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	02/11/2026

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. Based on review of facility contract, clinical record review, and resident family and staff interviews, it was determined that the facility failed to provide care and services to ensure the residents' highest level of functioning and well-being for one of three residents reviewed (Resident 1).Findings include:Review of facility contract with outside agency, titled Care Agreement with an effective date of August 5, 2025, read, in part, Providers shall furnish medically necessary hospital care, medical services, and/or extended care services that are authorized by [outside agency] in accordance with the terms of this agreement (covered services).Review of Resident 1's clinical record revealed diagnoses that included dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), emphysema (a long-term lung condition that causes shortness of breath), and post-traumatic stress disorder (PTSD - a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress).Review of Resident 1's clinical record revealed he had a BIMS (Brief Interview of Mental Status- a quick test used in long-term care settings to check cognitive function) score of 0.0, indicating severe impairment with thinking or memory. Review of Resident 1's nursing progress notes revealed a note on January 29, 2026, at 4:34 PM, that stated, Resident is back from appointment with no new orders. There was no note on January 29, 2026, indicating when he left the unit for his appointment.Further review of Resident 1's nursing progress notes revealed a note on January 30, 2026, at 11:10 AM, that stated, [Resident 1's wife] called in to ask why no escort was sent with resident yesterday at his appointment. This writer advised that facility was told she would be attending appointment, so facility did not send escort. Wife was advised that an escort would be present for all appointments whether family comes or not. Wife thanked writer for call.Interview with Resident 1's wife on February 11, 2026, at 11:47 AM, revealed the outpatient appointment center called her in the afternoon on January 29, 2026, stating her husband was not at his appointment and asking if she was there. She revealed she never discussed attending his appointment with anyone at the nursing facility or the outpatient center, as she would not have had the transportation to attend. During an interview with Employee 1 (Unit Secretary) on February 11, 2026, at 12:16 PM, she revealed she remembered hearing that Resident 1's wife was attending the appointment prior to the appointment, but she does not remember who she heard it from. She stated that on the day of Resident 1's appointment, the outside transport employee came into the facility to get Resident 1 for his appointment and took him to the transport vehicle. She confirmed that Resident 1 did not have an escort from the facility. Interview with Employee 2 (Nurse Unit Manager) on February 11, 2026, at 12:36 PM, revealed he spoke with Resident 1's wife on the day of the appointment and she was upset that he did not have an escort from the nursing facility. He further revealed they don't always put a note in the medical record as to what time residents leave the unit for their appointments. Interview with Employee 3 (Assistant Director of Nursing) on February 11, 2026, at 1:05 PM, revealed Resident (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: 395660	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER: Claremont Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Claremont Road Carlisle, PA 17013	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 left the unit around 11:30 AM or noon on January 29, 2026, but the exact time is unknown. She revealed his appointment was at 1:00 PM, and he returned to the facility at 4:34 PM, according to the note. She further revealed his appointment was not on his calendar in the health record as it should have been, and there should have been a note detailing what time he left the facility, written by the unit manager or designee. Interview with the Nursing Home Administrator (NHA) on February 11, 2026, at 1:43 PM, confirmed that Resident 1 did not have an escort the day of his appointment, but it was the facility's understanding that his wife was going to meet him there. He revealed he received an email from an employee for the outside agency surrounding the incident and reiterating the contract between the two entities, stating the facility is to send an escort unless a family member is meeting them at their appointment. He confirmed his appointment should have been on his calendar, and facility staff should have documented when he left for his appointment. Email correspondence between the NHA and Employee 4 (Outpatient Center Case Manager) on January 30, 2026, at 2:21 PM, read, in part, We received a call from [Resident 1's] spouse, who was very upset about an incident that occurred yesterday regarding transport to [the outpatient center]. Both the spouse and [our] staff reported that [he] was sent for an appointment without staff accompanying him from Claremont. The [resident] was located and safely transported to the correct area; however, the CT scan could not be completed per the case manager. If you have time, I would appreciate a quick call on Monday to ensure Claremont is aware of the policy: [Residents] being transported by [our] transportation must have someone accompany them from the [nursing home] facility unless it has otherwise been arranged that a family member will accompany the [patient] upon arrival at the [outpatient center]. Additionally, the spouse expressed concern that the [patient] was sent via transport wearing only a thin jacket when the temperature was 10 degrees outside. I would like an opportunity to discuss this incident and make sure we are all on the same page moving forward.During a phone interview with Employee 5 (Outpatient Center Employee) on February 11, 2026, at 3:05 PM, she revealed the outpatient center's transportation driver picked Resident 1 up from the nursing facility and dropped him off at the entrance to the outpatient center. She stated there are volunteers or employees of the center right inside the entrance that greet the patients as they walk in. She stated Resident 1 approached them and told them his name and they brought him to his appointment. Once there, he was registered for his scan. As he walked back with an employee for his scan, he started to become agitated and asked where his wife was. The outpatient center staff then called his wife who told them she was not at the appointment and that someone from the facility should have joined him. The Resident displayed confusion and started to become belligerent and refused the scan, and the outpatient center staff called their transportation to pick him up and return him to the center.Review of Resident1's clinical record revealed he frequently refuses care, tests, laboratory work, and medications due to agitation. Further into the phone interview with Employee 5 on February 11, 2026, at 3:12 PM, she stated she got a call shortly after the incident from Employee 2 stating Resident 1's wife called and said he was unattended at his appointment and he thought the outpatient agency was responsible to arrange an escort for transport. She explained that per the agreement, it is the responsibility of the nursing center to arrange an escort or a family member to meet a patient for their appointment. Employee 4 later called back to the facility to speak to Employee 3 about the event and make her aware of the concern that he was not dressed properly. Interview with the NHA on February 11, 2026, at 3:39 PM, revealed he would expect residents with cognitive impairment to be accompanied by a staff escort or a family member for outside appointments. He further revealed his expectation that staff document when residents leave and return from their appointments, the appointments to be noted on their calendars in their health records, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and for residents to be dressed appropriately for outside appointments. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12 (d)(1)(5) Nursing services