

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Clarview Nursing and Rehab Cen		STREET ADDRESS, CITY, STATE, ZIP CODE  14663 Route 68 Sligo, PA 16255	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</b></p> <p>Based on observations, review of facility policies and documents, and staff interview, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean environment for one of 17 residents observed (Resident R20).</p> <p>Findings include:</p> <p>Review of facility policy entitled Cleaning and Disinfection of Resident-Care Items and Equipment dated 1/04/24, revealed Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard.</p> <p>Review of Resident R20's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and enterocolitis due to Clostridium Difficile (inflammation of both the small intestine and the colon with bacteria causing an infection in the colon with symptom of diarrhea and the infection can be spread to others).</p> <p>Review of Resident R20's clinical record revealed a physician's order dated 5/28/24, for contact isolation related to Clostridium Difficile (C-Diff), another order dated 12/03/22, for fall mat (a preventative cushion to help prevent injury) to side of bed toward bathroom.</p> <p>Observations on 10/15/24, at 11:30 a.m. revealed a fall mat laying to the right side of Resident R20's bed. Observations on 10/15/24, at 11:30 a.m. revealed a brown substance that resembled dried feces and a white dry substance on the fall mat.</p> <p>Observations on 10/16/24, at 10:00 a.m. revealed the brown substance that resembled dried feces and the white dry substance remained on the fall mat.</p> <p>Observations on 10/17/24, at 9:15 a.m. revealed the brown substance that resembled dried feces and the white dry substance remained on the fall mat. Further observations on 10/17/24, at 12:30 p.m. with the Director of Nursing (DON) revealed the brown substance that resembled dried feces and the white dry substance remained on the fall mat.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24, at 12:30 p.m. the DON confirmed that there was a brown substance that resembled dried feces and a white dry substance on the fall mat lying next to Resident R20's bed. He/she also confirmed that the fall mat was not appropriately cleaned, and the fall mat should be clean.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47356</p> <p>Based on review of facility policy and clinical records, and staff interview it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) upon transfer for three of 17 residents reviewed (Residents R11, R17, and R44).</p> <p>Findings include:</p> <p>Review of a facility policy entitled, Bed Hold Policy dated 1/04/24, revealed, In order to comply with state regulations, the resident/responsible party is to be notified of the facility's bed hold policy upon admission to the facility and when the resident is transferred out of the facility.</p> <p>Review of Resident R11's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), hypertension (high blood pressure), and hypokalemia (low potassium level). Resident R11's clinical record revealed that he/she was transferred to the hospital on 3/28/24, 6/25/24, and 7/12/24. The clinical record lacked evidence that Resident R11 and/or their representative was provided with a copy of the facility bed-hold policy upon transfer.</p> <p>Review of Resident R17's clinical record revealed an admitted [DATE], with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), hypertension, and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Resident R17's clinical record revealed that he/she was transferred to the hospital on 4/12/24, and 9/21/24. The clinical record lacked evidence that Resident R17 and/or their representative was provided with a copy of the facility bed-hold policy upon transfer.</p> <p>Review of Resident R44's clinical record revealed an admitted [DATE], with diagnoses that included hypotension (low blood pressure), anxiety, muscle weakness, and chronic kidney disease. Resident R44's clinical record revealed that he/she was transferred to the hospital on 6/21/24 and 7/13/24. The clinical record lacked evidence that Resident R44 and/or their representative was provided with a copy of the facility bed-hold policy upon transfer.</p> <p>During an interview on 10/17/24, at approximately 1:15 p.m. the Nursing Home Administrator confirmed that the clinical records for Residents R11, R17, and R44 on the dates listed above lacked evidence that the residents and/or their representatives were provided with a copy of the facility bed-hold policy upon transfer.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47356</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS-periodic assessment of resident care needs) for one of 17 residents reviewed (Resident R54).</p> <p>Findings include:</p> <p>Resident R54's clinical record revealed an admitted [DATE], with diagnoses that included muscle weakness, dysphagia (difficulty swallowing), and hyperlipidemia (high cholesterol).</p> <p>Resident R54's order summary revealed that Methenamine Hippurate (an anti-infective/anti-bacterial medication, which is not classified as an antibiotic) was ordered on 9/24/24.</p> <p>Resident R54's Admission MDS dated [DATE], Medications Section N0145 High-Risk Drug Classes: Use and Indication F. Antibiotic indicated that Resident R54 Is taking an Antibiotic.</p> <p>During an interview on 10/17/24, at 1:00 p.m. the Licensed Practical Nurse Assessment Coordinator confirmed that R54's MDS Medication Section N0145 High-Risk Drug Classes: Use and Indication F. Antibiotic was coded incorrectly.</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48496</p> <p>Based on review of clinical record, observations, and staff interview, it was determined that the facility failed to ensure that physician's orders were followed for one of 17 residents reviewed (Residents R20).</p> <p>Findings include:</p> <p>Review of Resident R20's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and enterocolitis due to Clostridium Difficile (inflammation of both the small intestine and the colon with bacteria causing an infection in the colon with symptom of diarrhea and the infection can be spread to others).</p> <p>Review of Resident R20's physician's orders revealed an order dated 8/28/23, for Geri sleeves (cloth sleeves that protect the skin from injury) to be worn at all times. Review of Resident R20's care plans revealed a care plan for skin integrity with an intervention of Geri sleeves to arms at all times except hygiene.</p> <p>Observations on 10/15/24, at 11:50 a.m. revealed Resident R20 sitting in his/her wheelchair in his/her room with no Geri sleeves on his/her bilateral arms. Observations on 10/16/24, at 9:25 a.m. revealed Resident R20 sitting in his/her wheelchair in his/her room with no Geri sleeves on his/her bilateral arms. Observations on 10/17/24, at 9:15 a.m. revealed Resident R20 sitting in his/her wheelchair in his/her room with no Geri sleeves on his/her bilateral arms. Observations on 10/17/24, at 12:30 p.m. with the Director of Nursing (DON) revealed Resident R20 sitting in his/her wheelchair in the lounge with no Geri sleeves on his/her bilateral arms.</p> <p>During an interview on 10/17/24, at 12:30 p.m. the DON confirmed that Resident R20 did not have Geri sleeves on bilateral arms per physician orders. He/she also confirmed that Resident R20 should have Geri sleeves on his/her bilateral arms at all times as ordered by the physician.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		