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	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarion Nursing and Rehab	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to discard expired multi-dose insulin pens (medication to treat elevated blood sugar levels) in two of four medication carts (A and B Wings) and also failed to safely secure medications on one of four nursing unit medication carts (B Wing). Findings include: Review of a facility policy entitled Labeling of Medications and Biologicals dated [DATE], indicated that multi-use vials will be dated when opened, and discarded within 28 days or according to the manufacturer's expiration date. Review of facility policy entitled, Security of Medication Cart dated [DATE], indicated that the nurse must secure the medication cart during medication pass to prevent unauthorized entry, and medication carts must be securely locked at all times when out of nurse's view. Observation on [DATE], at 12:00 p.m. of the A Wing medication cart revealed two opened Lantus (long-acting) multi-dose insulin pens with open dates of [DATE], and [DATE], and one opened Humalog (short-acting) multi-dose insulin vial with an open date of [DATE]. Observation on [DATE], at 1:45 p.m. of the B Wing medication cart revealed one opened Lantus multi-dose insulin pen with an open date of [DATE], and one opened Humalog multi-dose insulin vial with an open date of [DATE]. During an interview at that time Licensed Practical Nurse Employee E2 confirmed that the insulin pens were expired and should be discarded. During an interview on [DATE], at 11:15 a.m. the Director of Nursing confirmed that the opened multi-dose pens of Humalog and of Lantus insulin should have been discarded that were expired. Observation on [DATE], at 12:30 p.m. of the B Wing medication cart revealed it was unsecured and parked next to the wall near room [ROOM NUMBER], and Registered Nurse (RN) Employee E1 was observed in the main dining room with a resident and not in view of medication cart. During an interview at that time RN Employee E1 confirmed that the cart should have been locked while out of view. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations and staff interview, it was determined the facility failed to maintain privacy of Protected Health Information (PHI) during medication administration for one of six medication passes observed.Findings include: A facility policy entitled, The Privacy Plan dated 2/23/26, indicated that to ensure the security of PHI, the company must ensure the confidentiality, integrity, and availability of all PHI that the company creates, receives, maintains, or transmits. Observation on 3/03/26, at 12:30 p.m. revealed that Registered Nurse (RN]) Employee E1 was performing resident medication administration in the main dining room and left the computer screen containing resident PHI visible to anyone passing in the corridor, and that housekeeping and dietary staff passed by the visible computer screen. During an interview at that time, RN Employee E1 confirmed that the computer screen containing resident PHI was visible to anyone passing in the corridor. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical records, and staff interview it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer and failed to have complete documentation related to a transfer for one of two residents reviewed (Closed Record Resident CR77).Findings include: Review of facility policy entitled Transfer/Discharge Documentation dated 2/18/25, indicated that when a resident is transferred to acute care the facility will:contact the provider hospital, when possible, for admission arrangements.original copies of the transfer form and advanced directives will accompany the resident, and copies will be retained in the medical record.contact information of the practitioner who was responsible for the care of the resident.resident representative information, including contact information.resident status, including baseline and current mental, behavioral and functional status, reason for transfer, and recent vital signs.diagnoses, allergies, and medications (including when last received).most recent relevant labs, other diagnostics, immunizations.special instructions and/or precautions such as contact, droplet, or airborne.special risks such as falls, elopement, bleeding, pressure injury, and/or aspiration precautions.comprehensive care plan goals.Resident CR77's clinical record revealed an admission date of 12/20/25, with diagnoses including partial intestinal obstruction, difficulty swallowing, unsteady on feet, weakness, and need for assistance with personal care. A departmental progress note dated 1/02/26, at 12:33 a.m. indicated that Resident CR77 was transferred to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 3/06/26, at 11:00 a.m. the Director of Nursing confirmed that the facility lacked evidence that Resident CR77's necessary clinical information was provided to the receiving healthcare provider upon transfer, and his/her clinical record lacked complete documentation. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(3)(e)(1) Management28 Pa. Code 211.12 (d)(1)(3) Nursing services