

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Green Valley Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Matthew Drive Pottsville, PA 17901	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of select facility policies and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food and failed to record and maintain food temperature logs to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of the facility policy titled Labeling/Dating last reviewed by the facility on November 26, 2025, revealed all food and non-food supplies will be clearly labeled and dated to ensure the risk of misuse of a product is reduced and that only fresh items are used. All open items or items not in original containers will be clearly labeled, dated and covered. Leftover food will be stored in appropriate containers or wrapping, and dated. Leftover food is checked daily to determine its usage. All perishable food products will follow the three-day rule, if not used within three days it will be thrown out. Items with a factory stamped expiration date (example: yogurt, milk, etc.) will be kept until the expiration date or until it is opened, at which time, date opened will be clearly marked and the three-day rule will apply. Review of the facility policy titled Food Temperatures Policy last reviewed by the facility on November 26, 2025, revealed the temperatures of the food items will be taken and properly recorded for each meal. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 130 degrees Fahrenheit. The initial tour of the dietary department was conducted with the Food Service Director on December 16, 2025, at 10:15 AM revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: Observation of inside the walk-in refrigerator revealed the following food and beverage items were opened and available for use with no open or discard date: one 32-ounce carton of almond milk with manufacturer's instruction to discard within 7-10 days after opening, two 32-ounce containers of thickened dairy beverage with manufacturer's instruction to discard within 4 days after opening, one 32-ounce bottle of thickened cranberry juice and one 32-ounce bottle of thickened apple juice with manufacturer's instruction to discard within 10 days after opening, and two packages of sweet bologna which the Food Service Director's confirmed should be discarded 3 days after opening. Observation of the resident food pantry on December 16, 2025, at 12:50 PM, revealed that inside the refrigerator the following beverage items were opened and available for use with no open or discard date: two 32-ounce containers of thickened dairy beverage with manufacturer's instruction to discard within 4 days after opening. The refrigerator also contained an opened 32-ounce container of almond milk with an opened date of November 1, 2025, exceeding the manufacturer's discard timeframe of 7-10 days after opening. Further observation revealed 16 thawed 4-ounce nutritional shakes without a thaw or discard date. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The manufacturer's safe food handling instructions indicate that once they are thawed, supplements are to be used within 14 days. The absence of open, thaw, and discard dates prevents the ability to determine product viability, representing a failure in proper food labeling and tracking procedures. During an interview conducted on December 16, 2025, at 1:00 PM the Food Service Director confirmed that food and beverages are expected to be labeled, dated, stored, and thawed in accordance with food safety standards. Observation of the kitchen tray line during lunch service on December 17, 2025, at 12:10 PM revealed that kitchen staff failed to obtain and record food temperatures prior to the meal service. Review of records indicated the facility was unable to provide a food temperature log for the December 17, 2025, breakfast meal. Interview with the Registered Dietitian and Food Service Director at the time of the observation confirmed that food temperatures are required to be obtained and documented for each meal, and that all hot food items must be held and served at a minimum of at least 130 degrees Fahrenheit. Following surveyor inquiry, food temperatures were obtained with the following results: Chicken 160 degrees Fahrenheit, vegetable 140 degrees Fahrenheit, and pasta 141 degrees Fahrenheit. The facility failed to ensure that food was properly labeled, stored, and used within safe timeframes, in accordance with facility policy, manufacturer guidelines, and federal food safety requirements. The facility also failed to consistently obtain and maintain required food temperature logs to prevent the potential for contamination and microbial growth in food. