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	12/07/2022

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46253 Based on review of the clinical record and resident and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice for medication administration that will meet each resident's physical, mental, and psychosocial needs for 14 out of 14 residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). Findings include: Review of medication administration records revealed the following: Resident 1: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of nine doses each date); Resident 2: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of six doses each date); Resident 3: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of eight doses each date); Resident 4: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 12 doses on November 6, 2022, and 15 doses on November 24, 2022); Resident 5: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 10 doses each date); Resident 6: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 11 doses each date); Resident 7: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 11 doses on November 6, 2022, and 12 doses on November 24, 2022); Resident 8: day shift medications were not signed as administered on November 24, 2022 (total of 10 medication doses each date); (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

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	12/07/2022

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 9: day shift medications were not signed as administered on November 24, 2022 (total of eight medication doses each date); Resident 10: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 10 medication doses each date); Resident 11: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 20 doses on November 6, 2022, and 16 doses on November 24, 2022); Resident 12: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 9 doses each date); Resident 13: day shift medications were not signed as administered on November 6, 2022 (total of 14 medication doses); and Resident 14: day shift medications were not signed as administered on November 6, 2022 (total of 7 medication doses). The Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of the concerns identified on November 28, 2022, at approximately 1:05 PM. The DON indicated that she was not aware that medications were not given and that she thought medication administration had improved. She indicated that she would look into it. Email communication received from DON on November 29, 2022, at 2:34 PM, revealed that there were notes dated November 7, 2022, and November 24, 2022 notifying the physician(s) of each Resident's missed doses of medications. Email communication received from NHA on November 29, 2022, indicated that with November 6, 2022, being a Sunday he believed this documentation omission would have been noted during an AM clinical meeting and addressed upon discovery on Monday, November 7, 2022, which was why the notes regarding the missed medications were dated for November 7, 2022. Additional email communication received from NHA on November 29, 2022, at 4:43 PM, stated that the Nurse that worked on November 6, 2022, had not worked since that date and was not able to provide an explanation for not documenting the medication administration. During a telephone interview with Employee 2 on December 1, 2022, at 11:19 AM, Employee 2 indicated that on November 6, 2022, she was the only one assigned to the east wing of the unit and that she passed all her resident's medications. She said she cannot speak as to what happened on the west wing portion. Review of deployment sheet for November 6, 2022, indicated that Employee 2 was the only nurse assigned to the whole unit (East and [NAME] wing). (continued on next page)

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	12/07/2022

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Employee 1 (Registered Nurse Supervisor) November 30, 2022, at approximately 10:30 AM, she confirmed that she was working on November 24, 2022. Employee 1 indicated that Employee 3 (Licensed Practical Nurse) came to her at around 1:00 PM, and said he had to go now. She said she went to the unit to complete the narcotic counts. During this process, Employee 3 indicated to her that he had not passed any medications to the residents on the second cart for the day. No reason was provided. She indicated that she then started to pass the medications. She said that she administered medications to Residents 13 and 14, but then she got a call from another unit indicating that a resident was having an acute change in condition. She said she was the supervisor and had to go to assess the other Resident and follow-up with the physician. She indicated that she ended up having to send that Resident to the hospital and, by the time she had completed all those tasks, it was too late to give the medications; so she contacted the physicians of the Residents and informed them of what had occurred. She indicated that the physicians gave no new orders and said to resume medications at the next scheduled time. Interview with Resident 11 on November 30, 2022, at approximately 12:15 PM, the Resident confirmed that they did not receive her medications on Thanksgiving Day during the day shift hours. Resident 11 said they kept mentioning it to the Nurse Aide who said they kept telling the Nurse, but the Nurse never came. Resident 11 further shared that there was another day that they did not get their medications on day shift, but that they could not recall the exact date. During an interview with NHA and DON on November 30, 2022, at approximately 2:20 PM, the above information was shared. During a phone interview with NHA and DON on December 1, 2022, at approximately 2:00 PM, they were informed of the conversation with Employee 2 and that, according to the deployment sheet, there was only one nurse assigned that date/shift. No information was provided. NHA confirmed that he would expect that there would be enough staff to meet the needs of the residents and that all residents would receive their medications as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18 (e)(1)(2)(3)(6) Management

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	12/07/2022

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46253 Based on clinical record reviews, review of facility deployment sheets, and resident and staff interviews, it was determined that the facility failed to provide adequate and sufficient nursing staff to provide medication administration in accordance with professional standards of practice and physician orders for 14 out of 14 residents reviewed (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) on the Transitions Unit. These staffing failures resulted in 269 missed medication doses including insulins, antipsychotics, antibiotics, antihypertensives, seizure medications, heart medications, and pain medications. These missed medications had the potential to cause the residents discomfort or pain, to exacerbate medical conditions including blood pressure, cardiac and diabetic issues, increase the potential for seizures, and jeopardized the health and safety resulting in Immediate Jeopardy. Findings include: Review of medication administration records revealed the following: Resident 1: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of nine doses each date); Resident 2: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of six doses each date); Resident 3: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of eight doses each date); Resident 4: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 12 doses on November 6, 2022, and 15 doses on November 24, 2022); Resident 5: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 10 doses each date); Resident 6: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 11 doses each date); Resident 7: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 11 doses on November 6, 2022, and 12 doses on November 24, 2022); Resident 8: day shift medications were not signed as administered on November 24, 2022 (total of 10 medication doses each date); Resident 9: day shift medications were not signed as administered on November 24, 2022 (total of eight medication doses each date); (continued on next page)

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	12/07/2022

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 10: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 10 medication doses each date); Resident 11: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of 20 doses on November 6, 2022, and 16 doses on November 24, 2022); Resident 12: day shift medications were not signed as administered on November 6, 2022, and November 24, 2022 (total of nine doses each date); Resident 13: day shift medications were not signed as administered on November 6, 2022 (total of 14 medication doses); and Resident 14: day shift medications were not signed as administered on November 6, 2022 (total of seven medication doses). The Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of the concern identified on November 28, 2022, at approximately 1:05 PM. The DON indicated that she was not aware that medications were not given. She indicated that she would look into it. During an interview with Employee 4 conducted on November 28, 2022, at approximately 1:44 PM, Employee 4 stated that the majority of the aides working are agency staff and it is difficult to manage them at times. Employee 4 indicated that it is difficult to get the agency aides to do their work and they are often disrespectful of supervising nurses. Email communication received from NHA on November 29, 2022, at 4:10 PM, stated that they had interviewed the Employee 2 (Nurse), who was on duty on November 6, 2022, and they indicated that they administered the medications. The email also stated that on November 24, 2022, the Nurse had to leave the shift unexpectedly and that the Registered Nurse (RN) Supervisor took over the unit. Additional email communication received from NHA on November 29, 2022, at 4:43 PM, stated that the Nurse that worked on November 6, 2022 has not worked since that date and she was not able to provide an explanation for not documenting the medication administration. Review of census reports and deployment sheets revealed that for day shift on November 6, 2022, Transitions had a census of 32 residents with one LPN assigned was responsible for medications and treatments and was responsible for two medication carts. Review of census reports and deployment sheets revealed that for day shift on November 24, 2022, Transitions had a census of 28 residents with one LPN that was responsible for medications and treatments. This LPN was responsible for two medication carts. It was also noted that on the evening shift the RN House Supervisor was assigned to the Transitions Unit and responsible for medications and treatments and was responsible for two medication carts. (continued on next page)

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	12/07/2022

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on November 30, 2022, at approximately 10:30 AM with Employee 1 (Registered Nurse Supervisor) that was working on November 24, 2022, Employee 1 indicated that Employee 3 (LPN) came to her around 1:00 PM, and said he had to go now. She said she went to the unit to complete the narcotic counts. During this process, Employee 3 stated to her that he had not passed any medications to the residents on the second cart for the day. No reason was provided. She then started to pass the medications. She said that she administered medications to Resident 13 and 14, but then she got a call from another unit indicating that a Resident was having an acute change in condition. She said she was the supervisor and had to go to assess the other Resident and follow-up with physician. She indicated that she ended up having to send that Resident to the hospital and, by the time she had completed all those tasks, it was too late to give the medications. She indicated that she contacted the Nursing Home Administrator and updated him on what had occurred. She also contacted the physicians of the residents at approximately 4:40 PM and informed them of what had occurred. She indicated that the physicians gave no new orders and said to resume medications at the next scheduled time. Interview with Resident 11 on November 30, 2022, at approximately 12:15 PM, the Resident confirmed that she did not receive her medications on Thanksgiving Day during the day shift hours. Resident 11 said she kept mentioning it to the nurse aide who said they kept telling the nurse, but the nurse never came. Resident 11 further shared that there was another day that they did not get their medications on day shift, but that they could not recall the exact date. During an interview with Resident 15 completed on November 30, 2022, at 1:40 PM. Resident stated, they don't have enough staff to take care of us. We shouldn't have to go without showers or care. I don't want to go somewhere else, but I may have to so I can get the care I need. During an interview with Resident 17 completed on November 30, 2022, at 1:45 PM, Resident revealed that they had finally gotten a good unit manager for her wing, but now she's leaving. They can't keep staff here and the residents are the ones that suffer for it. During an interview with NHA and DON on November 30, 2022, at approximately 2:20 PM, the above information was shared. During a telephone interview with Employee 2 on December 1, 2022, at 11:19 AM, Employee 2 indicated that on November 6, 2022, she was only assigned to the east wing of the unit and that she passed all her resident's medications. She said she cannot speak as to what happened on the west wing portion. Review of deployment sheet for November 6, 2022, indicated that Employee 2 was the only nurse assigned to the whole unit. During a phone interview with NHA and DON on December 1, 2022, at approximately 2:00 PM, they were informed of the conversation with Employee 2 and that, according to the deployment sheet, was the only nurse assigned that date/shift. NHA confirmed that he would expect that there would be enough staff to meet the needs of the residents and that all residents would receive their medications as ordered by the physician. (continued on next page)

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	12/07/2022

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's census (amount of residents residing in the facility) on November 24, 2022 was 169 with four bed holds (residents currently out of the building). On November 27, 2022 the census was 172 with two bed holds. On December 6, 2022 the census was 177 with two bed holds. Despite their known staffing challenges, the facility continued to admit new residents. The NHA was provided the immediate jeopardy template on December 6, 2022, at 4:15 PM, and an immediate action plan was requested. On December 6, 2022, at 6:47 PM, the facility's immediate action plan was accepted which included: 1) Claremont executed a new agency agreement for direct care staff on December 5, 2022. 2) Administrator, scheduler, nursing leadership, and Human Resources will conduct a staffing meeting to audit actual and projected hours and validate adequacy daily for three weeks and then monthly for three months. Issues identified will be corrected at the time of discovery. 3) Facility has communicated vacant shifts to agencies through January 1, 2023, on December 4, 2022. 4) Facility has signed three block agreements with agency nurses through the month of December on December 6, 2022. 5) Facility will continue to communicate vacant shifts to employees with bonus offerings and execute a comprehensive recruitment and retention plan that includes sign-on and referral bonus offerings. 6) RN Supervisors will be re-educated to communicate unforeseen staffing emergencies that would be impactful to the Director of Nursing and Nursing Home Administrator for further intervention. Interventions may include asking employed volunteers to stay, enhancing premium offerings to employees and agency staff to pick up shifts or supplementing staffing with nursing leadership team members or traveling agency staff to ensure care delivery. 7) Licensed Nurses will be educated to check in with the RN Supervisor at beginning of shift to verify assignment. 8) Licensed Nurses will be educated that, in the event of an emergency and after assumption of a new cart, they should begin medication administration based on red/ non-administered medications in the MAR. 9) Facility will hold new admissions temporarily, until such time as the Quality Assurance Performance Improvement Committee deems actual licensed staffing supports resumption. On December 7, 2022, at 3:18 PM, the Immediate Jeopardy was lifted during an onsite survey after ensuring that the immediate action plan had been implemented. 28 Pa. Code 211.12 (a)(c)(d)(1)(4)(5) Nursing Services 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management (continued on next page)

