STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395644	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Valley Health Care Center	81 Sturges Road Peckville, PA 18452

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, facility policies, and staff interviews, it was determined the facility failed to maintain a clean and sanitary environment in the resident unit food pantry room.Findings include: Review of the facility's policy and procedure entitled Pantry Cleaning Protocol last reviewed by the facility on February 1, 2026, indicated all staff are responsible for maintaining a clean, sanitary unit pantry. Soiled dishes and plates must not be left on pantry counters. To ensure a clean and sanitary pantry area, staff were to document refrigerator and freezer temperatures daily and ensure all items were properly labeled and dated, discard any foods greater than or equal to seven days old, clean and sanitize countertops, sweep and mop floors, clean microwave, verify ice machine is clean and no scoops left inside, ensure no dietary trays or plates are present, and clean inside drawers and cabinets and remove any expired items. Observations on June 10, 2026, at 11:58 AM, inside the facility's resident panty revealed two resident breakfast trays left on the counter and inside the microwave there was food splatter and debris. The pantry floor felt sticky with spots of red and brown staining on some floor tiles. Observed heavy accumulation of dirt and debris in the corners and along the perimeter of the panty. Underneath the counter, there were several pieces of a white-chalky material accumulated in the left corner and showing evidence of deterioration to the corner of the left wall. During an interview with the Director of Nursing on June 11, 2026, at 9:19 AM, it was reported it was the responsibility of housekeeping to maintain the resident pantry and confirmed the above observations. 28 Pa Code 207.2(a) Administrator's responsibility.

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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to develop and implement a discharge planning process to align with the resident's goals for one of twelve residents reviewed (Resident 42). Findings Include: Review of the facility's Discharge Planning Policy last reviewed February 1, 2026, revealed the facility will identify discharge needs of residents and develop a discharge plan for each resident, including regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan will be updated as needed to reflect these changes. Clinical record review revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses to include Type 1 diabetes (a chronic autoimmune condition where the body's immune system attacks and destroys insulin-producing beta cells in the pancreas. This results in little or no insulin production, leading to high blood sugar levels.) A review of Resident 42's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 28 2026, revealed that Resident 42 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates intact cognition). A review of Resident 42's closed record revealed the resident discharged to home AMA (against medical advice, resident chose to leave despite recommendations to remain in the facility) on April 28, 2026. Resident 42 managed her diabetes with an insulin pump (a small, computerized device that continuously delivers insulin to help control blood sugar levels). During a hospitalization that occurred prior to the resident's admission to the facility, the insulin pump malfunctioned. Upon admission to the facility, the resident received insulin lispro (a rapid-acting insulin used to lower blood sugar levels) according to a sliding scale order (a physician-directed method of adjusting insulin doses based on blood sugar readings). While residing in the facility, the resident's insulin pump was repaired. The facility informed the resident that residents were not permitted to use insulin pumps in the facility. Following that discussion, the resident chose to discharge home in order to resume use of the insulin pump. There was no documented evidence that the facility assessed or discussed the resident's desire to resume use of the insulin pump once repaired during the admission process, incorporated that preference into discharge planning, or evaluated how the facility's inability to accommodate use of the insulin pump could affect the resident's discharge needs, goals, or preferences. A review of the resident's comprehensive care plan, reviewed during the survey ending June 11, 2026, revealed a care plan last revised on April 28, 2026. The care plan did not include a discharge care plan. There was no documented evidence that the facility developed an individualized discharge plan that addressed the resident's expressed desire to use her repaired insulin pump, her decision to leave the facility, or her potential long-term placement needs. There was no documented evidence that the facility developed, updated, or implemented a discharge plan that addressed the resident's goals of care, treatment preferences, or discharge needs after learning the resident wished to resume use of the insulin pump. During an interview on June 11, 2026, at 12:00 PM, the Nursing Home Administrator confirmed there was no documented evidence of a discharge goal or discharge plan for Resident 42. 28 Pa. Code 201.18 (3)(e)(1) Management. 28 Pa. Code 211.10(a) Resident care policies.

