

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 05/23/2025
NAME OF PROVIDER OR SUPPLIER Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 Warrentown 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)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for two of five residents reviewed (Residents 72 and 86).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 72 on January 24, 2025. Review of a consultant pharmacist recommendation dated April 12, 2025, revealed as needed Ativan (an anti-anxiety medication) is the most effective intervention for reducing Resident 72's anxiety. The pharmacist recommended Ativan 0.5 milligrams (mg) every 12 hours as needed for anxiety for 30 days with a re-evaluation of Resident 72's Ativan use in 30 days to determine if ongoing use is indicated.</p> <p>Review of Resident 72's clinical record revealed a physician's order dated April 16, 2025, for Ativan 0.5 mg, one tablet every 12 hours as needed for agitation.</p> <p>Further clinical record review revealed that Resident 72's order for Ativan did not have a 14 day stop date and there was no physician's progress note that provided a rationale for the medication extending past 14 days.</p> <p>Interview with the Director of Nursing on May 22, 2025, at 2:50 PM confirmed the above noted findings related to Resident 72's Ativan.</p> <p>Clinical record review for Resident 86 revealed a physician's order dated April 18, 2025, for Ativan 0.5 mg every six hours as needed for anxiety/agitation.</p> <p>Further clinical record review revealed that Resident 86's order for Ativan did not have a 14 day stop date and there was no physician's progress note that provided a rationale for the medication extending past 14 days.</p> <p>Interview with the Director of Nursing on May 21, 2025, at 2:47 PM confirmed the above noted findings related to Resident 86's Ativan.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>(continued on next page)</p>

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to revise the comprehensive care plan for one of 35 residents reviewed (Resident 11).</p> <p>Findings include:</p> <p>Observation of Resident 11 on May 21, 2025, at 9:10 AM revealed a urinary collection bag hanging from the left side of his bed.</p> <p>Clinical record review for Resident 11 revealed an active physician's order dated May 19, 2025, for the use of a Foley catheter (flexible tubing inserted through the penis into the bladder to drain urine) due to urinary retention related to bladder cancer. The order instructed staff to change the Foley as needed for obstruction, leaking, or if the closed system is compromised.</p> <p>Review of active plans of care for Resident 11 (including a care plan to address Resident 11's risk for urinary retention, incontinence, chronic kidney disease, and urinary tract infection) during the onsite survey revealed no plan of care that included the intervention of an indwelling Foley catheter.</p> <p>The surveyor reviewed the above concerns regarding Resident 11's care plans during an interview with the Director of Nursing on May 23, 2025, at 10:15 AM.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, and staff and resident interview it was determined that the facility failed to ensure the highest practicable care for three of 35 residents reviewed (Residents 40, 230, and 94).</p> <p>Findings include:</p> <p>The facility policy entitled, Verbal, Telephone, and Written Physician Orders, last reviewed November 21, 2024, revealed that a physician's verbal or telephone order will be given to a licensed nurse and be immediately recorded on the resident's medical record by that licensed nurse. Telephone orders for medical treatment will be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the responsible practitioner, when the judgement of the professional nurse and the situation requires expedient action, or when the physician calls the facility and requests that a telephone order be accepted.</p> <p>The facility policy entitled, Skin Tears, Risk Reduction, last reviewed November 21, 2024, revealed that treatment of existing skin tears will be outlined in the Risk Reduction/Wound Care Protocol or as ordered by the physician. Weekly skin checks will be completed by the licensed nursing staff in concert with the resident shower/bath. Identified areas of concern will be reported to the registered nurse. Protocol Two, Skin Tears, Cuts, Abrasions, stipulated that treatment would include a wound cleanser and an Aquacel foam dressing (dressing that has a soft absorbent foam pad that gels on contact with wound drainage to maintain a moist wound environment, a silicone adhesive, and a waterproof/bacteria barrier).</p> <p>Clinical record review for Resident 40 revealed nursing documentation by the registered nurse (RN) dated May 18, 2025, at 7:57 PM that his daughter noted blood on his pant leg. Staff assessed two skin tears on Resident 40's left leg, calf area. The staff cleansed the wound with wound wash and applied a Tegaderm dressing (transparent film dressing that does not have a foam pad or materials that would gel on contact with wound drainage).