STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395895	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Rehab and Nursing Center	2140 Warrensville Road Montoursville, PA 17754

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on closed clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to immediately notify a resident's representative of a change in a resident's condition for one out of three residents reviewed (Resident CR1).Findings include: Closed record review for Resident CR1 revealed that the resident had a diagnosis list that included atrial fibrillation (an irregular heart rhythm). Physician orders for Resident CR1 revealed an order dated June 6, 2024, at 8:00 PM for Apixaban (Eliquis; an anticoagulant medication that is used to treat and prevent blood clots) oral table five milligrams (mg) given one table by mouth every 12 hours for atrial fibrillation. A review of the November 2025 medication administration record (MAR) for Resident CR1 revealed that staff were documenting the medication as administered per the physician order. Resident CR1's care plan revealed a care plan created on May 31, 2024, that indicated the resident was on anticoagulant therapy related to atrial fibrillation. Nursing documentation for Resident CR1 dated December 1, 2025, at 3:46 AM revealed that staff were assisting the resident from the wheelchair to the toilet. When standing the resident bent forward and hit her head on the wall and received a three-centimeter (cm) by three-centimeter hematoma (a collection of blood outside of a blood vessel) on the left side of the forehead and a skin tear to the right upper shin. Further review of nursing documentation for Resident CR1 dated December 1, 2025, at 3:55 AM revealed that the resident hit her head during a transfer onto the toilet and received a skin tear on the right shin and a three-centimeter hematoma to the right forehead. Neuro checks (assessments that evaluate an individual's brain function and mental status) were initiated but the resident was uncooperative to pupil checks and would not squeeze hands to check hand grasps. Medical provider documentation dated December 1, 2025, at 10:45 AM revealed that Resident CR1 was evaluated to follow-up on the right leg wound and AMS (altered mental status) noted above. The documentation noted the resident fell and hit head this morning, on Eliquis, and that the resident had a hematoma to the right upper forehead. The medical provider recommended transfer to ER for further evaluation and treatment. Nursing documentation dated December 1, 2025, at 10:54 AM for Resident CR1 again noted the resident has a hematoma on the forehead, is on Eliquis, and a new order was received to send the resident to the emergency room for evaluation and treatment and that staff spoke with the resident's family who agreed. Nursing documentation for Resident CR1 dated December 3, 2025, at 1:00 PM revealed that staff spoke with the resident's representative who was upset because they were not called when the resident hit her head causing a hematoma and should have been sent to the hospital ASAP (as soon as possible). There was no evidence to indicate Resident CR1's responsible party was notified of the incident that occurred on December 1, 2025, at 3:46 AM resulting in an injury which later required transfer to the hospital for further assessment until December 1, 2025, at 10:54 AM, when the resident was being transferred to the hospital, nearly seven hours after the incident/injury occurred. The facility failed to immediately notify the resident's responsible party of an (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accident involving the resident which resulted in injury and had the potential to require physician intervention. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January 29, 2026, at 4:20 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services