-up interview with the NHA and DON on April 11, 2024, at 2:00 PM, the NHA stated that the incident has since been reported to the State Agency via the electronic event reporting system. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management