</p> <p>The documentation did not indicate that the licensed nurse contacted Resident 40's physician or that Resident 40's physician provided an order for the wound treatment that prompted nursing staff to implement a dressing different from that stipulated in the wound care protocol noted above.</p> <p>Nursing documentation by Employee 3, licensed practical nurse (LPN), dated May 18, 2025, at 10:27 PM noted, N.O. (new order) Cleanse LLL (left lower extremity) skin tear with wound cleanser, pat dry, apply Tegaderm drsg. (dressing) Change drsg. Q (every) Friday 6-2 (6:00 AM to 2:00 PM) shift or prn (as needed) for soilage/dislodgement, check placement Q shift, measure Q Friday 6-2 shift. D/C (discontinue) when area healed. POA (power of attorney) aware of N.O.</p> <p>Nursing documentation by Employee 3 dated May 18, 2025, at 10:34 PM noted, N.O. Cleanse left calf skin tear with wound cleanser, pat dry, apply Tegaderm drsg. Change drsg. Q Friday 6-2 shift or prn for soilage/dislodgement, check placement Q shift, measure Q Friday 6-2 shift. D/C when area healed. POA aware of N.O.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The documentation by Employee 3 did not indicate that the licensed nurse contacted Resident 40's physician. The documentation insinuated that Resident 40's physician provided an order for the wound treatment that prompted nursing staff to implement a dressing different from that stipulated in the wound care protocol noted above.</p> <p>Documentation by Resident 40's physician (Employee 4) dated May 19, 2025, at 8:17 AM noted that, Upon my return to work today, it appears that multiple messages were left on my work phone from RN (registered nurse) Supervisor regarding this resident from this past weekend. This number is to be used only if I am on call or with specific permission, neither of which were the circumstances this weekend. There was an on-call provider available. I will investigate further. Nurse leaving messages not in today.</p> <p>The physician order recorded by Employee 3 dated May 18, 2025, at 10:31 PM for Resident 40's left calf skin tear treatment was electronically signed by Employee 4 on May 19, 2025, at 4:09 PM.</p> <p>The physician order for Resident 40's left lower extremity skin tear treatment was created by Employee 3 on May 18, 2025, at 10:25 PM as a verbal order from Employee 4 and was electronically signed by Employee 4 on May 19, 2025, at 4:09 PM.</p> <p>Interview with the Director of Nursing on May 22, 2025, at 11:20 AM confirmed that the facility had no evidence that either the RN or LPN spoke with a physician before implementing a treatment to Resident 40's skin tear sites. The interview indicated that licensed staff may implement a treatment per the facility's wound care protocol without speaking with a physician; however, the interview confirmed that the wound care protocol included a different dressing than the Tegaderm implemented for Resident 40 on May 18, 2025.</p> <p>Clinical record review for Resident 230 revealed that the facility admitted her on May 6, 2025.</p> <p>Diagnoses listed for Resident 230 upon her admission to the facility included the presence of a cardiac pacemaker (surgically inserted medical device with wires attached to the heart for the purpose of administering electrical impulses to regulate the heart rate).</p> <p>Review of Resident 230's baseline plan of care dated May 6, 2025, noted that Resident 230 had a pacemaker related to dysrhythmias (abnormal heart rhythms). The listed interventions included instructions to perform pacemaker checks; however, there was no intervention related to a pacemaker machine or method used to perform pacemaker checks.</p> <p>Interview with Resident 230 on May 21, 2025, at 10:42 AM revealed that she has had the cardiac pacemaker for three or four years. Resident 230 reported that she had one incident while she resided at her home when she went to bed when not feeling well and received a telephone call from her pacemaker monitoring company to inquire if she felt well. The pacemaker monitoring company instructed her to call emergency medical response services (911). Resident 230 stated that she was evaluated in the emergency room and diagnosed with a problem with her heart rate. Resident 230 confirmed that she had a machine in her home that is used to monitor her cardiac pacemaker. Resident 230 confirmed that she has not had this machine since her admission to the facility. Resident 230 stated, I didn't say anything, I just prayed a lot.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor reviewed the concern regarding Resident 230's pacemaker monitoring during an interview with the Director of Nursing, the Nursing Home Administrator, Employee 1 (infection preventionist), and Employee 5 (assistant director of nursing), on May 21, 2025, at 2:30 PM.</p> <p>Nursing documentation dated May 21, 2025, at 4:29 PM (following the surveyor's questioning) revealed that Employee 5 spoke with Resident 230 regarding her home monitor for her cardiac pacemaker. Resident 230 verified that she had a machine at home and that she didn't think to bring it. Resident 230 suggested that Employee 5 call her daughter to bring the machine to the facility.</p> <p>Nursing documentation dated May 21, 2025, at 6:21 PM revealed Resident 230's family brought the cardiac pacemaker monitor to the facility.</p> <p>The surveyor reviewed the concern regarding Resident 230's baseline care plan and omission of a pacemaker monitoring machine during an interview with the Director of Nursing on May 22, 2025, at 11:20 AM.</p> <p>Clinical record review for Resident 94 revealed that she was admitted to the facility on [DATE], with hospice services related to her terminal diagnosis of senile degeneration of the brain/dementia (a group of thinking and social symptoms that interfere with daily functioning).</p> <p>Review of Resident 94's current care plan revealed that the facility failed to implement an integrated plan of care with hospice services. The plan of care did not include evidence of all services that hospice will provide for the management of Resident 94's terminal illness.</p> <p>Resident 94's current care plan failed to identify the hospice entity providing services, the hospice disciplines that would provide her care and services, and how often.</p> <p>.</p> <p>The findings were reviewed with the Director of Nursing during a meeting on May 22, 2025, at 2:45 PM.</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 6/20/24</p> <p>28 Pa. Code 211.2(d)(3) Medical director</p> <p>28 Pa. Code 211.3(a)(e)(2) Verbal and telephone orders</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>38839</p> <p>Based on review of select facility policies, observation, clinical record review, and staff and resident interview, it was determined that the facility failed to assess for the risk of side rail entrapment for 6 of 7 residents reviewed for accident hazards (Residents 14, 44, 85, 102, 113, and 230).</p> <p>Findings include:</p> <p>Review of the facility's current policy entitled Maintenance Enabler Bar Procedure last reviewed November 20, 2024, revealed it is the facility policy that maintenance will place assist bars on the resident's bed and immediately conduct a bed inspection for bed entrapment points using a bed measurement device following the manufacturer's test methods to inspect each zone. The zones were not specified.</p> <p>Observation of Resident 102's room on May 20, 2025, at 10:51 AM revealed an enabler bar attached to the right side of the resident's bed. Resident 102 stated it was put there to help her in bed because she had falls.</p> <p>Review of facility documents revealed facility staff completed an enabler bar entrapment evaluation for Resident 102 on March 14, 2025, which revealed facility staff assessed the resident's right side enabler bar indicating it passed for no potential entrapment for zones one (within the rail), two (between the bottom of the rail and top of compressed mattress), three (between the edge of the mattress and inside of the rail, and four (between the top of the compressed mattress and the bottom of the rail at the end of the rail). There was no documentation that the facility assessed zone six (between the end of the rail and the side edge of the head or foot board) for potential entrapment.</p> <p>Observation of Resident 44's room on May 21, 2025, at 8:28 AM revealed an enabler bar placed on the right side of the bed. The resident indicated it helped her get out of bed.</p> <p>Review of an enabler bar entrapment evaluation for Resident 44 dated March 14, 2025, revealed facility staff assessed and passed the resident's right side enabler bar for entrapment risk in zones 1-4, but they did not assess the resident's risk for entrapment at zone 6.</p> <p>In an interview with Employee 2, director of facilities management, on May 22, 2025, at 10:45 AM revealed the maintenance staff assess the resident's risk of entrapment when enabler bars are placed assessing zones 1-4 with the bed rail measurement device tool, but did not specifically assess zone 6, the area between top of the bed end of the rail to the headboard of the bed for risk of entrapment.</p> <p>Facility staff updated Resident 102's entrapment zone risk assessment to include zone 6 as passing for any entrapment risk after the above interview with Employee 2.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The above information was reviewed during an interview with the Nursing Home Director and the Director of Nursing on May 22, 2025, at 2:30 PM.</p> <p>Clinical record review for Resident 14 revealed a current physician's order dated May 15, 2025, (same day as her readmission from the hospital) for bilateral enabler bars to her bed.</p> <p>Observation of Resident 14 on May 20, 2025, 11:30 AM revealed she was sitting in a chair in her room beside her bed. Her bed was noted to have bilateral enabler bars on it. Resident 14 indicated that she had the enabler bars for a long time, and she uses them to help move in bed and to help her get out of bed.</p> <p>Review of an enabler bar entrapment evaluation for Resident 14 dated March 14, 2024, revealed facility staff assessed and passed the resident's right and left side enabler bar for entrapment risk in zones 1-4, but they did not assess the resident's risk for entrapment at zone 6.</p> <p>Interview with Nursing Home Administrator on May 22, 2025, at 2:45 PM confirmed that the facility does not measure zone 6.</p> <p>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 a 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.