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	08/21/2025

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined the facility failed to post contact information for Adult Protective Services (APS) as required. Based on observations and staff interview, it was determined the facility failed to post contact information for Adult Protective Services (APS) as required. Findings include: The facility must post, in a form and manner accessible and understandable to residents, resident representatives; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements and requests for information regarding returning to the community. Observations conducted on 8/21/25, at approximately 8:30 a.m., on the first-floor lobby and the second-floor nursing unit, revealed the facility did not have any elements of the APS contact information (agency name, address, email, and phone number) information posted or accessible to residents or resident representatives. During an interview and rounds, on 8/21/25, at 8:30 a.m., the Director of Nursing confirmed the facility failed to post contact information for Adult Protective Services (APS) as required, in the building. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on observations and staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the facility. Based on observations and staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the facility. Findings include: During observations completed on 821/25, of the first-floor lobby and the second-floor nursing unit posting locations, failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid. During an interview and rounds, on 8/21/25, at 8:30 a.m., the Director of Nursing confirmed the facility failed to display (for residents and/or their responsible person) written information on applying for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the facility. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 make certain consistent dialysis communication was maintained for three of six residents (Residents R27, R41 and R46).Findings include: Review of the facility policy Hemodialysis dated 3/31/25, indicates the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The Licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: medication administration, treatment orders, laboratory values, vital signs, advanced directives, nutrition/fluid management, treatment provided, adverse reactions, changes in condition, injury and transportation concerns. The dialysis communication form has sections for both the skilled nursing facility and dialysis center documentation to be completed. Review of the admission record indicated Resident R27 was admitted to the facility on [DATE].Review of Resident R27's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 6/18/25, indicated diagnoses of end stage renal disease, hypertension, and type 2 diabetes.Review of Resident R27's physician orders dated 8/3/25, indicated dialysis: at [dialysis center] on Monday, Wednesday, and Friday. Pick up time 9:15 am-10:15 am. Review of Resident R27's current care plan indicated dialysis: at [dialysis center] on Monday, Wednesday, and Friday. Pick up time 9:15 am-10:15 am.Review of Resident R27's dialysis communication forms indicated the following:8/6, 8/11, 8/13, and 8/15/25 dialysis communication forms were incomplete Review of the admission record indicated Resident R41 was originally admitted to the facility on [DATE]. Review of Resident R41's MDS dated [DATE], indicated diagnoses of end stage renal disease (condition where kidneys lose the ability to remove waste and balance fluids), diabetes mellitus (impaired ability to produce or respond to insulin), and hypertension (high blood pressure). Review of Resident R41's physician orders dated 5/13/25, indicated dialysis: Monday, Wednesday, and Friday at [dialysis center]. Chair time scheduled at 7:30 a.m., pick up time 6-6:30 a.m., and return time 10:30-11:00 a.m. Review of Resident R41's current care plan indicated dialysis three times a week, treatments as scheduled: Monday, Wednesday, and Friday at [dialysis center]. Chair time scheduled at 7:30 a.m., pick up time 6-6:30 a.m., and return time 10:30-11:00 a.m. Monitor for side effects and notify physician accordingly. Review of Resident R41's dialysis communication forms indicated the following:5/2/25, 5/5/25, 5/7/25, 5/9/25, 5/12/25, 5/19/25, 5/28/25, 5/30/25, 6/2/25, 6/4/25, 6/23/25, 6/25/25, 7/4/25, 7/9/25, and 8/1/25 dialysis communication forms were incomplete. Review of the admission record indicated Resident R46 was re-admitted to the facility on [DATE]. Review of Resident R46's MDS dated [DATE], indicated diagnoses of end stage renal disease, heart disease, and bladder cancer. Review of Resident R46's physician orders dated 6/16/25, indicated dialysis: at [dialysis center]. Chair time scheduled at 5:50 a.m., pick up time 5:00 am-5:30 am a.m. Review of Resident R46's current care plan indicated dialysis: at [dialysis center]. Chair time scheduled at 5:50 a.m., pick up time 5:00 am-5:30 am a.m. Review of Resident R46's dialysis communication forms indicated the following: 6/24, 7/14, 7/19, 7/29, and 7/31/25 dialysis communication forms were incomplete. During an interview on 8/19/25, at 10:00 a.m. the Director of Nursing confirmed the facility failed to make certain consistent dialysis communication was maintained for three of six residents (Residents R27, R41 and R46). 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(2)(3) Nursing services