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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396085	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mon Valley Care Center	200 Stoops Drive Monongahela, PA 15063

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to document the invitation of the resident or their representative to care conference meetings for two of five residents (Resident R1 and R2).Findings include: Review of the facility policy, Care Planning - Interdisciplinary Team dated 4/14/25, indicated, The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Review of the facility policy, Care Plans, Comprehensive [NAME]-Centered dated 4/14/25, indicated, The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences. Review of Resident R1's admission record indicated resident was admitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS -a periodic assessment of resident care needs) dated 12/16/25, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and the need for care after surgical amputation. Review of the plan of care dated 1/14/26, for discharge planning, indicated that [Resident R1] will be discharged to home with family support and home health services. Review of a care conference meeting note dated 12/23/25, at 12:21 p.m. indicated, Care conference held this date. Resident and family declined invite. POC (plan of care) reviewed with IDT (interdisciplinary team). During an interview on 2/23/26, at 3:10 p.m. Resident R1's family member stated the facility did not provide information related to Medicare payment limitations and allowed time in the facility. When asked if he was invited to a care plan conference, Resident R1's family member stated he was never invited. Review of Resident R1's clinical record and the paper chart failed to reveal documentation that Resident R1, or his family member, was invited to a care conference meeting. Review of Resident R2's admission record indicated resident was admitted on [DATE]. Review of Resident R2's MDS dated [DATE], included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and a seizure disorder. Review of a care conference meeting note dated 12/2/25, at 12:26 p.m. indicated, Care conference held this date. Resident and family declined invite. POC (plan of care) reviewed with IDT (interdisciplinary team). Review of Resident R2's clinical record failed to reveal documentation that Resident R2, or his family member, was invited to a care conference meeting. During an interview on 2/21/26, at approximately 2:00 p.m. the Director of Nursing confirmed that the facility failed to document the invitation of the resident or their representative to care conference meetings for two of five residents. 28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.10 (c)(d) Resident care policies.28 Pa. Code 211.12(d)(3) Nursing services.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to permit a resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility for one of four residents (Resident R1).Findings include: Review of the facility policy, Discharge Summary and Plan dated 4/14/25, indicated, The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting. Discharge planning identifies the discharge destination, and ensures that it meets the resident's health and safety needs, as well as preferences. Review of Resident R1's admission record indicated resident was admitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS -a periodic assessment of resident care needs) dated 12/16/25, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and the need for care after surgical amputation. Review of the plan of care dated 1/14/26, for discharge planning, indicated that [Resident R1] will be discharged to home with family support and home health services. Review of a care conference meeting note dated 12/23/25, at 12:21 p.m. indicated, Care conference held this date. Resident and family declined invite. POC (plan of care) reviewed with IDT (interdisciplinary team). During an interview on 2/23/26, at 3:10 p.m. Resident R1's family member stated the facility was informed that the resident lives alone and would not have supervision upon discharge. Review of a progress note created 12/11/25, at 7:14 a.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 12/17/25, at 2:43 p.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 12/17/25, at 8:19 a.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 12/22/25, at 12:18 a.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 12/27/25, at 1:48 a.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 1/1/26, at 10:03 p.m., indicated, Patient lives alone in an apartment and plans to discharge home after rehab. Lives alone in an apartment. Review of a progress note created 1/7/26, at 4:28 a.m., indicated, Lives alone in an apartment. Review of a progress note created 1/10/26, at 7:58 p.m., indicated, Lives alone in an apartment. Review of a progress note created 1/16/26, at 10:19 a.m., indicated, Lives alone in an apartment. Review of a progress note created 1/20/26, at 6:23 a.m., indicated, Lives alone in an apartment. Review of a progress note created 1/24/26, at 8:18 p.m., indicated, Lives alone in an apartment. Review of a progress note created 1/24/26, at 8:18 p.m., indicated, Patient expressed to extend his rehab stay with a new prosthesis. Discussed the team multiple times about his discharge plan. S.W. is not in reach and other disciplinary members (nursing and rehab) don't have his insurance update. Review of a progress note dated 1/24/26, at 12:59 p.m. indicated, resident lost insurance appeal. Family chose to take resident home today. Home via [transportation company] pick up between 3 and 330 (3:00 p.m. and 3:30 p.m.). Resident has own wheelchair. Order for wheelchair seat cushion and sliding board was sent to [medical equipment provider]. Facility permitting resident to borrow wheelchair cushion and sliding board since items not delivered and pending snowstorm may have item delivery delayed additionally. Family to return once DME (durable medical equipment) received. During an interview on (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/21/26, at approximately 1:30 p.m. the Director of Nursing (DON) confirmed that Resident R1 was discharged home without his prosthetic leg. The DON stated that in place of the prosthetic leg, Resident R1 was provided with a sliding board that he could use with supervision/assistance. When asked how the resident was to use a sliding board with supervision/assistance when the resident was being