</p> <p>Observation of Resident 85's room on May 20, 2025, at 1:11 PM revealed assist bar devices located bilaterally at the head of his bed. Resident 85's bed was equipped with a headboard and footboard.</p> <p>Clinical record review of an active physician's order dated June 3, 2024, instructed that Resident 85 may have bilateral enabler bars on his bed.</p> <p>Review of a Bed System Measurement Device Test Results Worksheet dated March 14, 2025, indicated that facility staff assessed zones one through four for entrapment risks.</p> <p>Resident 85's clinical record did not indicate that the facility assessed the gap between the edge of the assist bar and Resident 85's headboard (zone six) for possible entrapment risks.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 113's room on May 21, 2025, at 8:56 AM revealed assist bar devices located bilaterally at the head of his bed. Resident 113's bed was equipped with a headboard and footboard.</p> <p>Clinical record review for Resident 113 revealed an active physician's order dated April 25, 2025, for bilateral enabler bars to Resident 113's bed.</p> <p>Review of a Bed System Measurement Device Test Results Worksheet dated April 26, 2025, indicated that facility staff assessed zones one through four for entrapment risks.</p> <p>Resident 113's clinical record did not indicate that the facility assessed zone six for possible entrapment risks.</p> <p>Observation of Resident 230's room on May 21, 2025, at 10:41 AM revealed assist bar devices located bilaterally at the head of her bed. Resident 230's bed was equipped with a headboard and footboard.</p> <p>Clinical record review for Resident 230 revealed an active physician order dated May 9, 2025, for bilateral enabler bars to her bed.</p> <p>Review of a Bed System Measurement Device Test Results Worksheet dated May 9, 2025, indicated that facility staff assessed zones one through four for entrapment risks.</p> <p>Resident 230's clinical record did not indicate that the facility assessed zone six for possible entrapment risks.</p> <p>The surveyor reviewed the above concerns regarding the assist bar assessments for Residents 85, 113, and 230 during an interview with the Nursing Home Administrator, the Director of Nursing, Employee 5 (assistant director of nursing), and Employee 1 (infection preventionist), on May 22, 2025, at 2:30 PM. The surveyor requested the identification of the facility's bed and assist bar manufacturer. The facility did not provide the manufacturer's identification information during the onsite survey.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, facility documentation, clinical record review, employee personnel record information, and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to obtaining verbal or telephone physician orders for one of one employee reviewed (Employee 3; Resident 40).</p> <p>Findings include:</p> <p>The Centers for Medicare and Medicaid Services (CMS) QSO-24-13-NH memo dated June 18, 2024, noted that requirements specify that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility must provide. The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess to deliver the necessary care required by the residents being served.</p> <p>The current Facility Assessment (noted as fourth quarter, April 2025) noted that staff receive yearly education and are assigned additional courses as needed. The Staff Development Coordinator maintains the current staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. Additional competencies are developed as needed. The list entitled, LPN (licensed practical nurse) Staff Competencies, included, Documentation/Order writing, as one of the competencies completed by the facility for LPN staff.</p> <p>The facility policy entitled, Verbal, Telephone, and Written Physician Orders, last reviewed November 21, 2024, revealed that a physician's verbal or telephone order shall be given to a licensed nurse and shall be immediately recorded on the resident's medical record by that licensed nurse. Telephone orders for medical treatment should be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the responsible practitioner, when the judgement of the professional nurse and the situation requires expedient action, or when the physician calls the facility and requests that a telephone order be accepted.</p> <p>Clinical record review for Resident 40 revealed nursing documentation by the registered nurse (RN) dated May 18, 2025, at 7:57 PM that his daughter noted blood on his pant leg. Staff assessed two skin tears on Resident 40's left leg, calf area. The staff cleansed the wound with wound wash and applied a Tegadern dressing (transparent film dressing).</p> <p>The documentation did not indicate that the licensed nurse contacted Resident 40's physician or that Resident 40's physician provided an order for the wound treatment.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing documentation by Employee 3, licensed practical nurse (LPN), dated May 18, 2025, at 10:27 PM noted, N.O. (new order) Cleanse LLL (left lower extremity) skin tear with wound cleanser, pat dry, apply Tegaderm drsg. (dressing) Change drsg. Q (every) Friday 6-2 (6:00 AM to 2:00 PM) shift or prn (as needed) for soilage/dislodgement, check placement Q shift, measure Q Friday 6-2 shift. D/C (discontinue) when area healed. POA (power of attorney) aware of N.O.