

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/21/2025
NAME OF PROVIDER OR SUPPLIER Claremont Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of four residents reviewed for pressure ulcers (Resident 8). Findings include: Review of facility policy, titled Wound Treatment Management, with a last review date of March 17, 2025, revealed, in part, 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound. Review of Resident 8's clinical record revealed that he was originally admitted to the facility on [DATE], with diagnoses that included a stage 3 pressure injury to the right buttock, unspecified severe protein-calorie malnutrition (nutritional status in reduced availability of nutrients that leads to changes in body composition and function), and cognitive communication deficit (a group of disorders that affect a person's ability to communicate, which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions). Review of Resident 8's current physician orders revealed the following orders: Measure right buttock wound and complete Wound Evaluation every Friday on evening shift for stage 4 pressure injury, dated September 17, 2025. Further review of Resident 8's physician order history revealed that this order was originally initiated on August 20, 2025. Review of Resident 8's August Treatment Administration Record (TAR) revealed that his wound evaluation was coded as being completed on August 20 and 27, 2025, but a wound evaluation form was not completed. Review of Resident 8's September TAR revealed that his wound evaluation on September 3, 2025, was coded as 9 (other/see progress note), but review of progress notes failed to reveal a corresponding progress note. His wound evaluation for September 19, 2025, was signed as completed but no wound evaluation form was completed. His wound evaluation for September 26, 2025, was blank, and no wound evaluation form was completed. Review of Resident 8's October TAR revealed that his wound evaluation was coded as being completed on October 3, 10, 17, 24, and 31, 2025. A wound evaluation form was not completed on October 3, 17, or 24, 2025. A wound evaluation form was completed on October 10 and 30, 2025. Review of Resident 8's November TAR revealed that his wound evaluation was coded as being completed on November 7, 2025; and on November 14, 2025, the wound evaluation was blank. There were no wound evaluation forms completed for November 2025. During a staff interview with Employee 6 (Registered Nurse/Wound Nurse) on November 21, 2025, at 9:50 AM, she indicated that if the in-house wound consultant follows a resident's wounds, the wound consultant completes the assessment/measurements of the wound weekly. Employee 6 further indicated that if a resident goes to an off-site wound clinic, then the staff nurses on the units are responsible for completing the weekly assessment/measurements of a resident's wound. Email communication received from the Director of Nursing (DON) on November 21, 2025, at 10:41 AM, she confirmed that there were missing wound evaluations. Review of Resident 8's most recent wound clinic consult dated November 13, 2025, revealed a recommendation for a Roho chair cushion to be utilized. Observation of Resident 8 with Employee 7 (Registered Nurse) on November 21, 2025, at (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:40 AM, revealed that the Resident was sitting in his wheelchair on a gel cushion. During a staff interview with the Nursing Home Administrator and DON on November 21, 2205, at 11:02 AM, the DON indicated that she would follow-up on the Roho cushion not being implemented as recommended by the wound clinic. During a staff interview with the DON on November 21, 2025, at 11:15 AM, she confirmed that she would expect nursing staff to have assessed, measured, and documented the findings accordingly. She also indicated that she would also expect the wound clinic to share their measurements and assessment findings. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to label medications properly in three of six medication carts observed (Third Floor [NAME] Hall, C-Wing C Hall, and Transitions East Hall) and two of four medication rooms observed (First Floor and Heritage Harbor); and the facility failed to discard expired medications in three of six medication carts observed (First Floor West, C-Wing C Hall, and Transitions East Hall) and in one of four medication rooms observed (Third Floor). Findings include: Review of facility policy, titled Medication Storage, with a last review date of March 17, 2025, revealed, in part, 8. Unused Medications: All medication rooms are routinely inspected by the IDT members for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy or returned to the pharmacy. Review of policy, titled Insulin Pen, with a last review date of March 17, 2025, revealed, in part, 2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. 3. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy. 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation. Review of policy, titled Medication Administration, with a last review date of March 17, 2025, revealed, in part, 10. Identify expiration date. If expired, notify nurse manager. Review of policy titled Multi-Dose Vials, with a last review date of March 17, 2025, revealed, in part, 2. Multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer). 3. The medication label will also include the initials of the nurse who opened the vial. 5. Visually inspect the vial before each use to double check the expiration date, beyond use date if previously opened, and ensure there is no visible contamination. 