

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
STATE LICENSE NUMBER: <b>034502</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0689 SS=G	<p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0689	Past noncompliance: no plan of correction required.	<p>Completion Date: <b>12/23/2024</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>12/23/2024</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	Continued from page 1  Based on review of manufacturer's guidelines, clinical records, and facility documentation, and staff interviews, it was determined that the facility failed to implement appropriate safety measures in a manner that resulted in actual harm of a hip fracture that required medical treatment at a hospital for one of three residents reviewed for falls (Resident R1). This deficiency is cited as past non-compliance.  Findings include:  Review of manufacturer's instructions for the shower chair indicated that all residents must always be securely safety belted at the waist when using any Penner Lift Systems.  Review of the "Job Description Nurse Aide (NA)" revealed that specific position responsibilities included the nurse aide will, demonstrate proper use of equipment and use required protective equipment.  Resident R1's clinical record revealed an admission	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	Continued from page 2  date of 7/03/24, with diagnoses that included dementia, Type 2 Diabetes (condition where the body doesn't use insulin well and can't keep blood sugar at normal levels), irregular heartbeat, non-Hodgkin's lymphoma (disease in which malignant [cancer] cells form in the lymph system), and adult failure to thrive (syndrome is characterized by unexplained weight loss, malnutrition and disability).  Review of Resident R1's quarterly Minimum Data Set (MDS-periodic assessment of resident care needs) assessment dated 10/03/24, revealed that Resident R15 was cognitively impaired.  Review of a departmental progress note dated 11/27/24, by Licensed Practical Nurse (LPN) Employee E2 revealed Resident R1 was found lying on the shower room floor beside the whirlpool, the whirlpool door was open, and the whirlpool chair was against the back wall, and that Resident R1 sustained a cut on his/her left elbow and was complaining of back and hip pain.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	<p>Continued from page 3</p> <p>Review of the employee Witness Incident Statement written on 11/27/24, by NA Employee E3 revealed that NA Employee E1 was bathing Resident R1 and NA Employee E3 heard a loud yell and a thud and entered the shower room to see Resident R1 lying on the floor.</p> <p>Review of the employee Witness Incident Statement written on 11/29/24, by Nurse Aid (NA) Employee E1 revealed that he/she did not put the seat buckle on, thinking it would be okay, and when NA Employee E1 went to get Resident R1 out of the tub, he/she lunged forward and fell out of the chair.</p> <p>Review of a departmental progress note dated 11/28/24, indicated that the facility was made aware that Resident R1 was admitted to the acute hospital for treatment of a fractured left hip.</p> <p>During an interview on 12/13/24, at 11:48 a.m. the Nursing Home Administrator confirmed that NA Employee E1 failed to utilize the safety belt on the</p>	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	Continued from page 4  shower chair which resulted in Resident R1 falling from the elevated chair and sustaining a fractured hip.  The facility failed to provide safety measures that resulted in actual harm of a hip fracture to Resident R1.  This deficiency is cited as past non-compliance.  On 11/27/24, the facility initiated a plan of correction that included the following:  On 11/27/24, the facility initiated education for all nursing staff including Registered Nurse's (RN's), LPN's, and NA's to ensure that staff utilized the safety seatbelt on the bathing lift chair, and was ongoing.  Immediate suspension of NA Employee E1.  Interviews with NA Employees E4 through E9, confirmed the facility initiated education starting	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	Continued from page 5  11/27/24, which included education on bathing safety, environment awareness, adaptive equipment, and caregiver positioning. Staff who were interviewed were also able to state how they can accurately identify which residents wish to use the whirlpool tub.  Audits were conducted to ensure staff utilized the safety set belt from 11/29/24, through 12/11/24, and remain ongoing. During an interview with the Nursing Home Administrator (NHA), these audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee meeting post incident. The NHA also identified that review of utilization of the safety seatbelt will continue to be reviewed at QAPI meeting and will continue until determined otherwise by the QAPI committee.  The facility has demonstrated compliance with using correct safety measures with bathing residents since 12/11/24.	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395458</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/18/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CLARVIEW NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>034502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>14663 ROUTE 68 SLIGO, PA 16255</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0689  SS=G	Continued from page 6  During an interview with the NHA on 12/13/24, at 11:48 a.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 all safety measures are implemented for residents to prevent falls with bathing and had achieved substantial compliance.  28 Pa. Code 201.14(a) Responsibility of licensee  28 Pa. Code 201.18(b)(1)(3) Management  28 Pa. Code 201.18(e)(1) Management  28 Pa. Code 211.10(d) Resident care policies  28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0689		



# Certified End Page

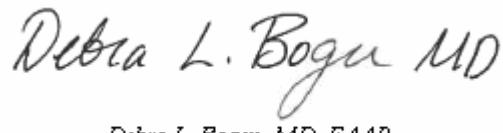
**CLARVIEW NURSING AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 034502**

**SURVEY EXIT DATE: 12/18/2024**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY