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	01/14/2025

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on review of facility policy, facility admission agreement, closed clinical records, resident account statements, and staff interview, it was determined that the facility failed to convey resident fund account balance and overpayment balance upon discharge in accordance with State law for three of three closed resident records reviewed (Residents 1, 2, and 3). Findings include: A review of the facility policy, titled Resident Personal Funds, last revised [DATE], stated, Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds and a final account of those funds to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. A review of the facility admission agreement stated the following,10.2 Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded .within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the duly authorized representative of Resident's estate or to such entities or persons entitled to the refund under current law.10.3 Refunds of Prepayments or Overpayments. Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the duly authorized representative of Resident's estate or to such other entities or persons entitled to the refund under current law. The closed clinical record confirmed that Resident 1 expired on [DATE]. Resident 1's account statement indicated that the Authorized Representative should have received a refund of $180.24 (one hundred eighty dollars and twenty-four cents). A refund check was not issued to the Authorized Representative until [DATE]. The closed clinical record confirmed that Resident 2 was discharged on [DATE]. Resident 2's account statement indicated that the Authorized Representative should have received a refund of $165.38(one hundred sixty-five dollars and thirty-eight cents). A refund check was not issued to the Authorized Representative until [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	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Nursing & Rehabilitation Center	1000 Claremont Road Carlisle, PA 17013

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The closed clinical record confirmed that Resident 3 expired on [DATE]. Resident 3's Authorized Representative prepaid for the entire month of [DATE]. Resident 3's account statement indicated an overpayment of $4,370.75 (four thousand, three hundred seventy dollars, and seventy-five cents). The facility provided a copy of the canceled check that revealed the facility dated the check [DATE], and the paid date was documented as [DATE]. During an interview with the Nursing Home Administrator (NHA) on [DATE], at approximately 1:00 PM, the NHA was aware that refunds on account balances should occur within 30 days. The NHA had to contact the corporate office for details of the refunds because they make the final approval. 28 Pa. Code 211.5(d) Clinical records 28 Pa Code: 201.18(e)(1) Management