6. Discard the vial accordingly if the vial is out of date (past the beyond use date/manufacturer's expiration date) or is visibly contaminated. 7. Unit Manager will perform random checks of opened multi-dose vials for appropriate dating. Review of DermaRite Liquid Active Protein data sheet on DermaRite.com revealed that the supplement should be used or discarded within three to six months of opening. Review of tuberculin testing solution information at www.pa.gov revealed that tuberculin skin testing solution expires 30 days after the initial puncture into the vial. Observation of the Third Floor [NAME] Hall Medication Cart on November 19, 2025, at 10:20 AM, with Employee 1 (Licensed Practical Nurse), revealed an opened bottle of DermaRite Liquid Protein Supplement with no open date indicated, and a bottle of geritussin that had no legible manufacturer expiration date noted. Employee 1 confirmed the findings and indicated that she would discard the medications. Observation of the Third Floor Medication Room on November 19, 2025, at 10:25 AM, with Employee 1, revealed an unopened box of lorazepam (a controlled medication used to treat anxiety) liquid for Resident 189 that had a manufacturer expiration date of September 2025. Employee 1 confirmed the finding and indicated that she would discard the medication when she could find another nurse to witness the destruction. Observation of the First Floor [NAME] Hall Medication Cart on November 19, 2025, at 10:37 AM, with Employee 2 (Licensed Practical Nurse), revealed a bottle of Senna Plus (a stool softener) with an opened date of June 25, 2025, and a manufacturer expiration date of October 2025. Employee 2 confirmed the finding. Observation of the First Floor Medication Room on November 19, 2025, at 10:40 AM, with Employee 2, revealed an opened vial of tuberculin testing solution with no opened date indicated. Employee 2 confirmed the finding. Observation of the C-Wing C Hall Medication Cart on November 19, 2025, at 10:47 AM, with Employee 3 (Licensed Practical Nurse), revealed an opened bottle of Nephro Vitamins C and B Complex with an opened date of October 18, 2025, and a manufacturer expiration date of August 2025; and a bottle of iron liquid supplement with an opened date of June 30, 2025, that had no (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legible manufacturer expiration date noted. Employee 3 confirmed the findings. Observation of the Transitions Unit East Hall Medication Cart with Employee 4 (Licensed Practical Nurse) on November 19, 2025, at 10:59 AM, revealed an opened Lantus Insulin Pen with no resident name or open date; a Lispro Insulin Pen for Resident 187 with no open date indicated; a bottle of Nephro Vitamins with an open date of November 1, 2025, and a manufacturer expiration date of October 2025; and an opened bottle of DermaRite Liquid Protein Supplement with no open date indicated. Employee 4 confirmed the findings. Observation of Heritage Harbor Medication Room on November 19, 2025, at 11:12 AM, with Employee 5 (Licensed Practical Nurse), revealed an opened vial of tuberculin testing solution with no open date indicated. Employee 5 confirmed the finding. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on November 19, 2025, at 2:13 PM, the DON confirmed that she would expect medications to be labeled properly and to be discarded when expired. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12(d)(1)(2)(3) Nursing services		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for two of 35 residents reviewed (Residents 14 and 173). Findings Include: Review of facility policy, titled Comprehensive Care Plans; Dated 2022, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of Resident 14's clinical record revealed diagnoses that included Vitamin D deficiency and osteoporosis (a condition in which the bones become brittle and fragile). Review of Resident 14's care plan revealed a care plan focus for surgical wound related to bilateral femur fractures, with an initiated date of July 3, 2025. Review of Resident 14's clinical record revealed that she no longer had any healing surgical incisions. Email communication received from the Director of Nursing (DON) on November 21, 2025, at 2:07 AM, indicated that Resident 14's care plan was revised to remove the surgical wound. During a staff interview with the Nursing Home Administrator and the DON on November 21, 2025, at 8:36 AM, the DON confirmed that Resident 14's care plan should have been revised when her surgical wounds healed. Review of Resident 173's clinical record revealed diagnoses that included congestive heart failure (a chronic condition where the heart muscle can't pump enough blood to meet the body's needs) and obstructive uropathy (a condition where urine flow is blocked in the urinary tract, which can cause urine to back up and damage the kidneys). Observation of Resident 173 on November 18, 2025, at 9:45 AM, revealed the Resident lying in bed with his nephrostomy (a procedure where a tube is placed through the skin and into the kidney to drain urine) tube and bag lying in bed next to him. Review of current physician orders for Resident 173 revealed a current order for Left Nephrostomy Tube Site: Observe for signs/symptoms of infection, with a start date of October 30, 2025. Review of Resident 173's care plan failed to reveal any indication that Resident 173 had a Nephrostomy tube or required care pertaining to his nephrostomy tube. An interview with the DON on November 21, 2025, at 8:01 AM, revealed that Resident 173 should have a care plan that included nephrostomy care. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, facility policy review, state regulation, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of 35 residents reviewed (Resident 4). Findings Include: Review of the Pennsylvania Nursing Practice Act, Chapter 21.145. Functions of the LPN (Licensed Practical Nurse), revealed The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: The LPN may accept a written order for medication and therapeutic treatment from a practitioner authorized by law and by facility to issue orders for medical and therapeutic measures. Review facility policy, titled Medication Administration, without date, revealed that after the nurse prepares the medication for a resident, they must observe the resident consuming the medication. Review of Resident 4's clinical record revealed diagnoses that included dementia (a progressive loss of mental functions) and anxiety disorder (a mental health condition characterized by excessive and persistent fear, worry, or dread that can interfere with daily life). Observation of Resident 4 on November 18, 2025, at 10:24 AM, revealed the Resident lying in bed. Beside Resident 4, on the overbed table, was a cup containing 7 tablets in a medication cup. Further observation on November 18, 2025, at 11:12 AM, revealed the medication was still there and Resident 4 refused an interview at that time because she said that she didn't feel good. Review of Resident 4's physician's orders failed to reveal a physician's order for self-administration of medications. Review of Resident 4's care plan failed to reveal a care plan for self-administration of medications. Interview with Employee 1 LPN (Licensed Practical Nurse) on November 20, 2025, at 1:59 PM, revealed that when she was administering Resident 4's morning medications on November 18, 2025, she was interrupted and called away to do another task and left Resident 4's medications with Resident 4. Interview with the Director of Nursing on November 20, 2025, at 9:46 AM, revealed that Resident 4 did not have an evaluation or physician's order for self-administration of medications. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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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 clinical record review, observation, facility documentation review, and resident 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 two of 35 residents reviewed (Residents 145 and 232). Findings include: Review of Resident 145's clinical record revealed diagnoses that included lymphedema (tissue swelling caused by an accumulation of protein-rich fluid) and hypothyroidism (when the thyroid gland doesn't make enough thyroid hormone). Observation conducted on November 18, 2025, at 10:55 AM, in Resident 145's room, revealed compression wraps lying on the floor on the left side of Resident 145's bed. Interview conducted with Resident 145 on November 18, 2025, at 10:57 AM, revealed that she does not wear the compression wraps and that they have been on her floor for multiple days. Review of Resident 145's clinical record revealed that she was seen by a Certified Lymphedema Specialist on August 19, 2025, with a recommendation for the Resident to wear compression wraps for lymphedema. Further review of Resident 145's clinical record revealed that a compression vendor came to the facility on October 28, 2025, and fitted Resident 145 with full-leg garments. Resident 145's record failed to reveal any physician's orders or care plan regarding the administration of the full-leg garments. Interview conducted with the Nursing Home Administrator (NHA) on November 20, 2025, revealed that it took time to get Resident 145 compression wraps due to their insurance not covering the initial wraps and having to find an outside vendor to come in. The NHA revealed it normally takes a week or two since a resident is trialed for wraps for the vendor to provide them with an order for them to be administered. NHA revealed the vendor fitted Resident 145 on October 28, 2025, and they are waiting for them to provide any order. Review of electronic mail provided by the facility revealing communication between the facility and the vendor on November 20, 2025, at 4:07 PM, stating the prescription for Resident 145's new wraps arrived on that day, will be signed by the physician, and then the new wraps will start being applied to Resident 145. Review of Resident 145's clinical record revealed a compression garment prescription dated November 20, 2025, for four pairs of bilateral compression wraps. Review of Resident 232's clinical record revealed diagnoses that included presence of a cardiac pacemaker (an artificial device for stimulating the heart muscle and regulating its contractions), dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), and muscle weakness. Review of Resident 232's 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) with the assessment reference date (last day of the assessment period) of September 29, 2025, revealed in Section C. Cognitive Patterns that her score was a 6, indicating severe cognitive impairment. Review of Resident 232's clinical record revealed that she had a pacemaker replacement procedure on October 31, 2025. Review of Resident 232's physician orders revealed an order for bilateral enabler bars to promote independence with bed mobility, transfers and turning/repositioning every shift, dated September 26, 2025; and an order for left arm restrictions of: Do not lift, push or pull more than 2 pounds with left arm. No tub baths or soaking-ok to cleanse with soap and water. No lotions, ointments or powder to incision. Keep L[eft] elbow lower than shoulder