

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Clarion Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356</p> <p>Based on review of facility policy, Pennsylvania Code Title 49. Professional and Vocational Standards, clinical records, and facility documentation, and staff interview, it was determined that the facility failed to follow nursing standards of practice for safe medication administration for one of two residents reviewed for medication administration (Resident R1).</p> <p>Findings include:</p> <p>Review of Facility Policy entitled, Administering Medications, dated 1/2/2024, indicated, 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications.</p> <p>Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.145. Functions of the Licensed Practical Nurse (LPN) (a)(3) stated, The LPN shall question any order which is perceived as unsafe or contraindicated for the patient or which is not clear and shall raise the issue with the ordering practitioner. If the ordering practitioner is not available, the LPN shall raise the issue with a Registered Nurse (RN) or other responsible person in a manner consistent with the protocols or policies of the facility. and 21.11. General functions of the RN (a)(4) stated, Carries out nursing care actions which promote, maintain and restore the well-being of individuals and (b) The RN is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice.</p> <p>Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (disease causing difficulty breathing), cough, edema (retention of fluid in the body), and chronic atrial fibrillation (irregular heartbeat). Keflex (an antibiotic used to treat an infection) was listed as an allergy on admission and is highlighted red in the clinical record.</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 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes revealed that on 6/17/2024, at 12:03 p.m. RN Employee E1 contacted the physician and received a verbal order for Keflex (antibiotic) 500 milligrams every eight hours for 10 days for pain, redness, and tenderness of the right lower extremity around a skin tear and that the LPN Employee E2 was notified of the order. On 6/17/2024, at 12:57 p.m. LPN Employee E2 administered the Keflex as ordered by the physician. On 6/17/2024, at 1:20 p.m. RN Employee E1 documented one dose of Keflex, which was listed as an allergy was administered to Resident R1. On 6/17/2024, LPN Employee E2 documented that one dose of Keflex was administered to Resident R1 and that he/she did not notice the allergy until after the dose was given.</p> <p>Review of an investigation initiated on 6/18/2024, by the Director of Nursing (DON) revealed that RN Employee E1 failed to verify Resident R1's allergies prior to placing the order into the facility computer system and contacting the LPN Employee E2 and LPN Employee E2 failed to review Resident R1's clinical record for allergies prior to administering a newly ordered medication.</p> <p>During an interview with LPN Employee E2 on 7/2/2024, at approximately 10:30 a.m. he/she confirmed that the medication was administered to Resident R1 before the allergies were reviewed in the clinical record and that allergies should have been reviewed prior to administering a newly ordered medication.</p> <p>During an interview on 7/2/2024, at approximately 2:00 p.m. the Nursing Home Administrator and the DON confirmed that RN Employee E1 did not review allergies prior to placing a new order into the facility computer system and contacting LPN Employee E2 and LPN Employee E2 did not review Resident R1's allergies prior to administering a newly ordered medication.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>