discharged home alone, the DON stated, It was thought that the son would be of more of a help. The DON was asked how this was an expectation when the clinical record documented numerous times that the resident was to discharge home alone, the DON was unable to provide an answer. During an interview on 2/23/26, at 3:10 p.m. Resident R1's family member confirmed a previous statement that Resident R1 was discharged on 1/24/26 after my appeal to continue his care was denied. I was unaware of the Medicare time frame for skilled care. He was sent home to fail, and his safety was very much in question. They discharged him only hours before a major snowstorm hit our region. I was only given a two-hour window to try and get him groceries and get his apartment rearranged to accommodate him. He was also sent home without his prosthetic leg. I was told he could stand and pivot without his leg, which was false. They refused to look for it so he could be safely sent home. I pleaded with them to not send him home without his leg but I was told he could pay out of pocket, which he does not have. He is a widower and on a fixed income. He slept the entire weekend in his scooter leaned up against his bed. He could not safely get from the scooter to his bed or the toilet; he spent the day Saturday until Monday (1/24/26 - 1/26/26) morning when I got to him once it was cleared to get him cleaned up. The home health RN (registered nurse) who was doing the initial visit immediately sent him back to the ER (emergency room). Review of hospital documentation dated 1/26/26, at 11:41 a.m. indicated, Patient presenting requesting placement. He had left below the knee amputation done a couple of months ago and was just recently fitted with a prosthesis and was discharged because he had no more skilled days from a skilled nursing facility. He lives at home by himself. He has been having a very difficult time getting around for the past couple of days. He had to sleep in his scooter last night. He feels that he is not able to care for himself especially without his prosthesis. Review of a hospital note dated 1/26/26, at 12:44 p.m. indicated, SW (Social Worker) spoke with pts son. [Son] states pt was dc from [facility] on Friday without his prosthetic leg and slept in a WC (wheelchair) all weekend. SW contacted [facility] to see where his prosthetic leg is as [Son]stated he was told they were getting it adjusted. admission director at [facility] states she reached out to the facility, and they are stating they still have the leg. SW reached out to facility directly. PT department did not answer, and nursing supervisor did not know about the situation. SW attempted contacting admissions director again with no answer. Pt is out of his skilled days, and pts son did submit an appeal which was denied. Review of a hospital note dated 1/26/26, at 4:10 p.m. indicated, [Resident R1] presents to the ED (emergency department) due to being sent home from [facility]with inability to ambulate and take care of himself. The patient was sent home without the prosthesis that he was recently ordered. It is still at [facility] now. The patient coming in for inability to take care of himself. During an interview on 2/21/26, at approximately 2:00 p.m. the Director of Nursing confirmed that the failed to permit a resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility for one of six residents. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical record review, and family and staff interview it was determined that the facility failed to provide medically related social services to one of four residents (Resident R1).Findings include: Review of the United States Code of Federal Regulations S42 CFR 483.10(g)(4) indicated:(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including; (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes- (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (iii) Information regarding Medicare and Medicaid eligibility and coverage; Review of the facility provided job description for the Director of Social Services indicated that they will, Assist discharged residents and families with placement options. Review of Resident R1's admission record indicated resident was admitted on [DATE]. Review of Resident R1's Minimum Data Set (MDS -a periodic assessment of resident care needs) dated 12/16/25, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and the need for care after surgical amputation. Review of the plan of care dated 1/14/26, for discharge planning, indicated that [Resident R1] will be discharged to home with family support and home health services. Review of a progress note dated 1/24/26, at 12:59 p.m. indicated, resident lost insurance appeal. Family chose to take resident home today. Home via [transportation company] pick up between 3 and 330. Resident has own wheelchair. Order for wheelchair seat cushion and sliding board was sent to [medical equipment provider]. Facility permitting resident to borrow wheelchair cushion and sliding board since items not delivered and pending snow storm may have item delivery delayed additionally. Family to return once DME (durable medical equipment) received. Review of a progress note created 1/24/26, at 8:18 p.m., indicated, Patient expressed to extended his rehab stay with a new prosthesis. Discussed the team multiple times about his discharge plan. S.W. is not in reach and other disciplinary members (nursing and rehab) don't have his insurance update. Review of a progress note dated 1/26/26, at 12:34 p.m. indicated, personal care 3rd floor was offered to son on 1-24 as well as continued stay at the SNF level off of insurance coverage however son denied the offer. During an interview on 2/23/26, at 3:10 p.m. Resident R1's family member stated the facility was informed that the resident lives alone and would not have supervision upon discharge and confirmed that Resident R1 lacked the funds to be able to stay in the facility as a private pay resident. Resident R1's family member stated that Resident R1 was not offered assistance with completing applications for Medicare/Medicaid or social security disability. Review of the clinical record failed to include any referral/assistance with completing applications for Medicare/Medicaid or social security disability. During an interview on 2/21/26, at approximately 2:00 p.m. the Director of Nursing confirmed that the facility failed to provide medically related social services to Resident R1. 28 Pa. Code 211.16 (a) Social services. 28 Pa. Code 211.5 (h)Clinical records.