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	12/07/2022

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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee

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	12/07/2022

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on clinical record review, pharmacy contract review, and interviews with staff, it was determined that the facility failed to provide routine drugs to Resident 6 in a timely manner, and coordinate with a licensed pharmacist to provide a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation of controlled medications for one of seven residents reviewed (Resident 6). Findings include: Review of pharmacy contract, dated February 2022, stated, under pharmacy obligations, that the pharmacy will provide the facility with pharmaceutical dispensing systems as required in compliance with all conditions and/or standards of federal and state regulations. The contract stated, under the client [facility] obligations section, pharmaceutical products will be provided to individual facility residents only upon presentation to the pharmacy of written/electronic order from a resident ' s physician. Client is responsible for ensuring that the physician orders are made available to Pharmacy as necessary for Pharmacy to provide pharmaceutical products. Review of Resident 6's clinical record documented he was admitted to the facility on [DATE], at 1:14 PM, and had diagnoses that included epilepsy. Review of Resident 6's December 2022, physician orders included: phenobarbital 64.8 mg at bedtime, start December 28, 2022, scheduled to be administered at 9:00 PM; Lyrica 75 mg (pregabalin) two times a day for epilepsy control, start date December 28, 2022, scheduled to be administered at 8:00 AM and 5:00 PM; Phenytoin sodium (Dilantin) 100 mg two times a day, start December 28, 2022, scheduled to be administered at 9:00 AM and 5:00 PM. Phenobarbital is a barbiturate (a class of drugs that act as central nervous system depressants, meaning they suppress the actions of the neurons in the brain and spinal cord), classified by the Drug Enforcement Administration as scheduled IV controlled substance (signifying that it can result in the development of physical dependence when used for a significant length of time and is a potential drug of abuse). Lyrica is a controlled substance that is classified as a schedule V drug (class of medications rated as having lower potential for abuse and physical or psychological dependence, and has an euphoria effect). Review of Resident 6's December 2022 Medication Administration Records (MAR - documentation of medication administration) revealed phenobarbital was documented as 9- other see documentation on December 28, 2022; December 29th, 2022; and December 31st, 2022. Review of corresponding orders administration notes read, in part: on December 29, 2022, at 11:34 AM, called physician to request a signed prescription for Lyrica and that Resident missed one dose that date, and at 4:37 PM, waiting pharmacy delivery of Lyrica. On December 29, 2022, at 8:45 PM, awaiting pharmacy delivery of phenobarbital. (continued on next page)

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	12/07/2022

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of corresponding note for December 31, 2022 at 8:24 PM, stated, phenobarbital was not available to administer, the pharmacy and physician was made aware. The MAR was blank (no documentation) for December 30th, 2022. Review of Resident 6 ' s January 2023 MAR revealed that phenobarbital was documented as administered on January 1st, 2023; January 3rd, 2023; and January 4th, 2023. On January 2, 2023 phenobarbital was documented as 9- other see documentation . The corresponding orders administration note read, in part: on January 3, 2023 at 11:17 PM, the pharmacy and the physician were notified and pharmacy was awaiting a prescription for the phenobarbital. Further review revealed a corresponding orders administration note that read, in part: on January 5, 2023, at 3:30 PM, phenobarbital not available, registered nurse (RN) supervisor notified. Review of progress note dated January 5, 2023, at 1:17 PM, read, in part, the pharmacy was called regarding phenobarbital. Per pharmacy, they never received the prescription. Communicated with physician, who provided the pharmacy with a verbal prescription for the phenobarbital, which will arrive in the evening. A statement from the contract pharmacy dated January 5, 2023, read, in part, the facility sent new admission orders for Resident 6 on December 28, 2022. Resident 6 had an order for a controlled substance, phenobarbital. Controlled substances don't transmit form the electronic medical record platform utilized by the facility. The physician provided a valid script, the pharmacy is dispensing and delivering the medication to the facility immediately. Further review of Resident 6's MAR revealed Lyrica was documented as 9- other, see documentation for December 28th, 2022, at 5:00 PM; December 29th, 2022 for 8:00 AM and 5:00 PM; and documented as administered per physician orders as of December 30th, 2022 at 8:00 AM. Interview on January 5, 2023, at 12:13 PM, with the Director of Nursing revealed that phenobarbital and Lyrica require a written physician prescription to be provided to the pharmacy when placing an order. The facility was not aware that a written prescription was needed for the phenobarbital and Lyrica when the initial order was submitted to the pharmacy on December 28, 2022. It was noted that the physician was made aware on December 31, 2022, that the phenobarbital was not available, and a prescription needed to be provided to the pharmacy. It was revealed that the facility obtained the prescription on December 31, 2022, and it was sent to pharmacy. The facility was unable to provide proof that the prescription was obtained, and the pharmacy was unable to provide proof they received a prescription for Resident 6's phenobarbital. Interview with the Nursing Home Administrator on January 5, 2023, at 3:30 PM, revealed that there was a break in communication between the facility and the pharmacy, and Resident 6 shouldn't have missed four doses of a medication spanning four days. Neither the facility nor the pharmacy could provide information or produce documentation as to when the initial written prescription for the phenobarbital was submitted to the pharmacy. The facility and the pharmacy failed to provide information or documentation as to if and when the prescription for phenobarbital was fulfilled and delivered to the facility prior to January 5, 2023. (continued on next page)

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	12/07/2022

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee 211.9(a)(1)(k) Pharmacy services 211.10(c) Resident Care Policies 211.12(d)(5) Nursing Service

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. 46253 Based on clinical record review, as well as resident and staff interviews, it was determined that the facility failed to follow accepted professional standards and principles for administering medications and ensure the prevention of significant medication errors for 13 out of 14 residents sampled (Residents 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, and 14) on the Transitions Unit. This resulted in an Immediate Jeopardy situation because the missed medications had the potential to cause the residents discomfort or pain, to exacerbate medical conditions including blood pressure, cardiac and diabetic issues, increase the potential for seizures, and jeopardized the health and safety of 13 out of 14 residents reviewed. Findings include: Review of Resident 1's clinical record revealed diagnoses that included atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow and can result in blood clot formation) and hypertensive chronic kidney disease (medical condition referring to damage to the kidneys due to chronic high blood pressure). Orders included amlodipine 10mg give one tablet by mouth every day (medication used to treat high blood pressure and coronary artery disease which is damage or disease in the heart's major blood vessels which causes limited blood flow to the heart). Review of medication administration record revealed that Resident 1 was not administered this medication on November 6, 2022, and November 24, 2022. Review of Resident 2's clinical record revealed diagnoses that included chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Orders included phoslo capsule 667 mg one capsule three times a day with meals (a medication used to reduce phosphorus in the blood of people with end stage renal disease). Review of medication administration record revealed that Resident 2 was not administered this medication at breakfast and lunch on November 6, 2022, and November 24, 2022. Review of Resident 3's clinical record revealed diagnoses that included prostate cancer and pneumonia. Orders included: Lactulose Encephalopathy Solution 10gm/ml Give 30ml by mouth daily (medication derived from lactose that is used to treat liver disease by lowering ammonia levels); Levaquin 500mg by mouth daily for 7 days (an antibiotic used to treat infections); and MS Contin ER (morphine) 15mg one tablet by mouth every 12 hours (a narcotic pain medication). Review of medication administration record revealed that Resident 3 was not administered the morning dose of lactulose and MS Contin on November 6, 2022, and November 24, 2022. In addition, medication administration record revealed that Resident 3 was not administered the daily dose of Levaquin on November 24, 2022, which was the last dose of the seven day course of antibiotic. (continued on next page)