</p> <p>Nursing documentation by Employee 3 dated May 18, 2025, at 10:34 PM noted, N.O. Cleanse left calf skin tear with wound cleanser, pat dry, apply Tegaderm drsg. Change drsg. Q Friday 6-2 shift or prn for soilage/dislodgement, check placement Q shift, measure Q Friday 6-2 shift. D/C when area healed. POA aware of N.O.</p> <p>The documentation by Employee 3 did not indicate that the licensed nurse contacted Resident 40's physician. The documentation insinuated that Resident 40's physician provided an order for the wound treatment.</p> <p>Documentation by Resident 40's physician (Employee 4) dated May 19, 2025, at 8:17 AM noted that, Upon my return to work today, it appears that multiple messages were left on my work phone from RN (registered nurse) Supervisor regarding this resident from this past weekend. This number is to be used only if I am on call or with specific permission, neither of which were the circumstances this weekend. There was an on-call provider available. I will investigate further. Nurse leaving messages not in today.</p> <p>Interview with the Director of Nursing on May 22, 2025, at 11:20 AM confirmed that the facility had no evidence that either the RN or LPN spoke with a physician before documenting a treatment order for Resident 40's skin tear sites.</p> <p>The surveyor requested evidence of Employee 3's competency evaluations regarding obtaining and documenting verbal or telephone physician orders during an interview with the Nursing Home Administrator and Director of Nursing on May 22, 2025, at 2:30 PM.</p> <p>Documentation provided by the facility dated August 29, 2018, indicated that Employee 3 completed the facility's test regarding, Competency Test for Writing Orders.</p> <p>The facility failed to provide evidence that Employee 3 received any education after August 29, 2018, related to obtaining/documenting verbal or telephone physician orders although this competency was identified through the Facility Assessment as necessary to provide the level and types of care needed for the resident population.</p> <p>Cross Refer F684</p> <p>28 Pa Code 201.20(a)(6)(d) Staff development</p>		

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NAME OF PROVIDER OR SUPPLIER Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 Warrenton Road Montoursville, PA 17754	
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by two of four residents reviewed (Residents 86 and 89).</p> <p>Findings include:</p> <p>Clinical record review for Resident 86 revealed that the facility admitted her on November 25, 2024, with diagnosis of Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 86's significant change minimum data set (MDS, a form completed at specific intervals to determine care needs) assessment dated [DATE], indicated that the facility assessed Resident 86 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 86's care plan entitled, Impaired cognitive function/dementia or impaired thought processes r/t (related to) Vascular Dementia initiated on December 3, 2024, failed to identify individualized person-centered interventions to address Resident 86's dementia and cognitive loss.</p> <p>Clinical record review for Resident 89 revealed that the facility admitted her on November 10, 2022, with a diagnosis of Dementia added on January 12, 2023. A review of Resident 89's annual MDS assessment dated [DATE], indicated that the facility assessed Resident 89 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 89's care plan entitled, Impaired cognitive function/impaired thought processes, moderately impaired per BIMS (brief interview for mental status, determines level of cognition); dementia with psychosis, dated August 7, 2023, failed to identify individualized person-centered interventions to address Resident 89's dementia and cognitive loss.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 22, 2025, at 2:55 PM.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, and family and staff interview, it was determined that the facility failed to obtain routine dental services for one of three residents reviewed for dental concerns (Resident 67).</p> <p>Findings include:</p> <p>The facility policy entitled, Dental Exams, last reviewed November 21, 2024, revealed that each resident will receive, at a minimum, an annual oral examination with a dentist or his/her choice. In addition to the minimum oral examination, each resident will be offered dental services every six months as his/her insurance will allow. Any resident or resident's responsible party may elect to have the annual oral examination done with the contract dentist.</p> <p>Interview with Resident 67's daughter on May 20, 2025, at 10:10 AM revealed that Resident 67 has natural teeth; however, Resident 67's daughter did not know the last time Resident 67 received professional dental services. Resident 67's daughter stated that she, .would love to see that happen.</p> <p>Clinical record review for Resident 67 revealed that the facility admitted her on May 3, 2023, with Medicare as her primary payer source. Resident 67 began to pay privately for her care on June 1, 2023. Resident 67's primary payer source converted to Medicaid on May 1, 2024.