

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on a review of select facility policies and procedures, clinical record review, personnel record review, and staff interview, it was determined that the facility failed to protect a resident's right to be free from neglect by staff that resulted in actual harm with a serious injury of a fractured finger for one of six residents reviewed (Resident 1). This deficiency is cited as past noncompliance. Findings include: The current facility policy entitled Abuse Prevention/Elder Justice Act Suspicious Crime Reporting, revealed the facility will protect all residents, resident representatives, visitors, and staff from abuse. The facility will prevent abuse and neglect through screening of potential employees, identifying risk factors through assessment and monitoring of residents with behaviors which lead to abuse, educating employees, residents, and resident representatives, protecting the rights of our residents and staff, prompt reporting and investigation of incidents of alleged resident abuse, and responding to abuse or neglect. Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This refers to failure through inattentiveness, carelessness, and omission to provide timely, consistent, safety adequate and appropriate services and treatment. Clinical record review revealed the facility admitted Resident 1 on March 13, 2026. Review of her diagnoses list included the need for assistance with personal care, Alzheimer's disease, and senile dementia (brain disorder that impairs memory, thinking, and the ability to perform everyday activities that contribute to behaviors such as agitation, aggression, delusions, and resistance to care). Review of Resident 1's plan of care (individualized document outlining a resident's medical, functional, and support needs) initiated by the facility on March 13, 2026, to address Resident 1's activities of daily living self-care performance deficit revealed an intervention that included to transfer Resident 1 with a mechanical stand aid lift with the assistance of two staff. A physician's order-initiated May 20, 2026, instructed staff to transfer Resident 1 with a full body mechanical lift with the assistance of two staff. Nursing documentation dated June 2, 2026, at 10:05 AM revealed the licensed practical nurse requested the registered nurse assess Resident 1's left forearm. Resident 1's forearm to her wrist was bruised and there was a hematoma (pooled blood that forms outside of a blood vessel, usually caused by trauma or injury) on her mid forearm that was raised one inch. Review of facility investigation dated June 2, 2026, at 10:05 AM revealed therapy notified nursing of a raised bruise on Resident 1's left forearm, which was painful to touch. A physician's progress note dated June 2, 2026, at 10:08 AM revealed Resident 1 was evaluated due to acute concerns regarding her left arm pain. Nursing staff reported no recent falls or injuries. Resident 1 stated, I don't know what happened. Resident 1 reported pain in her left arm. The physician noted a large hematoma with deformity present, unclear if deformity is from hematoma or underlying musculoskeletal issue. The documentation revealed Resident 1 reported significant discomfort. The (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
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F 0600 Level of Harm - Actual harm Residents Affected - Few	physician reported due to acute onset and severity of discomfort, and deformity, will transfer Resident 1 to ER (emergency room) for further evaluation and treatment. Nursing documentation dated June 2, 2026, at 1:49 PM noted Resident 1's daughter called the facility and stated the resident's arm was not broken, but her right pinky finger was found to have a bruise. Resident 1's daughter reported they are going to do a CT scan (a specialized medical imaging test) to make sure there is no active bleeding. Nursing documentation dated June 2, 2026, at 9:07 PM revealed Resident 1 was being admitted to the emergency department for a displaced fracture of her right little finger and hematoma of her left arm. Review of the radiology report dated June 2, 2026, noted a soft tissue hematoma in Resident 1's dorsal distal (back) forearm and wrist measuring 4.2 cm (centimeters) by 3.1 cm by 10.0 cm. with suspected active bleeding, and an acute nondisplaced fracture of her fifth proximal phalanx (small finger bone closest to the main body) base. Review of the interdisciplinary team review of the incident dated June 3, 2026, revealed a staff member utilized the lift unattended and probably caught Resident 1's arm and hand between the bar and chair. A review of the facility's PB22 (Provider Bulletin 22 form, a standardized Pennsylvania Department of Health document used to report and investigate allegations of abuse, neglect, or misappropriation of property in long-term care facilities) investigation of the above incident noted that the facility substantiated the allegation of staff-to-resident neglect and terminated Employee 1's employment at the facility. Review of Employee 1's (nurse aide) witness statement noted, I was in doing morning care and she (Resident 1) was trying to hit me and bite me. I put my hand over her hand to stop her from hitting me. She was swinging at me during care. I got her out of bed with the lift. I used the lift by myself. Review of Employee 1's personnel file revealed the facility hired her on April 7, 2026. Employee 1 received abuse training and completed a competency on transfers on April 7, 2026. Further review of Employee 1's personnel file revealed a mechanical lift competency was completed April 16, 2026. The facility completed an investigation into Resident 1's injury of unknown origin and allegation of only being transferred using one person instead of the two required and sustaining a fracture. The facility interviewed all staff working in the time frame surrounding the incident and determined Employee 1 did not follow Resident 1's plan of care regarding the mechanical lift for transfers with two people, and Employee 1 admitted there was not a second person present. Employee 1 was terminated from the facility on June 3, 2026. The Director of Nursing and Employee 2 (assistant director of nursing and nurse educator) provided staff on the spot education on using the correct transfer status when providing residents with care and transfers to all nursing care staff starting June 8, 2026. Education of all nursing care staff working in the facility was completed on June 25, 2026. Interview with the Nursing Home Administrator and Director of Nursing on July 15, 2026, at 12:49 PM confirmed these findings. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(2)(e)(1) Management 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(b)(d) Staff development		