STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395707	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarion Healthcare and Rehabilitation Center	999 Heidrick Street Clarion, PA 16214

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy, facility documentation and clinical record, and resident and staff interviews, it was determined that the facility failed to ensure that one of three residents reviewed (Resident R1) was free of neglect during care which resulted in actual harm of a completely dislocated entire left hip hemiarthroplasty (a complete dislocation of a partial hip replacement that replaces half of the hip joint). This deficiency is cited as past non-compliance. Findings include: Review of facility policy entitled, Identifying Types of Abuse, dated 1/2/24, revealed that Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them, and this has resulted in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort or safety results in physical harm, pain, mental anguish, or emotional distress. Review of facility policy entitled, Safe Lifting and Movement of Residents dated 1/2/24, revealed that Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Review of Resident R1's clinical record revealed an admitted [DATE], that included diagnoses of hypomagnesemia (low magnesium level), hyperlipidemia (high cholesterol), hypertension (high blood pressure), and unsteadiness on feet (the inability to maintain your balance while standing). Review of Resident R1's Quarterly Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], revealed that Resident R1 required extensive assistance with two person assistance for transfers. Review of Resident R1's care plans with a focus of ADL Self Care and mobility . with an initiated date of 12/7/23, revealed under interventions/tasks transfers extensive assistance of two. Review of Resident R1's Kardex (an easy reference of resident care needs for the nursing assistants to reference), revealed under transferring Transfer Extensive assistance of two. (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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NAME OF PROVIDER OR SUPPLIER: Clarion Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 999 Heidrick Street Clarion, PA 16214	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's clinical record revealed a nursing note dated 12/23/23, at 5:41 p.m. which revealed, Resident R1 was up in his/her chair for lunch, after lunch he/she rang to go back to bed. Nursing Assistant (NA), Employee E1 informed the nurse that he/she tried to lay Resident R1 down by him/herself and Resident R1's leg gave out and he/she began to fall so Employee E1 lowered Resident R1 onto the bed. Nurse went to Resident R1's room and found Resident R1 on the edge of the bed. Resident R1 was assisted by the nurse and a NA to a laying position on the bed. Resident R1 stated her left leg and hip were hurting, he/she stated that he/she landed hard on the bed, and it hurt his/her hip. Resident R1 stated that the NA dropped him/her on the bed. Further review of another nursing note dated 12/23/23, at 4:05 p.m. revealed Resident R1 was having pain to left hip and was refusing to move left extremity or let the nurse assess the left hip. Resident R1's physician was notified and ordered an x-ray of left hip. Review of Resident R1's x-ray report dated 12/23/23, revealed under impression Completely dislocated entire left hip hemiarthroplasty. Review of Resident R1's progress note dated 12/23/23, at 6:28 p.m. revealed, x-ray report returned to facility, physician was updated and gave orders to transfer Resident R1 to the Emergency Department. Review of information submitted by facility dated 12/23/23, and interview with the Nursing Home Administrator and Director of Nursing revealed Resident R1 was transferred to the hospital with a dislocation of left hip. Resident R1 remained at the hospital and on 1/10/24, resident was not anticipated to return to the facility. Review of facility's investigation revealed that NA Employee E1 confirmed on 12/23/23, he/she transferred Resident R1 by stand and pivot without the required two staff members. NA Employee E1's statements revealed that he/she grabbed under Resident R1 arms and the back of his/her pants to assist him/her to stand and pivot onto the bed. Resident R1 stood up with NA Employee E1's assistance but he/she was not strong enough to hold him/herself up so his/her left leg buckled and he/she began to fall towards the bed. NA Employee E1 continued to hold Resident R1's arm and pants to guide him/her to the bed but he/she landed on her left leg and said it hurt. Review of documentation submitted by the facility dated 2/21/24, revealed that the facility initiated an investigation, regarding resident neglect on 12/23/23. The investigation revealed that NA Employee E1was suspended pending investigation. Interview with the Nursing Home Administrator and Director of Nursing on 3/7/24, at 12:15 p.m. confirmed that NA Employee E1 did not get another staff member to assist in the transfer of a resident that required transfers of two staff. Interview also revealed that NA Employee E1 has not worked in the facility since the incident on 12/23/23. The facility failed to ensure that Resident R1 was free from neglect resulting in actual harm of a completely dislocated entire left hip hemiarthroplasty from a transfer with assistance of one staff that required assistance of two staff. This deficiency is cited as past non-compliance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/23/23, the facility initiated education for all nursing staff including Registered Nurse's (RN's), Licensed Practical Nurses (LPN's), and NA's to ensure that resident transfers are performed per resident care plans. This plan included the following: Immediate suspension of NA Employee E1. Immediate education regarding checking transfer status before ambulating or transferring a resident was provided to nursing staff which included RN's, LPN's, and NA's, which occurred 12/23/23, through 1/9/24. Review of all resident transfer status compared with resident care plan and posted on resident's nametag outside of resident rooms, which occurred on 12/23/23. Interview of alert and oriented residents on how they are being transferred to verify they are being transferred per their care plan, which occurred on 12/23/23. All staff included in the education also completed competencies conducted by the DON and the Charge Nurse's to ensure that they understood the education and could perform the task correctly. Competencies included how to access the Kardex to review transfer status prior to transfers. All competencies were reviewed during this onsite investigation. Interviews with LPN Employees E3 and E4 and NA Employees E1, E2, E5, and E6 on 3/7/2024, confirmed the facility initiated education and competencies starting 12/23/2023, which included education on checking transfer status before ambulating or transferring a resident and performing a return demonstration to ensure proper knowledge and technique. Audits were conducted to ensure residents are transferred per their care plan which occurred on 12/24/23, through 1/15/24. Per interview with the NHA and DON these audits were reviewed by the Quality Assurance Performance Improvement (QAPI) Committee meeting post incident completed on 1/23/24. Per NHA and DON review of resident transfers will continue to be reviewed at Quality Assurance Performance Improvement (QAPI) Committee meeting and will continue until determined otherwise by the QAPI committee. The facility has demonstrated compliance with using correct transfer status for residents since 1/15/2024. During an interview with the NHA and the DON on 3/7/2024 at 12:15 p.m. and review of the facility's immediate actions, education, competencies, audits, and review of the QAPI monitoring process to sustain solutions, it was verified that the facility had implemented a plan of correction to ensure residents are free from neglect regarding transfer status of residents and had achieved substantial compliance. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services