</p> <p>A Dental Services form (document the facility utilized to obtain consent for contracted dental services) signed by Resident 67's daughter on May 3, 2023, (while Resident 67 did not receive Medicaid payment for services) indicated that Resident 67's daughter declined dental care.</p> <p>Annual MDS assessments (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated May 2, 2024, and May 3, 2025, assessed Resident 67 with obvious or likely cavities or broken natural teeth. The Care Area Assessment for Dental Care indicated that the facility would proceed to a care plan in May 2024; however, the facility decided to not proceed to a care plan in May 2025.</p> <p>Review of Resident 67's plans of care revealed no evidence that the facility developed a care plan to address the likelihood that Resident 67 had decayed or broken teeth or attempted an intervention for professional dental services following either the May 2, 2024, or May 3, 2025, MDS assessments.</p> <p>Care Conference Meeting documentation dated November 6, 2024, at 10:00 AM indicated that Resident 67's daughter attended the meeting.</p> <p>Care Conference Meeting documentation dated January 15, 2025, at 10:43 AM indicated that Resident 67's daughter attended via telephone.</p> <p>Care Conference Meeting documentation dated May 14, 2025, at 12:57 PM indicated that staff emailed updates to Resident 67's daughter because she was unable to attend.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 67's clinical record contained no evidence that the facility afforded Resident 67's daughter the opportunity to accept dental services provided under the Medicaid benefit in the year since her mother's payment source changed.</p> <p>The surveyor reviewed the above information regarding concerns related to Resident 67's dental needs during an interview with the Nursing Home Administrator and the Director of Nursing on May 21, 2025, at 2:30 PM and the Director of Nursing on May 22, 2025, at 11:20 AM.</p> <p>Nursing documentation dated May 22, 2025, at 11:32 AM (following the surveyor's questioning) revealed that staff contacted Resident 67's daughter regarding dental services now that Resident 67 is approved for medical assistance (Medicaid). Resident 67's daughter stated that she would be interested in services for her mother from the facility's contracted dental provider and asked that the forms be mailed to her for signature.</p> <p>28 Pa. Code 211.15 Dental services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>18229</p> <p>Based on a review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of six residents reviewed for infection control (Resident 83).</p> <p>Findings include:</p> <p>The policy entitled Standard Precautions and Transmission-Based Precautions, last reviewed without changes March 18, 2025, revealed the CDC recommends two tiers of precautions. In the first tier are those precautions designed for the care of all residents, regardless of their diagnosis or presumed infection status. Implementation of these standard precautions is the primary strategy for successful infection prevention and control. The second tier of precautions are designed only for the care of specified residents on a case-by-case basis. Airborne, Contact, and Droplet precautions are used for persons known or suspected to be infected or colonized with highly transmissible pathogens. These precautions will be instituted for any resident who has an active infection and/or requires more extensive infection control measures. These precautions are to be used in addition to standard precautions. Contact precautions are used for residents known or suspected to be infected or colonized with microorganisms transmitted by direct contact with a resident or by indirect contact such as touching environmental surfaces. Examples of such illnesses include Vancomycin Resistant Enterococcus (VRE).</p> <p>Clinical record review revealed the facility admitted Resident 83 on February 21, 2025. A urine culture collected on April 23, 2025, noted with 10,000-50,000 cfu (colony forming unit)/mL (milliliter) of enterococcus faecium VRE.</p> <p>A physician's progress note dated April 25, 2025, at 10:35 AM indicated Resident 83's urine was positive for enterococcus faecalis and enterococcus faecium VRE. The physician noted they would start Macrobid 100 milligrams (mg) twice a day for five days but may need to change depending on pending sensitivities.</p> <p>Further review of Resident 83's clinical record revealed an order for contact precautions for VRE in her urine on April 27, 2025.</p> <p>Interview with Employee 1 (infection preventionist) on May 23, 2025, at 9:40 AM confirmed there was a delay in starting Resident 83's transmission-based precautions. Employee 1 stated the nurse supervisor did not implement contact precautions over the weekend.</p> <p>The surveyor reviewed the concerns related to transmission-based precautions during an interview with the Director of Nursing on May 23, 2025, at 10:31 AM.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control</p> <p>Previously cited deficiency 6/20/24</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing services