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	04/15/2026

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 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. Findings include: Review of Resident 1's clinical record revealed diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident 1's current physician orders revealed the following orders dated April 3, 2026:Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML (medication to treat diabetes) inject 28 units subcutaneously two times a day.If blood sugar is less than 150 or NPO/not eating hold and notify provider. If blood sugar is greater than 400 notify provider; check blood sugar for signs and symptoms of high/low blood sugars and notify physician if the blood sugar is less than 60 or greater than 400.Give appropriate snack or administer as needed glucagon per physician orders; and glucagon solution prefilled syringe inject one syringe subcutaneously every 15 minutes as needed for blood sugar less than 50 for unresponsive (stuporous, unable to take oral intake) resident; inject one syringe and repeat blood sugar in 15 minutes, may repeat injection twice if resident remains unresponsive. Notify physician. If resident is able to after first injection, give a snack/drink Review of Resident 1's emergency medical service (EMS) report dated April 10, 2026, revealed that they arrived at the facility at 6:40 PM, and found Resident 1 laying in bed, conscious, breathing without difficulty, not alert and not responding normally. Nursing home staff reported they had the pt in a wheelchair and he all of a sudden slumped over. Pt is normally A[lert] & O[riented] x 4 (person, place, time, and event), is not a diabetic, does not have a seizure history and he just has an extensive cardiac history. The report further indicated that at 6:45 PM the EMS crew took Resident 1's blood sugar and that it was 34 and that Resident 1 was given a dextrose intravenous infusion, and by 6:50 PM Resident 1's blood sugar was up to 177. The report further indicated that after treatment was provided to Resident 1, he was able to answer EMS questions and that he stated he was a really bad diabetic and was able to state his name and age, which did not match the paperwork provided by the facility. Resident 1 refused to go the emergency room for further evaluation and was taken back into the facility at 7:00 PM. Review of Resident 1's clinical record failed to reveal any nurses' notes on April 10, 2026, about Resident 1's change in condition, actions taken to include calling EMS or that Resident 1's physician was made aware. Review of Resident 1's clinical record vital signs section failed to reveal that any blood sugars were taken on April 10, 2026, after 12:00 PM. Review of Resident 1's April 2026 Medication Administration Record (MAR) revealed that his blood sugar on April 10, 2026, at 12:00 PM, was 117 and insulin was documented as being administered. Further review of Resident 1's MAR revealed that on April 9th at 12:00 PM his blood sugar was 119; on April 11th at 8:00 AM his blood sugar was 145; and on April 12th at 12:00 PM his blood sugar was 147. Insulin was signed as being administered outside of physician ordered parameters. Further review of Resident 1's clinical record failed to reveal any documentation that his physician was made aware of his blood sugars being below 150. During a staff interview with the Nursing Home Administrator (NHA) and DON on April 15, 2026, at 1:45 PM, the DON indicated that she was notified via email by EMS representative on April 14, 2026, of the situation with Resident 1 that occurred on April 10, 2026. She said that she then began looking into the situation. She indicated that Employee 1 was out of the country on a family emergency, but that she was able to speak to him by phone and she wrote the note based on what he told her during their (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussion. She said that Employee 1 also indicated he had Employee 2 print paperwork for transfer while he remained with Resident 1 and that he had called 911 from Resident 1's room. She indicated that Employee 1 said he was the nurse who gave report to the EMS crew and that Employee 2 handed the crew the paperwork. She said that Employee 2 usually works on the other hall of the unit and was not familiar with the residents on the hall where Resident 1 resided. The DON confirmed that the paperwork given to EMS was for Resident 3 who has the same first name as Resident 1. The DON also indicated that Employee shared that he did not understand the discrepancies in Resident 1's blood sugars at the time the event occurred. The NHA indicated that they are looking at measures to ensure accurate information is provided to care providers, as well as entering name alerts in their electronic health records to prevent reoccurrence. During a final staff interview with the NHA and DON on April 15, 2026, at 2:38 PM, both confirmed that they would expect nurses to complete all necessary documentation at time of occurrence. In addition, the DON confirmed that she would expect nurses to provide EMS with accurate records and to follow a physician's orders. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.