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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** Based on select facility policy review, clinical record review, resident observation, and resident and staff interview, it was determined the facility failed to develop and maintain a comprehensive, person-centered care plan that accurately reflected a resident's communication needs for one of 12 residents reviewed (Resident 3).Findings include: Review of the facility's Comprehensive Care Planning policy, last reviewed February 1, 2026, revealed a comprehensive care plan should include measurable goals and meet a resident's medical, nursing, mental, and psychosocial needs. The policy indicated the care plan will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. A clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric fracture of right femur (the right thigh bone is broken just below the hip, and the broken parts have moved out of place). A review of Resident 3's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 26, 2026, revealed that Resident 3 was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates clear and significant difficulties with cognitive tasks like remembering information and understanding time). At 8:00 AM on June 10, 2026, Resident 3 was observed seated in a wheelchair wearing small devices that fit directly in her ears. Around her neck were small, lightweight speakers that connected to the devices in her ears. During the interview, Resident 3 demonstrated the ability to communicate clearly and effectively, both understanding and expressing verbal information. The Director of Nursing (DON) was present at the time of the observation. Upon interview, the DON indicated the family of Resident 3 supplied the hearing devices and the devices are used daily to assist Resident 3 with hearing and communication. The DON was uncertain when Resident 3 received the hearing devices but stated she believed Resident 3 has had the hearing devices since her admission. Review of the resident's current comprehensive care plan, initially developed September 26, 2025, failed to identify the presence of the hearing devices or staff interventions including storage, assessment, maintenance (including cleaning), verifying for proper function, and assistance with application and removal of the devices. During an interview conducted on June 10, 2026 at 2:30 PM, the DON confirmed the clinical record failed to identify the presence of the communication, hearing assistive devices or the implications associated with the care of the hearing devices. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to develop and implement an individualized plan to restore bladder continence to the best extent possible for one of 12 residents reviewed (Resident 6).Findings include: A review of facility policy titled Continence Management Program (last reviewed February 1, 2026), revealed the facility will provide services to restore or improve normal bladder function to the extent possible. A plan designed to manage incontinence (involuntary loss or leakage of urine) is developed according to the residents' needs and capabilities. According to the policy, an assessment titled Continence Evaluation will be conducted to determine if a three-day bowel and bladder hourly evaluation is indicated. The policy further revealed that if the hourly evaluation identified a pattern of incontinence or continence (control over the bladder and urine), a new Continence Evaluation will be completed. The information from the evaluation will be used to develop a toileting plan (written guide that explains when and how staff will help the resident use the bathroom) and determine the approaches needed to achieve the stated goal. A review of the clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by a decline in memory, thinking, reasoning, and the ability to perform everyday activities), unspecified severity, without behavioral disturbance (actions or behaviors that may be disruptive, aggressive, resistive to care, or otherwise interfere with the resident's well-being or care), psychotic disturbance (a loss of contact with reality that may include hallucinations, seeing or hearing things that are not present, or delusions, fixed false beliefs), mood disturbance (a disruption in a person's emotional state, such as persistent sadness, irritability, or unusually elevated mood), and anxiety (a feeling of excessive worry, nervousness, or fear that may interfere with daily functioning). A review of Resident 6's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 18, 2026, revealed that Resident 6 was moderately cognitively impaired with a BIMS score of 8 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment indicating the resident is having more trouble than expected remembering things, knowing the date or time, and thinking clearly). A clinical record review of the document titled Admission/ readmission Observation, Genitourinary History dated September 30, 2025, revealed that when Resident 6 was admitted to the facility, Resident 6 was always continent (always able to maintain control over bladder/urinary function). A review of the admission MDS dated [DATE], revealed Resident 6 was occasionally incontinent (during the seven days prior to the assessment, Resident 6 experienced less than seven episodes of involuntary loss or leakage of urine). A review of a care plan-initiated on October 6, 2025, identified Resident 6 was at risk for incontinence due to impaired mobility and generalized weakness. The stated goal of the care plan was for Resident 6 to maintain the current level of bladder continence (control over one's bladder function). Among the approaches initiated on October 6, 2025, included: administer medications as ordered, apply moisture barrier to the skin, complete a bladder record (log used to track urinary habits, also referred to as toileting diary) for three days on admission, quarterly, and as needed. The care plan also included an assessment of reversible problems (e.g. conditions, environment, medications, etc.) that may contribute to incontinence or the involuntary loss or leakage of urine). A review of the document titled '72 Hour Toileting Diary' revealed hourly documentation of Resident 6's bladder activity from October 29, 2025, to November 1, 2025. Review of the hourly documentation revealed Resident 6 experienced bladder incontinence during the day and evening hours (from 7:00 AM until 10:00 PM). According to the toileting diary, Resident 6 did not experience bladder incontinence and was observed to be continent/dry from 11:00 PM until 07:00 AM. A nursing (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note dated November 7, 2025, summarized the toileting diary indicating Resident 6 experienced incontinence during daytime and evening hours, but not during nighttime hours. The notes revealed that Resident 6 would be assisted with toileting every two hours during the day and evening, and additionally as needed. A clinical record review of the nursing care plan included an approach on November 7, 2025, to assist Resident 6 with toileting every two hours during the days and evenings, and as needed. A review of the quarterly MDS dated [DATE], revealed Resident 6 was frequently incontinent of bladder (seven or more episodes of urinary incontinence, but least one episode of continence in the seven days prior to the assessment). The December 16, 2025, MDS revealed an increase in bladder incontinence (frequent incontinence) when compared to the October 6, 2025, MDS when Resident 6 experienced occasional incontinence. Review of the document titled Quarterly Observation Bundle, Continence Retraining/Scheduled Toileting Review, dated December 25, 2025, indicated Resident 6 had medical conditions and medications that contribute to incontinence. The review also noted the resident had longˆterm memory difficulties, neurological conditions, and used a wheelchair for mobility, but remained consistently aware of the need to use the bathroom. Despite the risk factors for incontinence identified in the December 25, 2025 review and the increase in incontinence noted in the December 15, 2025 MDS, there was no evidence of further evaluation, such as a bladder diary, to assess incontinence patterns. The clinical record also lacked documentation of additional care plan interventions or a continence program developed and implemented to address the decline and restore Resident 6's continence to the highest level possible. Review of the quarterly MDS dated [DATE] indicated Resident 6 was always incontinent, with no episodes of bladder control in the seven days before the assessment. This represents a further decline compared to the December 25, 2025 MDS, which documented frequent incontinence but at least one episode of continence. Review of the Quarterly Observation Bundle, Continence Retraining/Scheduled Toileting Review dated March 24, 2026 revealed Resident 6 had no memory or physical conditions that interfere with toileting. The review also indicated the resident was usually aware of the need to use the bathroom. Review of the 72ˆHour Toileting Diary revealed hourly documentation of Resident 6's bladder activity from March 26-29, 2026. The documentation indicated Resident 6 was incontinent during the day, evening, and nighttime hours. Nighttime incontinence represented a decline when compared to the October 2025 toileting diary, which showed the resident remained continent and dry during nighttime hours. Despite the increase in incontinence demonstrated by Resident 6 in March 2026, the clinical record contained no assessment to identify the type or possible causes of urinary incontinence. The record also lacked evidence of new interventions or consideration of a toileting program developed and implemented to restore Resident 6's bladder continence to the best extent possible. An interview with the Director of Nursing on June 11, 2026, at 12:15 PM confirmed the facility failed to ensure Resident 6 received individualized services and assistance to maintain bladder continence to the highest extent possible, as required by nursing standards of practice and facility policy. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions and failed to evaluate the severity of pain prior to the administration of a narcotic pain medication prescribed on an as needed basis one of 12 residents reviewed (Resident 29).Findings include:A review of the facility policy, Pain Management (last reviewed February 1, 2026), indicated the facility will ensure residents are assessed for pain or potential for pain in order to attain or maintain the highest practicable level of well-being. The policy further revealed the presence and severity of pain will be measured using an appropriate scale such as the numeric rating scale (a tool that asks a person to choose a number to show how strong or severe something feels), faces scale (a tool that uses pictures of faces, from a happy face to a very upset face, to help the resident show how much pain they are feeling), or verbal descriptor scale (a tool that asks the resident to choose a word or phrase that best describes how strong their pain or discomfort feels). According to the policy, non-pharmacological interventions (ways to help the resident manage pain without using medicine) will be attempted prior to the administration of pain medication. A review of the clinical record revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses to include displaced fracture of medial malleolus of left tibia (broken left ankle bone where the pieces have shifted out of place). A review of Resident 29's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 2, 2026, revealed that Resident 29 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 15 is the highest possible score, indicating memory and thinking abilities showed no signs of impairment at the time of the assessment). Clinical record review revealed Resident 29 had a physician order dated May 23, 2026, for Oxycodone (a controlled substance, narcotic used to treat pain) 2.5 milligrams (mg) every six hours as needed for moderate to severe pain. A review of Resident 29's May medication administration record (MAR) revealed staff administered the pain medication on:May 23, 2026, at 10:38 AMMay 24, 2026, at 8:59 AMMay 25, 2026, at 10:22 AMMay 25, 2026, at 7:32 PMMay 26, 2026, at 10:09 PMMay 27, 2026, at 8:57 AM Documentation showed that non-pharmacological interventions were not attempted or documented prior to any of these six administrations, nor was the pain assessed for severity using one of the tools mentioned in the facility policy. An interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on June 10, 2026, at 2:15 PM confirmed the facility failed to follow the facility policy specifically regarding rating Resident 29's pain and using nonpharmacological interventions prior to administration of pain medication. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f)(viii)(x) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, it was determined the facility failed to ensure residents received routine dental services and failed to obtain required dental clearances necessary to facilitate recommended dental treatment in a timely manner for two of twelve residents reviewed (Residents 14 and 32). Findings Include: Review of the facility's policy, entitled Dental Services, reviewed on February 1, 2026, documented, in part, The facility will assist residents in obtaining routine and 24-hour emergency dental care to meet the needs of each resident. Review of Resident 32's clinical record revealed the resident had been admitted [DATE], with diagnoses that included encephalopathy (a group of conditions that cause brain dysfunction, which may result in confusion, memory loss, personality changes, or, in severe cases, coma). A review of Resident 32's clinical record revealed no evidence that the resident received dental consultations or evaluations for routine dental services from the date of admission on [DATE], through the time of survey. Review of Resident 32's clinical record revealed a nursing progress note dated June 8, 2026, indicating the resident informed staff that she feels something sharp in her left lower jaw area and believed her partial bridge was broken. The facility notified their contracted dental services and on June 9, 2026, the facility received communication that the contracted dental provider did not accept the resident's insurance. The facility then contacted the resident's responsible party and obtained information regarding the resident's community dentist. However, at the time of survey exit on June 11, 2026, the facility had not scheduled a dental appointment or otherwise arranged treatment to address the resident's reported dental concern. During an interview conducted on June 11, 2026, at 9:00 AM, the Director of Nursing was unable to provide additional information regarding arrangements for emergency dental treatment for Resident 32. A clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive brain disorder that impairs memory, thinking, reasoning, and the ability to perform daily activities) with agitation (patterns of disruptive or inappropriate behaviors that interfere with daily functioning and emotional regulation), dysphagia (difficulty swallowing), and history of protein calorie malnutrition (a condition that occurs when the body does not receive enough protein and calories to maintain proper health and functioning). A review of the resident's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2, 2026, revealed that Resident 14 had severe cognitive impairment with a BIMS score of 3 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). A nursing progress note dated February 19, 2026, at 10:45 AM, documented that Resident 14 had a broken molar tooth causing oral pain. On February 20, 2026, at 11:14 AM, the Resident 14 was evaluated by contracted dental services. The dentist identified an infection in tooth number two and prescribed Clindamycin 300 milligrams four times daily for ten days to treat the infection while awaiting physician and responsible party clearance for a tooth extraction (a procedure to remove a tooth because of infection, decay, or damage). The dentist also recommended saltwater rinses twice daily. The clinical record contained a Physician Clearance for Dental Treatment form completed by the attending physician on February 20, 2026, at 2:43 PM. A review of the Medication Administration Record (MAR, a legal record documenting medications administered to a resident) dated February 2026, revealed Resident 14 received all 40 prescribed doses of Clindamycin. A social service progress note dated March 10, 2026, at 10:41 AM, documented that staff contacted the resident's responsible party and advised that forms needed to be signed so the contracted dental provider could perform the recommended tooth extraction during an upcoming visit. A nursing progress note dated May 4, 2026, at 2:46 PM, documented that the dentist evaluated the resident and noted the resident refused care despite multiple attempts. However, the clinical (continued on next page)

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