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.10 (c) Resident Care Policies		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff and resident interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of two residents out of 15 sampled (Residents 16 and 34). Findings include: The Long-Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 2025, requires the assessment to accurately reflect the resident's status; a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A clinical record review revealed Resident 16 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a serious, chronic brain disorder that interferes with a person's ability to think clearly, manage emotions, make decisions, and distinguish between reality and delusions or hallucinations) and cataracts (a gradual clouding of the eye's natural lens, which is normally clear). A review of a Quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 16 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). A review of Resident 16's Significant Change in Status MDS assessment dated [DATE], Section A 1500 Preadmission Screening and Resident Review (PASRR, a required federal screening to ensure residents receive care in the most appropriate, least restrictive setting and get needed specialized services, rather than being placed inappropriately in a nursing home) revealed the resident was not currently considered by the state level II PASRR (a level II PASRR indicates the resident has been identified through the state mental health authority as having a serious mental health diagnosis and qualifies for additional services to meet the resident's needs) process to have serious mental illness and/or intellectual disability or a related condition. However, further review of Resident 16's clinical record revealed a letter dated February 20, 2018, from the Pennsylvania Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS) indicated Resident 16 had evidence of a mental health condition that meets the criteria for review by OMHSAS. The letter indicated that Resident 16 was eligible and appropriate for the nursing facility level of care, and the facility must provide or arrange for the provision of mental health services for the resident. A review of Resident 16's Quarterly MDS assessment Section B 1200 Corrective Lenses dated October 18, 2025, revealed that the resident does not use corrective lenses (contacts, glasses, or magnifying glass). However, further review of Resident 16's clinical record revealed a community provider glasses adjustment note, dated December 11, 2025, stating that an external provider adjusted her glasses' frame. During an interview on December 17, 2025, at 10:25 AM, Resident 16 explained that she has been having problems with her vision and she needed new glasses. She explained that last week a man was in to adjust her frames but did not listen to her when she explained that she was having difficulty seeing despite her glasses. During an interview on December 17, 2025, at 1:30 PM, the Registered Nurse Assessment Coordinator (RNAC) confirmed Resident 16 utilized glasses, and Resident 16's MDS assessment dated [DATE], Section B 1200 Corrective Lenses dated October 18, 2025, was not accurate. Also, the RNAC confirmed that Resident 16 had a serious mental health diagnosis and was considered by the state mental health authority as a level II PASRR. The RNAC indicated the Significant Change in Status MDS assessment dated [DATE], Section A 1500 Preadmission Screening and Resident Review, was not accurate. A clinical record review revealed that Resident 34 was admitted to the facility on [DATE], with diagnoses that include schizophrenia. A review of Resident 34's Annual MDS assessment dated [DATE], Section A 1500 Preadmission (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication for two of 15 sampled residents (Resident 12 and 36). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. A review of the facility policy titled Administering Medications, last reviewed by the facility on November 26, 2025, revealed that medications are administered as prescribed and in a safe and timely manner. The policy required staff to verify medication allergies and obtain vital signs (basic health measurements such as blood pressure, temperature, heart rate, and breathing rate), as applicable, prior to administering medications. A review of the clinical record revealed Resident 12 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and osteomyelitis (an infection of the bone that can be either acute or chronic). A review of the physician's order dated November 28, 2025, directed staff to administer Clonidine HCl (medication used to treat high blood pressure) 0.1 mg by mouth two times a day for hypertension and to hold the medication if the systolic blood pressure is less than 120 millimeters of mercury (mm/Hg). Systolic blood pressure is the top number in a blood pressure reading and reflects the pressure when the heart is actively pumping. A review of the Medication Administration Record (MAR) for December 2025 revealed Clonidine was administered 9 times outside the physician-ordered parameters (outside parameter means the medication was given when the blood pressure reading did not meet the hold instruction). The following blood pressure readings were documented at the time the medication was given: December 2 at 8:00 AM: 110/68 mm/Hg December 3 at 8:00 AM: 112/68 mm/Hg December 3 at 8:00 PM: 101/60 mm/Hg December 6 at 8:00 AM: 113/98 mm/Hg December 6 at 8:00 PM: 112/96 mm/Hg December 7 at 8:00 AM: 106/66 mm/Hg December 7 at 8:00 PM: 110/80 mm/Hg December 13 at 8:00 PM: 110/70 mm/Hg December 14 at 8:00 PM: 98/58 mm/Hg These readings show the medication was administered repeatedly when systolic blood pressure was below the required 120 mm/Hg. A review of the clinical record revealed Resident 36 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues) and chronic atrial fibrillation (an irregular heartbeat). A review of the physician's order dated May 10, 2025, directed staff to administer Midodrine HCl (medication used to treat low blood pressure) 2.5 mg by mouth three times a day for blood pressure, and to hold the medication if the systolic blood pressure is greater than 120 millimeters of mercury (mm/Hg). A review of the MAR for December 2025, revealed Midodrine was administered 7 times outside the physician-ordered parameters. The following blood pressure readings were documented at the time the medication was given: December 2 at 7:00 AM: 128/68 mm/Hg December 2 at 11:00 AM: 128/68 mm/Hg December 3 at 7:00 PM: 123/60 mm/Hg December 7 at 7:00 PM: 130/68 mm/Hg December 11 at 7:00 AM: 122/63 mm/Hg December 13 at 7:00 PM: 145/36 mm/Hg December 16 at 11:00 AM: 121/62 mm/Hg These readings show the medication was administered repeatedly when systolic blood pressure was above the required 120 mm/Hg. During an interview on December 17, 2025, at 11:20 AM, the above information was reviewed (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the Director of Nursing and it was confirmed that nursing staff failed to follow acceptable standards of nursing practice during medication administration as the medications were administered outside of the physician ordered parameters. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services28 Pa Code 211.10 (c)(d) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's plan of correction from the survey ending December 18, 2025, the documented outcomes of the facility's Quality Assurance and Performance Improvement (QAPI) committee, clinical record reviews, and staff interviews, it was determined the facility failed to ensure its quality assurance program effectively identified and addressed recurring deficient practices related to nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders (Residents 1, 2, and 3). Findings include: A review of the facility policy titled Quality Assurance Performance Improvement, last reviewed by the facility on November 26, 2025, revealed that the primary goal of the Performance Improvement Plan is to continually and systemically plan, design, measure, assess, and improve the performance of the nursing center's key functions and processes relative to resident care. As a result of the deficiencies cited under the requirements related to nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders during the survey of December 18, 2025, the facility developed a plan of correction to serve as their allegation of compliance, which included a quality assurance monitoring component to ensure that solutions were sustained. This corrective plan was to be completed and functional by January 20, 2025. However, during the survey ending February 11, 2026, continuing deficient facility practice was identified with these same requirements. According to the facility's plan of correction for the deficiency cited on December 18, 2025, relating to nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders, procedures implemented to ensure deficient practice was corrected included (1) Physicians were made aware of medications being administered outside of hold parameters and incident reports were generated for the affected residents, (2) Medications with hold parameters will be audited for proper administration for seven days, and any medications administered outside the hold parameters will be addressed accordingly, (3) Licensed staff will be educated on proper medication administration, following physicians' orders, and medication hold parameters, (4) Audits to be conducted on five medications with hold parameters for correct administration and will be conducted by the DON/designee weekly for two weeks, then monthly for two months. Results of the audits will be reviewed at the QAPI meetings. A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including hypertension (blood pressure higher than normal) and osteomyelitis (infection of bone tissue). A review of a physician's order dated January 8, 2026, revealed an order to administer Lisinopril 10 milligrams by mouth daily and to hold the medication if systolic blood pressure (top number of a blood pressure reading measuring pressure during heart contraction) was less than 110 millimeters of mercury (mm/Hg). A review of the January 2026 MAR revealed the medication was administered on January 31, 2026, at 8:00 AM when the documented blood pressure was 109/52 mm/Hg, which was below the physician-ordered hold parameter. A review of a physician's order dated January 8, 2026, revealed an order to administer Metoprolol Tartrate 25 milligrams twice daily and to hold the medication if systolic blood pressure was less than 100 mm/Hg or heart rate was less than 60 beats per minute. A review of the February 2026 MAR revealed the medication was administered on February 7, 2026, at 5:00 PM with no documented blood pressure at the time of administration and a heart rate of 68 beats per minute. A review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses including congestive heart failure (condition in which the heart cannot pump effectively, causing fluid buildup) and chronic atrial fibrillation (irregular heart rhythm). A review of a physician's order dated January 7, 2026, revealed an order to administer Midodrine HCl 2.5 milligrams by mouth every eight hours and to hold the medication if systolic blood pressure was (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	greater than 120 mm/Hg.A review of the January and February 2026 MARs revealed the medication was administered outside physician-ordered parameters on the following dates and times:January 22, 2026, at 8:00 AM: blood pressure 129/76 mm/HgJanuary 29, 2026, at 12:00 AM: blood pressure 122/60 mm/HgFebruary 5, 2026, at 8:00 AM: blood pressure 126/64 mm/HgThese readings indicated the medication was administered when systolic blood pressure exceeded the ordered hold parameter.A review of the clinical record revealed Resident 3 was admitted to the facility on [DATE], with diagnoses including hypertension and hypovolemic shock (life-threatening condition caused by severe loss of blood or body fluids resulting in inadequate circulation).A review of a physician's order dated January 7, 2026, revealed an order to administer Midodrine HCl 5 milligrams by mouth every eight hours and to hold the medication if systolic blood pressure exceeded 120 mm/Hg.A review of the January 2026 MAR revealed the medication was administered outside physician-ordered parameters on the following dates:January 26, 2026, at 12:00 AM: blood pressure 126/64 mm/HgJanuary 27, 2026, at 12:00 AM: blood pressure 122/80 mm/HgThese readings indicated the medication was administered when systolic blood pressure exceeded the ordered hold parameter.A review of facility QAPI documentation failed to reveal evidence the facility identified these medication administration errors through monitoring activities, trended the errors, performed root cause analysis, or implemented corrective action to ensure sustained compliance after the prior citation. During an interview on February 11, 2026, at 3:30 PM, the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to ensure licensed nurses properly evaluated and provided nursing care according to physician orders for Residents 1, 2, and 3. The DON confirmed the facility failed to prevent the recurrence of similar quality deficiencies in the areas of ensuring licensed nurses properly evaluate and provide nursing care according to physician orders.Cross Refer to F68428 Pa. Code 201.18(e)(4) Management. 28 Pa. Code 211.5 (f)(xi) Medical records. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, a review of select facility policy, and interviews with staff, it was determined that the facility failed to ensure personnel must handle, store, process, and transport linens in order to prevent the spread of infection in one out of one laundry room. Findings include: According to the Centers for Disease Control Healthcare-Associated Infections (HAIs) Appendix D dated March 19, 2024, best practices for linen and laundry management in global healthcare settings include maintaining a separation between the soiled linen and clean linen storage areas. A review of the facility policy titled Linen Handling, Storage, Process, and Transportation, last reviewed by the facility on November 26, 2025, revealed it is the facility policy that linen will be handled, stored, processed, and transported to prevent the spread of infection to other residents and the environment. The policy indicated soiled laundry shall be treated as if it were contaminated and shall be handled as little as possible and with a minimum of agitation. The policy indicated soiled laundry and clean laundry will be stored in separate areas in the laundry room. Soiled linen must be clearly separated from areas where clean linen is handled. An observation on December 18, 2025, at 9:53 AM in the facility's laundry room revealed nine blue plastic bags containing soiled laundry. The soiled laundry bags were stored next to the resident's clean laundry (less than 1 foot). The Infection Preventionist confirmed that the soiled laundry was stored directly adjacent to the clean laundry. The Infection Preventionist confirmed that the clean laundry was not stored in a separate area from the soiled laundry. During an interview on December 18, 2025, at 10:45 AM, the above findings were reviewed with the Director of Nursing (DON). The DON confirmed that resident soiled laundry and clean laundry were not stored separately. The DON indicated that the facility would implement a procedural change to ensure that the resident's clean and soiled laundry would not be stored in the same area of the facility's laundry room. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(3) Nursing services		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, the Center for Disease Control and Prevention (CDC) Adult Vaccine Schedules, and staff interview, it was determined the facility failed to ensure residents were offered and/or provided recommended influenza and pneumococcal immunizations for two of five residents reviewed for immunizations (Residents 6 and 16). Findings include: A review of the facility policy titled Pneumococcal Vaccination Policy, last reviewed by the facility on November 26, 2025, revealed that adults over [AGE] years of age are at increased risk for developing pneumococcal infections and that all residents will be offered the pneumococcal vaccination/revaccination as deemed necessary in accordance with the Center for Disease Control and Prevention (CDC) standards of practice. According to the current CDC Adult Vaccine Schedule for Pneumococcal Vaccinations for adults 50 years or older who previously received PCV13, residents should be offered an additional pneumococcal vaccine (one dose of PCV20 protects against 20 pneumococcal bacteria/viruses) or one dose of PCV21 at least one year after the last PCV13 (Pvna 13, a pneumococcal vaccine that protects against serious infection caused by 13 different types of bacteria) dose to complete their pneumococcal vaccination series. A review of the facility policy titled Annual Influenza Immunizations Policy, last reviewed by the facility on November 26, 2025, revealed that residents who are residing in the facility during the influenza season (typically October through March) will be included in the facility's influenza immunization program. A review of the clinical records revealed Resident 6, [AGE] years of age, was admitted to the facility on [DATE], with diagnosis that included Type 2 diabetes (body has trouble controlling blood sugar and using it for energy). A review of immunization records revealed the resident received one dose of PVC13 on February 8, 2019. A clinical record revealed no documented evidence to indicate that the facility offered the resident or resident representative an opportunity for Resident 6 to receive the recommended additional pneumococcal vaccinations nor documentation of refusal or contraindication. Further review of Resident 6's immunization record revealed the resident received an influenza vaccine on October 11, 2023. There was no documented evidence that the facility offered or administered an annual influenza vaccination for the 2024 or 2025 influenza season. A clinical record review revealed Resident 16, [AGE] years of age, was admitted to the facility on [DATE], with diagnoses that include schizophrenia (a serious, chronic brain disorder that interferes with a person's ability to think clearly, manage emotions, make decisions, and distinguish between reality and delusions or hallucinations). A clinical record review of immunization records revealed Resident 16 received one dose of PVC13 on October 16, 2019. A clinical record revealed no documented evidence to indicate that the facility offered the resident or resident representative an opportunity for Resident 16 to receive the recommended additional pneumococcal vaccinations nor documentation of refusal or contraindication. Further review of Resident 16's immunization record revealed the resident last received an influenza vaccine on October 17, 2023. There was no documented evidence that the facility offered or administered an annual influenza vaccination for the 2024 or 2025 influenza season. An interview with Employee 1, Infection Preventionist, on December 18, 2025, at 10:45 AM confirmed that the facility was unable to provide documented evidence that Residents 6 or 16 were offered or provided the recommended pneumococcal and annual influenza immunizations, or that refusals were obtained. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code: 211.10 (c) (d) Resident care policies. 28 Pa Code: 211.12 (d)(1) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Green Valley Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Matthew Drive Pottsville, PA 17901	
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff and resident interviews, it was determined the facility failed to ensure that residents receive proper treatment and assistive devices to maintain vision and arrange for treatment by a professional specializing in the provision of vision assistive devices as needed for one out of 15 residents sampled (Resident 16). Findings include: A clinical record review revealed Resident 16 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a serious, chronic brain disorder that interferes with a person's ability to think clearly, manage emotions, make decisions, and distinguish between reality and delusions or hallucinations) and cataracts (a gradual clouding of the eye's natural lens, which is normally clear). A review of a Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 18, 2025, revealed that Resident 16 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). A clinical record review revealed that Resident 16's last evaluation for visual acuity (a test to determine how clearly a person can see, the ability to see details and objects at near or far distances, with or without glasses) was on November 21, 2024. A progress note dated November 28, 2025, at 1:38 PM revealed Resident 16 indicated her vision was blurry as usual. A progress note dated December 2, 2025, at 3:44 AM revealed that Resident 16 had complaints of slight blurry vision. A community provider eye glass adjustment note dated December 11, 2025, revealed that Resident 16's eye glasses were adjusted for comfort. During