STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395787	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Haven, Inc	4702 East Main Street Belleville, PA 17004

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 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. Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide the highest practicable care related to intravenous access for one of 23 residents reviewed (Resident 102) and physician ordered devices for one of 23 residents reviewed (Resident 40).Findings include: The facility policy entitled, Intravenous Therapy, last reviewed without changes on February 3, 2026, revealed that the facility will adhere to accepted standards of practice regarding infusion practices. An emergency kit will be in place at the bedside. Clinical record review for Resident 102 revealed active physician orders dated February 26, 2026, for staff to: Administer Ceftriaxone Sodium (used to treat a wide range of bacterial infections and to prevent infections in certain surgical procedures) intravenous solution, two grams, every 24 hours until April 1, 2026 Monitor right upper extremity PICC line (A PICC line is a long, thin tube inserted into a vein in the arm that reaches the large central veins near the heart, used for long-term delivery of medications, nutrition, or blood draws.) insertion site for increased erythema (redness), edema (swelling), or drainage every shift Observation of Resident 102 on March 18, 2026, at 11:21 AM revealed a sign above her chair that instructed staff to not use her right arm (e.g., for blood pressure assessments). There was no emergency kit visible in Resident 102's living area. Interview with Resident 102 on the date and time of the above observation revealed that staff were to avoid using her right arm because she had a PICC line in that arm. Resident 102 stated that she did not believe there were any dressings or equipment left in her room for her PICC line care. Resident 102 stated that staff bring dressings with them when they are going to change the dressing to the site. Review of the plan of care developed by the facility to address Resident 102's intravenous antibiotics failed to include the intervention of an emergency kit at her bedside or that she had a right arm limb restriction. Observation of Resident 102's room with Employee 1 (licensed practical nurse) on March 19, 2026, at 2:48 PM confirmed that there was no emergency kit in Resident 102's living area. The surveyor reviewed the above concerns regarding Resident 102's PICC line care during an interview with the Nursing Home Administrator and Employee 2 (registered nurse/assistant director of nursing) on March 19, 2026, at 2:00 PM. Clinical record review for Resident 40 revealed an active physician order dated March 3, 2026, for the implementation of thigh-high TED hose (TED hose are stockings that help prevent blood clots and swelling in your legs by applying graduated compression to the legs, which promotes blood flow and reduces the risk of venous pooling and clot formation), ensure applied in the morning, and removed at hour of sleep, every morning and at bedtime. Resident 40's active physician orders instructed staff to administer Eliquis (an anticoagulant that works to prevent blood clotting) 2.5 milligrams two times a day for DVT (deep vein thrombosis, a blood clot in the deep veins of the leg) prophylaxis (prevention) until April 3, 2026. Plans of care developed by the facility to address Resident 40's care needs included that she had self-care performance deficits completing activities of daily living related to a right knee replacement and was at risk for bleeding related to Eliquis use. The plans of care did not address the use of TED hose to prevent the development of DVT. Interview with Resident 40 on March 18, 2026, at 11:41 AM revealed that she was not wearing her thigh-high compression stockings. Resident 40 stated that, .they told (her) that (she) did not need to wear them once (she) was up and around. Observation of Resident 40 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the date and time of the observation revealed that she did not have thigh-high compression stockings on. Resident 40 revealed her left knee incision to the surveyor and she was wearing socks and sneakers. Resident 40's left ankle and lower leg were slightly larger when compared to her right ankle and lower leg. Review of Resident 40's treatment administration record (TAR, electronic documentation completed by licensed staff for the completion of treatments) dated March 2026 revealed that staff initialed the implementation of the thigh-high TED hose (ensure applied in AM and removed at HS) every morning and at bedtime for March 18 and 19, 2026. Interview with Resident 40 on March 19, 2026, at 2:47 PM confirmed that she was not wearing thigh-high compression stockings. Resident 40 reiterated that she believed that she did not need to wear them once she was, up and around. Interview with Employee 1 (licensed practical nurse) on March 19, 2026, at 2:48 PM indicated that she believed Resident 40 had her compression stockings on, and initialed for the implementation of them on this date. She did not apply the stockings or interview Resident 40 if she had the stockings on. The surveyor reviewed the above concerns regarding Resident 40's compression stockings during an interview with the Nursing Home Administrator and Employee 2 on March 19, 2026, at 2:00 PM. 483.25 Quality of carePreviously cited deficiency 