STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395867	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Healthcare and Rehab	15 West Willow Street Smethport, PA 16749

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan for two of 13 residents reviewed (Residents R9 and R16). Findings include: Review of a facility policy entitled Resident Participation - Assessments / Care Plans dated 5/2/24, indicated that a seven day advance notice of the care planning conference is provided to the resident and his or her representative and that such notice is made by mail and/or telephone. The policy also indicated that the social services director or designee is responsible for notifying the resident/representative and for maintaining records of such notices. The notices include the name of each person contacted and the date he or she was contacted, the method of contact, refusal of participation if applicable, and the date and signature of the individual making the contact. Review of a facility policy entitled Care Plans, Comprehensive Person Centered dated 5/2/24, indicated that the interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care needs) assessment. Resident R9's clinical record revealed an admitted [DATE], with diagnoses that included high blood pressure, osteoporosis (condition affecting the bones putting you at higher risk for fractures), and depression. Resident R9's clinical record revealed a Quarterly MDS, with an Assessment Reference Date (ARD - a look back period of time for the MDS assessment) of 5/6/24. The clinical record lacked any evidence that the resident or resident representative was invited to or attended a care plan meeting in conjunction with the 5/6/24, quarterly MDS. Resident R16's clinical record revealed an admitted [DATE], with diagnoses that included hypertension (high blood pressure), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hyperlipidemia (high cholesterol). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R16's clinical record revealed a Quarterly MDS, with an ARD of 5/21/24. The clinical record lacked any evidence that the resident or resident representative was invited to or attended a care plan meeting in conjunction with the 5/21/24, quarterly MDS. During an interview on 6/17/24, at approximately 3:00 p.m. the Registered Nurse Assessment Coordinator and the Social Worker confirmed that there was no evidence of Residents R9 or R16 or their representatives being invited to/or attending a Care Plan Meeting. 28 Pa. Code 201.29 (a) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that a written summary of the baseline care plan was provided to residents and/or the resident's representative for five of 13 residents reviewed (Residents R9, R23, R26, R79, and R80). Findings include: Review of a facility policy entitled Care Plans - Baseline dated 5/2/24, indicated the resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident / representative can understand) that includes goals an objectives, summary of resident's medications and dietary instructions, and any services and treatments to be administered. The policy further stated that the provision of the summary to the resident and/or resident representative is documented in the medical record. Resident R9's clinical record revealed an admitted [DATE], with diagnoses that included high blood pressure, osteoporosis (condition affecting the bones putting you at higher risk for fractures), and depression. Resident R9's clinical record lacked evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative. Resident R23's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (lung disease resulting in difficulty breathing and persistent cough), dementia (a condition that affects your memory, thinking, and social abilities), and high blood pressure. Resident R23's clinical record lacked evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative. Resident R26's clinical record revealed an admitted [DATE], with diagnoses that included high blood pressure, fractures right clavicle and right femur (broken right collarbone and right hip), and osteoporosis (condition affecting the bones putting you at higher risk for fractures) Resident R26's clinical record lacked evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative. Resident R79's clinical record revealed an admitted [DATE], with diagnoses that included encephalopathy (disease that affects the brain structure and/or function resulting in a change in mental status and confusion), osteoporosis, and seizures. Resident R79's clinical record lacked evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R80's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease, seizures, and schizophrenia (a complex mental condition that affects the way someone thinks, feels, and behaves). Resident R80's clinical record lacked evidence that a written summary of the baseline care plan was provided to the resident and/or resident representative. During an interview on 6/17/24, at approximately 11:05 a.m. the Nursing Home Administrator confirmed there was no evidence that a written summary of the baseline care plan was provided to Residents R9, R23, R25, R79, R80 and/or their representatives. 28 Pa. Code 201.24 (e)(4) Admissions Policy

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop comprehensive care plans for one of 13 residents reviewed (Resident R12). Findings include: Review of facility policy entitled Care Plans, Comprehensive Person Centered dated 5/2/24, indicated Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' condition change. and The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. Review of Resident R12's clinical record revealed an admitted [DATE], with diagnoses that included peripheral vascular disease (a condition when there is restricted blood flow to the limb, usually legs), heart failure (a condition where the heart cannot supply the body with enough blood) and hypokalemia (low potassium level). Review of Resident R12's clinical record revealed a progress note dated 4/25/24, that indicated the- resident was found lying on the floor with a large laceration to the right side of his/her head. Resident was transferred to the emergency room for evaluation and treatment. Resident returned from the emergency room with sutures to the laceration on the right side of his/her head. Resident's clinical record lacked evidence of a plan of care for his/her fall with laceration to his/her head requiring sutures. During an interview on 6/17/24, at 1:45 p.m. the Registered Nurse Assessment Coordinator confirmed that Resident R12's clinical record lacked a plan of care for fall with laceration requiring sutures. He/she also confirmed that the plan of care should have been initiated. 28 Pa. Code 211.12(d)(1)(5) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical record, and staff interview, it was determined that the facility failed to review and/or revise resident care plans and failed to provide evidence of care plan meetings being held for two of 13 residents reviewed (Residents R9 and R16) Findings include: Review of a facility policy entitled Care Plans, Comprehensive Person Centered dated 5/2/24, indicated that the interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care needs) assessment. Resident R9's clinical record revealed an admitted [DATE], with diagnoses that included high blood pressure, osteoporosis (condition affecting the bones putting you at higher risk for fractures), and depression. Resident R9's comprehensive care plans revealed that of the 22 care plans present, 12 had an outstanding target date(a date that the care plan is to be updated by) of 5/22/24. The care plans included the problem categories of: Impaired vision related to history of cataract removal, Respiratory impairment related to COVID, Pain-knee related to age related osteoporosis, Does not show potential for discharge into the community, Nutritional Status, Advanced Directive, Mood related to depression, Anxiety, Infection of Wounds/Skin/Tooth, Behaviors, Risk for falls, and Hoarding. Resident R9's clinical record revealed a Quarterly MDS, with an Assessment Reference Date (ARD - a look back period of time for the MDS assessment) of 5/6/24. Resident R9's clinical record lacked evidence that a care plan meeting was held anytime after the 5/6/24 ARD. During an interview on 6/17/24, at approximately 2:55 p.m. Registered Nurse Assessment Coordinator confirmed that Resident R9's care plans were not reviewed and/or revised as required. During an interview on 6/17/24, at approximately 3:05 p.m. Registered Nurse Assessment Coordinator and Social Worker were unable to verify when the last care plan meeting was held for Resident R9 and confirmed that the clinical record lacked evidence of any care plan meetings being held. Resident R16's clinical record revealed an admitted [DATE], with diagnosis that include hypertension (high blood pressure), Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and Hyperlipidemia (high cholesterol). Resident R16's care plans revealed a plan of care for risk for behaviors with a target date of 5/17/24. Resident R16's clinical record revealed a Quarterly MDS, with an ARD of 5/21/24. Resident R16's clinical record lacked evidence that a care plan meeting was held anytime after the 5/21/24 ARD. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/24, at approximately 1:45 p.m. Registered Nurse Assessment Coordinator confirmed that Resident R16's care plan was not reviewed and/or revised as required. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of clinical records, observation, and staff interview, it was determined that the facility failed to ensure physician's orders were accurate and reflected the status and care provided to one of 13 residents reviewed (Resident R79). Findings include: Resident R79's clinical record revealed an admitted [DATE], with diagnoses that included encephalopathy (disease that affects the brain structure and/or function resulting in a change in mental status and confusion), osteoporosis (condition affecting the bones putting you at higher risk for fractures), and seizures. Resident R79's clinical record revealed an elopement risk evaluation completed on 6/7/24, that indicated resident is at risk for elopement and a wanderguard / alarming security bracelet was placed on the resident. A progress note dated 6/7/24, indicated a wanderguard applied due to exit seeking. Further review of Resident R79's clinical record revealed it lacked a physician's order for the wanderguard bracelet. Observation of Resident R79 on 6/15/24 at 2:44 p.m., 6/16/24, at 11:50 a.m., and 6/17/24, at 9:59 a.m. revealed a wanderguard bracelet to his/her right wrist. During an interview on 6/17/24, at approximately 9:56 a.m. the Director of Nursing confirmed that Resident R79's wanderguard bracelet was on his/her right wrist and there was no physician's order for use of the wanderguard bracelet. 28 Pa. Code 211.5(f)(i) Clinical records 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for two of two residents reviewed for respiratory care (Residents R6 and R17). Findings include: Review of a facility policy entitled Departmental (Respiratory Therapy) - Prevention of Infection dated 5/2/24, indicated to change the oxygen tubing every seven days, or as needed. Resident R6's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD-lung disease resulting in difficulty breathing and persistent cough), high blood pressure, and congestive heart failure (a progressive heart disease that affects the hearts pumping ability resulting in difficulty breathing and fatigue). Resident R6's physician orders dated 4/21/24, indicated to change oxygen tubing every night shift every Sunday. Observation on 6/16/24, at 12:15 p.m. revealed that Resident R6's oxygen tubing connected to his/her portable oxygen tank contained a piece of white tape wrapped around it with a date of 5/20/24. During an interview on 6/16/24, at approximately 12:23 p.m. the Director of Nursing (DON) confirmed that the oxygen tubing on Resident R6's portable oxygen tank was dated for 5/20/24, and was not changed weekly as ordered. Resident R17's clinical record revealed an admitted [DATE], with diagnoses that included COPD, high blood pressure, and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R17's physician orders dated 6/6/24, indicated to change oxygen tubing every night shift every Sunday. Observation on 6/15/24, at 12:40 p.m. revealed that Resident R17's oxygen tubing connected to his/her portable oxygen tank contained a piece of white tape wrapped around it with a date of 6/3/24. Further observations on 6/16/24, at 8:50 a.m. revealed the oxygen tubing connected to his/her portable oxygen tank remained with a piece of white tape wrapped around it and a date of 6/3/24. During an interview on 6/16/24 at 12:20 p.m. the DON confirmed that the oxygen tubing was dated for 6/3/24 and that the oxygen tubing should have been changed as ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing services