

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Lakeview Healthcare and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185</p> <p>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to maintain dignity during a dressing change for one of two residents with pressure ulcers requiring wound care reviewed (Resident R31).</p> <p>Findings include:</p> <p>Review of Resident R31's clinical record revealed an admitted [DATE], with diagnoses that included fractured right femur, heart failure, dementia and high blood pressure.</p> <p>Review of Resident R31's physician's orders dated 5/08/25, included an order to cleanse the coccyx wound and apply silvercell to the wound and cover with border foam.</p> <p>Observation of wound care on 5/28/25, at 9:05 a.m. revealed that the Licensed Practical Nurse (LPN) Employee E1 placed the new dressing on Resident R31 and then proceeded to date the dressing while on Resident R31.</p> <p>During an interview on 5/28/25, at 9:20 a.m. LPN Employee E1 confirmed he/she dated the dressing while on Resident R31 and should have dated the dressing prior to placing it on the resident.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177</p> <p>Based on review of clinical records and Minimum Data set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of one of 15 residents reviewed (Resident R18).</p> <p>Findings include:</p> <p>MDS instructions for section P0200 Alarms subsection E Wander / Elopement Alarm indicated to identify all alarms that were used at any time (day or night) during the seven-day look-back period and to code the frequency of use as not used, used less than daily, or used daily. The MDS instructions further indicated that a wander / elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exits sensors worn by/attached to the resident that activates an alarm and/or alert staff when the resident nears or exits a specific area of the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.</p> <p>Resident R18's clinical record revealed an admitted [DATE], with diagnoses that included encephalopathy (a group of conditions that cause problems with the brain that can appear as confusion, memory loss, and personality changes), seizures, and pleural effusion (buildup of excess fluid between the layers of the pleura outside your lungs).</p> <p>Resident R18's clinical record revealed a physician's order dated 8/1/24, for an alarming security bracelet to be worn at all times. Review of treatment administration records for February 2025 revealed staff signage indicating the placement of an alarming security bracelet was checked every shift for the entire month. A quarterly MDS with an Assessment Reference Date (ARD) of 2/10/25, revealed that section P0200E was coded as Not Used.</p> <p>During an interview on 5/29/25, at 2:32 p.m. Registered Nurse Assessment Coordinator confirmed that the 2/10/25, quarterly MDS was coded incorrectly regarding the usage of a wander / elopement alarm and should have been coded as Used Daily.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.5(f)(ix) Medical Records</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177</p> <p>Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders for one of one residents reviewed regarding respiratory care (Resident R15).</p> <p>Findings include:</p> <p>A facility policy dated 5/2/25, entitled Oxygen Administration revealed to turn on the oxygen flow to 2 to 3 liters per minute, unless otherwise ordered by the physician.</p> <p>Resident R15's clinical record revealed an admitted [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure.</p> <p>Resident R15's clinical record revealed a physician's order dated 1/26/25, for oxygen at 1 liter per minute (lpm) via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) PRN (as needed) for SOB (shortness of breath) or comfort.</p> <p>Observation on 5/27/25, at 2:00 p.m. and again on 5/28/25, at 8:57 a.m. revealed Resident R15 lying in bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 3.5 lpm.</p> <p>During an interview on 5/28/25, at 9:00 a.m. Licensed Practical Nurse Employee E2 confirmed that Resident R15's oxygen concentrator was on and set at 3.5 lpm and was not in accordance with the physician's order dated 1/26/25, for oxygen at 1 lpm.</p> <p>During an interview on 5/29/25, at 3:00 p.m. the Nursing Home Administrator indicated that Resident R15 messes with his concentrator and changes the settings. Facility was unable to provide any evidence that despite knowing this, they implemented routine interventions to verify concentrator settings are according to physician's orders.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185</p> <p>Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to prevent the potential for cross contamination during a dressing change for one of two residents with pressure ulcers requiring wound care reviewed (Resident R31).</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Dressings, Dry/Clean, dated 5/02/25, indicated to remove the soiled dressing, remove soiled gloves and then wash hands.</p> <p>Review of Resident R31's clinical record revealed an admitted [DATE], with diagnoses that included fractured right femur, heart failure, dementia and high blood pressure.</p> <p>Review of Resident R31's physician's orders dated 5/08/25, included an order to cleanse the coccyx wound and apply silvercell to the wound and cover with border foam.</p> <p>Observation of wound care on 5/28/25, at 9:05 a.m. revealed that Licensed Practical Nurse (LPN) Employee E1 removed the soiled dressing without removing gloves or washing hands and then continued to cleanse the wound without removing gloves or washing hands.</p> <p>During an interview on 5/28/25, at 9:20 a.m. LPN Employee E1 confirmed he/she did not change gloves and did not complete hand hygiene when indicated.</p> <p>28 Pa. Code 201.18 (b)(2) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>