height every shift for pacemaker care through December 1, 2025, with an original order date of October 31, 2025. Review of Resident 232's care plan and nurse aide Kardex failed to reveal left arm precautions for staff to follow. Review of Resident 232's nurse aide task documentation for lying to sitting on side of bed and rolling side to side from October 31, 2025, through November 21, 2025, revealed that Resident 232 had been coded as being independent to needing substantial assistance. Review of Resident 232's progress notes revealed a nurses note dated November 4, 2025, at 12:34 PM, indicated, in part, Resident denied pain/discomfort to area during skin assessment. Pushed resident back to dayroom after body assessment in room. While turning resident towards table in wheelchair, resident stated 'I can feel that pulling when you turned me.' Refused pain medication when offered. During a staff (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the NHA and Director of Nursing (DON) on November 20, 2025, at approximately 2:00 PM, the concern was shared regarding Resident 232's ordered left arm restrictions not being communicated for nurse aides to follow, and potential safety concerns with her cognitive status and the independent use of the enablers possibly exceeding her ordered restrictions. During a staff interview with the NHA and DON on November 21, 2025, at 10:58 AM, the DON indicated that they removed the enablers yesterday after surveyor concerns were shared. She further indicated that the enablers had originally been placed after Resident 232 requested them to help with bed mobility and to help her feel safer in bed. When questioned if the facility had reevaluated Resident 232 for the safe use of the enablers when her restrictions were ordered on October 31, 2025, the DON confirmed that they did not do so. She also indicated that they had not considered utilizing only one enabler on the right side of the bed to limit use of the left arm. She confirmed that Resident 232 does have fluctuating cognition throughout the day and may not have been in adherence with her restrictions and independent use of the enablers. The DON confirmed that Resident 232's left arm restrictions were not care planned for staff to follow but should have been. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent accidents for one of 35 residents reviewed (Resident 8). Findings include: Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure) and cognitive communication deficit (a group of disorders that affect a person's ability to communicate, which can cause difficulty with understanding or producing language and nonverbal communication skills, such as gestures and facial expressions). Observation of Resident 8's room on November 19, 2025, at 9:35 AM, revealed a pair of shearing scissors that were approximately six to eight inches in length laying on the stand near Resident 8's television. Subsequent observations of Resident 8's room on November 20, 2025, at 10:37 AM, and 12:37 PM, revealed the same findings. During an observation of Resident 8's room on November 20, 2025, at 12:48 PM, with the Nursing Home Administrator (NHA) and Director of Nursing, the NHA acknowledged the presence of the scissors and confirmed that the scissors should not be in Resident 8's room within access of residents. He removed the scissors from Resident 8's room. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure care and services to ensure acceptable parameters of nutrition and hydration for one of 35 residents reviewed (Resident 1). Findings include: Review of facility policy, titled Hemodialysis, dated 2024, revealed in section 5, that a licensed nurse will monitor and communicate a resident's nutritional/fluid management including weights, compliance with food/fluid restrictions, and intake/output measurements as ordered. Review of Resident 1's clinical record revealed diagnoses that included chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly, leading to a buildup of waste and fluid) and dependence on renal dialysis (a patient's life is sustained by a medical process that artificially filters their blood because their kidneys have failed). Review of Resident 1's physician orders revealed a physician's order for a fluid restriction of 720 ml daily, with a start date of September 4, 2025. Review of Resident 1's TAR (Treatment Administration Record) for November 18, 2025, revealed Resident 1's fluid was being tracked by the medication nurse. Further review of the TAR revealed that Resident 1's fluid consumption was over the 720 ml limit four times in the month of November 2025: on 3, 6, 7, and 13. Review of Resident 1's Task section of the electronic medical record revealed Resident 1's fluid intake was being tracked by nurse aids. Further review revealed that as of November 18, 2025, Resident 1's fluid intake was over the 720 ml limit on 17 times in the month of November 2025: on 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, and 18. Further review and comparison of the Task documentation and Resident 1's TAR for November 2025 revealed that the amount of fluid documented that Resident 1 consumed did not match on any days. Interview with the Director of Nursing on November 21, 2025, at 8:00 AM, revealed that she had reviewed the documented amount of Resident 1's fluid intake with the unit manager and they were unable to determine the amount of fluid consumed by Resident 1. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that the licensed pharmacist's report of a medication irregularity was reviewed and acted upon for two of five residents reviewed for unnecessary medications (Residents 5 and 8). Findings include: Review of Facility policy, titled Medication Monitoring, with a last review date of March 17, 2025, revealed, in part, 5. Each resident's medication regimen is reviewed by a licensed pharmacist at designated intervals, and whenever changes in condition that could be related to medications are noted. Irregularities are reported and addressed in accordance with facility policy for medication regimen reviews and addressing irregularities. Review of facility policy, titled Medication Regimen Review, (MRR) with a last review date of March 17, 2025, revealed, in part, 4. The pharmacist, physician or CRNP [Certified Registered Nurse Practitioner] should document, either manually or electronically, that a medication regimen review has been completed. a. The pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation. 5. The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. 6. Written communications from the pharmacist shall become a permanent part of the resident's medical record. 7. Timelines and responsibilities for pharmacist Medication Regimen Review: a. The consultant pharmacist should schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete all required activities. b. The pharmacist shall communicate any recommendations and identified irregularities via written communication. f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Review of Resident 5's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), anxiety disorder (a persistent feeling of worry, nervousness, or unease), and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 5's physician orders revealed an active order for Sennosides Tablet as needed, with a start date of August 6, 2025. Further review of Resident 5's physician orders revealed an active order for Senna-Docusate Sodium Oral Tablet as needed, with a start date of August 18, 2025. Review of Resident 5's clinical record revealed an MRR on August 31, 2025, that read, in part, A medication regimen review was performed- see report for comments/recommendations(s) noted. Comments: Resident has PRN (as needed) orders for senna and senna/docusate with diagnosis of constipation. Consider discontinuing one of these orders. If both are to remain active, please add more specific directions to help determine when each should be used. Thank you. During an email correspondence with the Director of Nursing (DON) on November 20, 2025, at 1:55 PM, she revealed she was unable to provide a signed copy of the aforementioned MRR to indicate that it was reviewed by the physician. During a follow up interview with the DON on November 21, 2025, at 11:06 PM ?AM, revealed the physician was going to review the aforementioned MRR later that day, as there was no evidence to indicate it was responded to prior. She further revealed her expectation that monthly MRRs should be reviewed by the physician timely and recommendations to be implemented, if applicable. Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure) and unspecified severe protein-calorie malnutrition (nutritional status in reduced availability of nutrients that leads to changes in body composition and function). Review of Resident 8's clinical record revealed that the facility consultant pharmacist reviewed his medication regimen on July 3, 2025, and made recommendations. Review of facility provided Drug Regimen Review Documentation note for Resident 8's July 3, 2025, medication (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regimen review revealed that the pharmacist had identified the following concerns: Resident has two active orders for Tylenol PRN [as needed] for pain-650 milligrams every six hours as needed, and 1000 milligrams every eight hours as needed. Please verify which is correct and discontinue the other to avoid possible duplication of therapy. 2. There are active orders for Imodium 2 milligrams TID [three times a day] for diarrhea and Senna 8.6 milligrams daily for constipation. These are conflicting diagnoses. Please evaluate. The note was initialed by Resident 8's Certified Registered Nurse Practitioner (CRNP) on July 7, 2025, with no documentation or orders provided. In addition, the note was initialed by a staff nurse also dated July 7, 2025. Review of Resident 8's physician order history revealed that the Tylenol orders were clarified on July 17, 2025, and that the Imodium and Senna conflicting orders were clarified on August 6, 2025. Further review of Resident 8's clinical record revealed that the facility consultant pharmacist reviewed his medication regimen on July 31, 2025, and noted no irregularities, even though Resident 8 was continuing to receive both the Imodium and Senna daily for the previously identified conflicting diagnoses. During a staff interview with the Nursing Home Administrator and DON on November 21, 2025, at 11:00 AM, the DON confirmed that no clear order was given by the CRNP even though he had initialed the document and, therefore, the Imodium and Senna continued. She further indicated that nursing staff should have followed up with the CRNP when no documentation or order was provided about the Imodium and Senna. She indicated that the pharmacist should have utilized the correct form when making recommendations on July 3, 2025, and confirmed that the pharmacist should have identified on Resident 8's medication regimen review on July 31, 2025, that the diagnoses conflict had not been addressed and should have reissued a report of the irregularity. 28 Pa. Code 211.2(d)(3) Medical director.28 Pa. Code 211.9(a)(1) Pharmacy services.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		