04/14/25 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to thoroughly assess the use of bed system assistive devices for one of five residents reviewed for accident hazards (Resident 102).Findings include: The facility policy entitled, Proper Use of Mobility Enabler Device(s), last reviewed without changes on February 6, 2026, revealed that it is the facility policy to utilize a person-centered approach when determining the use of mobility enabler device(s). The resident assessment must assess the resident's risk from using bed mobility devices. Examples of the potential risks with the use of bed mobility devices include accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard), barriers to residents from safely getting out of bed, physical restraint, skin integrity issues, etc. The medical record should include evidence of an assessment of the resident, the bed, the mattress, and rail for entrapment risk. The FDA (The United States Food and Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, is guidance that identifies key parts of the body at risk for entrapment, describes potential entrapment areas or zones, and recommends maximum and minimum dimensional limits of gaps or openings in hospital bed systems. Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the head, neck, and chest. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. The FDA is using a head breadth dimension of 120 mm (4.75 inches) as the basis for its dimensional limit recommendations. To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. FDA is recommending 60 mm (two and three-eighths inches) as an appropriate dimension for neck diameter. The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. The FDA concurs with the dimension of 318 mm (12.5 inches) to represent chest depth for the population vulnerable to entrapment and has used this dimension as the basis for its recommended dimensional limits. This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Zone six is the space between the end of the rail and the side edge of the headboard or footboard. This space may present a risk of either neck entrapment or chest entrapment. Clinical record review for Resident 102 revealed that the facility admitted her on February 26, 2026. An active physician order dated February 27, 2026, implemented the use of a right HALO bar (The Halo Safety Ring is an adjustable bed mobility device, specifically designed to assist individuals with limited mobility, helping them regain independence in daily activities.) to promote independence with bed mobility. A physical therapy assessment dated [DATE], included Resident 102's use of a HALO device on the right side of her bed. Observation of Resident 102's room on March 18, 2026, at 11:22 AM revealed that her bed was equipped with a right-sided circular assistive device (HALO), a headboard, and a footboard. Review of a Test Results Worksheet dated February 27, 2026, revealed that staff failed to assess a potential entrapment risk for zone six. The assessment also errantly noted an assessment of an assistive device on the left side of Resident 102's bed when she did not have an assistive device on that side. Interview with Resident 102 on March 19, 2026, at 2:45 PM confirmed that since her admission, she had an assistive device mounted only on the right side of her bed and she never had an assistive device on the left side of her bed. Interview with the Nursing Home Administrator on March 19, 2026, at 11:43 AM reviewed the above findings regarding Resident 102's assistive device assessment. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of four residents reviewed (Resident 18).Findings include: Clinical record review for Resident 18 revealed the facility admitted her on October 25, 2025, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 18's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated October 25, 2025, indicated that the facility assessed Resident 18 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. Nursing documentation dated February 4, 2026, at 5:44 PM revealed Resident 18 was bothering other residents, getting very close, and telling them they need to move to other locations. Nursing documentation dated February 10, 2026, at 10:10 AM revealed Resident 18 made an accusation toward a staff member because Resident 18 was upset that she could not enter her room since her heater was being repaired. Documentation revealed Resident 18 has a history of accusing family and other residents of abuse. The facility implemented two staff for all Resident 18's care. Nursing documentation dated February 11, 2026, at 8:58 PM revealed Resident 18 stopped the laundry aide in the hallway, nursing staff intervened. Nursing documentation dated February 28, 2026, at 1:00 PM revealed activities staff placed a resident in a chair and when her husband tried sitting in the seat beside his wife, Resident 18 demanded to sit in that chair. Documentation revealed Resident 18 became agitated, began pacing, and nursing staff had to intervene. Nursing documentation dated March 6, 2026, at 5:37 PM, revealed Resident 18 refused her shower, stating that she is a registered nurse and knows when to clean herself. A review of Resident 18's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings for Resident 18 were reviewed with the Nursing Home Administrator during a meeting on March 20, 2026, at 10:49 AM. 483.40(b)(3) Dementia Treatment and ServicesPreviously cited 4/14/2528 Pa Code 211.12 (d)(1)(3)(5) Nursing services