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 4's clinical record revealed diagnoses that included type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar; either the body doesn't produce enough insulin or it resists insulin). Orders included Insulin Lispro 100 units/ml inject three units three times a day and blood sugar check with each meal (a rapid acting insulin taken with meals used to lower levels of glucose in the blood). Review of medication administration record revealed that Resident 4 did not have their blood sugar checked at breakfast and lunch and was not administered the breakfast and lunch doses of insulin on November 6, 2022, and November 24, 2022. Review of Resident 5's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly). Orders included lasix (furosemide) 40mg give one tablet by mouth daily (a medication used to fluid retention or edema caused by congestive heart failure) and lisinopril 30mg give one tablet by mouth daily (a medication used to treat high blood pressure and heart failure). Review of medication administration record revealed that Resident 5 was not administered the aforementioned medications on November 6, 2022, and November 24, 2022. Review of Resident 6's clinical record revealed diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures) and human immunodeficiency virus (virus that damages the immune system and interferes with the body's ability to fight infection and disease). Orders included Genvoya Tablet 150-150-200-10 mg (Elviteg-Cobic-Emtricit-TenofAF), Give one tablet by mouth in the morning (a combination of 4 medications into one used to treat human immunodeficiency virus); and divalproex sodium tablet delayed release 500 mg one tablet by mouth in the morning and at bedtime (a medication used to treat seizures). Review of medication administration record revealed that Resident 6 was not administered the Genvoya on November 6, 2022, or November 24, 2022. It also revealed that Resident 6 was not administered the Divalproex Sodium in the morning on November 6, 2022, and November 24, 2022, and was not administered the evening dose on November 25, 2022. Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure). Orders included amlodipine besylate tablet 10 mg give one tablet by mouth one time a day (medication used to treat high blood pressure); and tramadol tablet 50 mg give one tablet by mouth two times a day (a narcotic medication used to treat pain). Review of medication administration record revealed that Resident 8 was not administered the amlodipine on November 24, 2022, and was not administered the morning dose of tramadol on November 24, 2022. (continued on next page)

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 9's clinical record revealed diagnoses that included type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar; either the body doesn ' t produce enough insulin or it resists insulin) and cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain). Orders included clopidogrel bisulfate tablet 75 mg give one tablet by mouth daily (medication used to prevent formation of blood clots); and Insulin Aspart FlexPen Solution Pen-injector 100 units/ml (Insulin Aspart) Inject as per sliding scale: if Less than 70 notify MD; if 131 - 180 = two units 181 - 240 = four units; 241 - 300 = six units; 301 - 350 = eight units; 351 - 400 = 10 units; 401 - 599 = 12 units; Call MD if greater than 400, subcutaneously with meals (a rapid acting insulin taken with meals to lower levels of glucose in the blood). Review of medication administration record revealed that Resident 9 was not administered the clopidogrel on November 24, 2022. It also revealed that Resident 9 did not have their blood sugar checked on November 24, 2022, at 8:00 AM and 12:00 PM. Review of Resident 10's clinical record revealed diagnoses that included hypertensive heart disease with heart failure (heart failure that is a result of heart problems that occur because of high blood pressure that is present over a long time) and deep vein thrombosis (condition that occurs when a blood clot forms in a vein deep inside a part of the body). Orders included: amlodipine besylate tablet 10 mg give one tablet by mouth one time a day (medication used to treat high blood pressure); isosorbide mononitrate extended release tablet 24 Hour 30 mg give one tablet by mouth one time a day (medication used to treat heart disease and prevent chest pain); and heparin sodium (porcine) solution 5000 units/ml inject 1 ml subcutaneously every eight hours (a blood thinner used to prevent blood clot formation). Review of medication administration record revealed that Resident 10 was not administered the amlodipine besylate and isosorbide mononitrate on November 6, 2022, and November 24, 2022. It also revealed that Resident 10 was not administered the heparin on November 6, 2022, at 8:00 AM. Review of Resident 11's clinical record revealed diagnoses that included Parkinson's (a long term degenerative disorder of the central nervous system that mainly affects the motor system) and bacteremia (the presence of bacteria in the bloodstream). Orders included pramipexole dihydrochloride tab 0.25 mg give one tablet at bedtime (medication used to treat Parkinson's); heparin sodium 5000 units/ml inject 5000 units subcutaneously twice a day (a blood thinner used to prevent blood clot formation); cefazolin sodium solution reconstituted 2 gm intravenously every eight hours (an antibiotic used to treat infections); hydralazine tablet 50 mg give one tablet by mouth three times a day (medication used to treat high blood pressure); and Medrol Dose Pack give as directed (a steroid medication used to treat inflammation). Review of medication administration record revealed the following: the pramipexole dihydrochloride was not administered on the night of November 25, 2022; the heparin sodium was not administered on the morning of November 6, 2022, and November 24, 2022, or the evening of November 25, 2022; the cefazolin was not administered at 8:00 AM on November 6, 2022; the hydralazine was not administered at 8:00 AM and 2:00 PM on November 6, 2022, and November 24, 2022; and the medrol dose pack was not administered at 8:00 AM, 12:00 PM, or 5:00 PM on November 6, 2022. (continued on next page)

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 12's clinical record revealed diagnoses that included atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow and can result in blood clot formation). Orders included Eliquis 5 mg one tablet by mouth twice a day (blood thinning medication used to prevent blood clot formation). Review of medication administration record revealed that Resident 12 was not administered the morning dose of Eliquis on November 6, 2022, and November 24, 2022. Review of Resident 13's clinical record revealed diagnoses that included hypertension, angina pectoris, and borderline personality disorder. Orders included: isosorbide mononitrate tablet 30 mg give one tablet by mouth daily(medication used to treat heart disease and prevent chest pain); lasix (furosemide) tablet 40 mg give one tablet by mouth in the morning and in the afternoon (a medication used to fluid retention or edema); lisinopril tablet 5 mg give one tablet by mouth one time a day (medication used to treat high blood pressure); olanzapine tablet 2.5 mg give one tablet by mouth in the afternoon (medication used to treat mental disorders); and olanzapine tablet 5 mg give one tablet by mouth one time a day. Review of medication administration record revealed that Resident 13 was not administered the isosorbide, lasix, lisinopril, or olanzapine on the morning of November 6, 2022. In addition, Resident 13 was not administered the afternoon dose of lasix or olanzapine on November 6, 2022. Review of Resident 14's clinical record revealed diagnoses that included atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow and can result in blood clot formation) and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures) . Orders included apixaban 5 mg one tablet by mouth twice a day (blood thinning medication used to prevent blood clot formation); and levetiracetam (Keppra) Tabs 1000 mg one tablet by mouth twice a day (medication used to treat seizures). Review of medication administration record revealed that Resident 14 was not administered the morning dose of apixaban and levetiracetam on November 6, 2022. Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of concerns identified on November 28, 2022, at approximately 1:05 PM. DON indicated that she was not aware that medications were not given and that she thought medication administration had improved. Email communication received from the DON on November 29, 2022, at 2:34 PM, revealed that there were notes dated November 7, 2022 (the day after the missed medications). There were also notes dated November 24, 2022 notifying the physician(s) of each Resident's missed doses of medications. Email communication received from NHA on November 29, 2022, at 4:43 PM, indicated that the nurse that worked on November 6, 2022 has not worked since that date and she was not able to provide an explanation for not documenting the medication administration. He further indicated that with November 6, 2022, being a Sunday he believed this documentation omission would have been noted during an AM clinical meeting and addressed upon discovery on Monday, November 7, 2022, which was why the notes were dated for November 7, 2022. These notes were timed for 11:45 AM. (continued on next page)

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Email communication received from NHA on November 29, 2022, at 4:10 PM, indicated that they had interviewed Employee 2 (Nurse) who was on duty on November 6, 2022, and he indicated that the nurse administered the medications. The email also included that on November 24, 2022, the nurse had to leave the shift unexpectedly and that the Registered Nurse (RN) Supervisor took over the unit. During a telephone interview with Employee 2 on December 1, 2022, at 11:19 AM, Employee 2 indicated that on November 6, 2022, she was only assigned to the east wing of the unit and that she passed all of her resident's medications. She said she cannot speak as to what happened on the west wing portion. Review of deployment sheet for November 6, 2022, indicated that Employee 2 was the only nurse assigned to the whole unit. During a phone interview with NHA and DON on December 1, 2022, at approximately 2:00 PM, they were made aware of the conversation with Employee 2 and that, according to the deployment sheet, she was the only nurse assigned that date/shift. No further information was provided. The NHA confirmed that he would expect that there would be enough staff to meet the needs of the residents and that all residents would receive their medications as ordered by the physician. During an interview on November 30, 2022, at approximately 10:30 AM with Employee 1 (Registered Nurse Supervisor) who was working on November 24, 2022, Employee 1 indicated that Employee 4 (Licensed Practical Nurse) came to her at around 1:00 PM, and said they had to go now. She said she went to the unit to complete the narcotic counts. During this process, Employee 4 indicated to her that he had not passed any meds to the residents on the second cart for the day. He provided no reason as to why he had not administered the medications. She indicated that she then started to pass the medications. She said that she administered medications to Resident 13 and 14, but then she got a call from another unit indicating that a Resident was having an acute change in condition. She said she was the supervisor and had to go to assess the other Resident and follow-up with physician. She indicated that she ended up having to send that Resident to the hospital and, by the time she had completed all those tasks, it was too late to give the medications. She indicated that at that time she notified the NHA of what had occurred. She also contacted the physicians of the Residents and informed them of what had occurred. She indicated that the physicians gave no new orders and said to resume meds at the next scheduled time. Review of the progress notes revealed that the physician was notified at 4:40 PM. Phone interview with Employee 4 was attempted on December 1, 2022, at 10:32 AM. At the time of survey exit on December 1, 2022, at 2:00 PM, Employee 4 had not returned the call. Interview with Resident 11 on November 30, 2022, at approximately 12:15 PM, the Resident confirmed that they did not receive her medications on Thanksgiving Day during the day shift hours. Resident 11 said they kept mentioning it to the nurse aide who said they kept telling the nurse, but the nurse never came. Resident 11 further shared that there was another day that they did not get their meds on day shift, but that they could not recall the exact date. During an interview with the NHA and DON on November 30, 2022, at approximately 2:20 PM, the above information was shared. (continued on next page)

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	12/07/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The NHA was provided the immediate jeopardy template on December 6, 2022, at 4:15 PM, and an immediate action plan was requested. On December 6, 2022, at 6:05 PM, the facility's immediate action plan was accepted, which included: 1) Physicians were notified upon discovery concerning medication administration observations of November 6, 2022 and November 24, 2022, and did not provide new orders at that those times 2) Agency Employees 1 and 2 have not worked since November 6, 2022, and November 24, 2022, respectively, and will not be utilized by the facility. 3) Licensed Nurses were re-educated concerning the expectation to administer medications as ordered on November 30, 2022. 4) NHA and DON initiated a review of performance and charting expectations with individual agencies for additional review with oncoming staff on December 5, 2022. 5) Registered Nurse Unit Managers or designee will complete an audit of medication administration documentation weekly for three weeks and monthly for three months to validate compliance with each shift included. Issues will be corrected upon discovery. 6) Registered Nurse Unit Managers or designee will complete a random medication administration observational audit for five residents weekly for three weeks and monthly for three months to validate compliance with each shift included. Issues will be corrected upon discovery. 7) NHA and DON will review facility policies concerning medication administration and medication administration documentation, update as necessary by December 7, 2022, and initiate staff education based on updates if required. On December 7, 2022, at 3:18 PM, the Immediate Jeopardy was lifted during an onsite survey after ensuring that the immediate action plan had been implemented. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.9(d) Pharmacy services