an interview on December 16, 2025, at 10:45 AM, Resident 16 explained that she had been having problems with her vision and she needs new glasses. She explained that she was upset because last week a man adjusted her frames but did not listen to her when she explained that she was having difficulty seeing even while wearing her glasses. She indicated that she had been reporting problems with her vision to staff, but nothing has been done. Resident 16 indicated that she could not remember when her last vision examination occurred. A progress note dated December 16, 2025, at 4:47 PM indicated Resident 16 reported complaints with vision and needed new eye glasses. A referral was sent to the community provider to be seen on the next visit. During an interview on December 18, 2025, at 10:45 AM, the above findings were reviewed with Director of Nursing (DON). The DON was unable to provide documented evidence that Resident 16 received a comprehensive eye examination in the last year. The DON was unable to provide evidence Resident 16 was scheduled to receive an evaluation with complaints of blurry vision until inquiries were made during the week of the survey ending on December 18, 2025. The facility failed to ensure Resident 16 received proper treatment and assistive devices to maintain vision and arrange for treatment by a professional specializing in the provision of vision assistive devices. 28 Pa. Code 211.12 (d)(3)(5) Nursing services		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies, clinical records, and staff interviews, it was determined the facility failed to assess, evaluate, and monitor the nutritional parameters of a resident with significant weight loss for one of 15 residents reviewed (Resident 2). Findings include: A review of a facility policy titled Weight Policy, last reviewed by the facility on November 26, 2025, revealed that to ensure prompt identification of residents who are at nutritional risk, each resident will be monitored consistently and closely by the interdisciplinary team, and all residents will be monitored to prevent undesirable significant weight gain or loss. Further review of the policy revealed that if a weight loss or gain of five (5) pounds is noticed, the resident is to be re-weighed using a consistent scale within 24 hours, and after an accurate weight has been established, weight and re-weight checks are to be documented by the charge nurse in the weight record. In the event of a pattern of weight loss or significant loss/gain of 5% or more in 30 days or 10% in 180 days, the following interventions will be carried out: the resident will be assessed for signs and symptoms of dehydration or fluid overload; the attending physician and family member/responsible party will be notified by the nursing department; a dietary referral will be sent to the dietitian to review the resident and make appropriate recommendations as indicated; and the documentation will be entered into the resident's medical record. A review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 12, 2025, revealed that Resident 2 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of Resident 2's care plan dated October 1, 2025, revealed the resident had a nutritional problem related to protein-calorie malnutrition (a condition caused by inadequate intake of protein and calories, which may result in weight loss, weakness, decreased muscle mass, and delayed healing). The care plan included tasks to monitor, record, and report signs and symptoms of malnutrition, including weight loss, to the physician. A review of Resident 2's documented weights revealed the following: September 9, 2025- 111.8 lbs. September 10, 2025 - 113.2 lbs. September 16, 2025 - 109.3 lbs. September 22, 2025- 117 lbs. September 23, 2025- 121 lbs. October 1, 2025- 121 lbs. October 8, 2025-115.8 lbs. October 10, 2025- 114.8 lbs. October 15, 2025- 114.6 lbs. October 22, 2025- 112 lbs. October 23, 2025 - 113.2 lbs. October 29, 2025- 113 lbs. November 5, 2025- 113.6 lbs. December 2, 2025- 108.6 lbs. December 3, 2025- 107.6 lbs. A review of a Registered Dietitian (RD) progress note dated October 16, 2025, documented Resident 2 triggered for significant weight gain and weight loss. The note indicated the resident's weights had fluctuated, food and fluid intake was variable, and the resident had a history of weight fluctuations. No dietary changes were recommended at that time. A review of an RD progress note dated October 31, 2025, documented Resident 2 continued to trigger for significant weight loss and that weights continued to fluctuate. No dietary changes were recommended at that time. A review of an RD progress note dated November 27, 2025, documented Resident 2 triggered for significant weight loss and that weights were stabilizing in the 113-pound range. Intake remained variable, and no dietary changes were recommended. A review of an RD progress note dated December 8, 2025, documented Resident 2 triggered for significant weight loss and was noted to have consistent good intake of meal trays. The note indicated the resident had C. difficile (Clostridioides difficile, a bacterial infection that can cause diarrhea and inflammation of the colon) and anticipated weight (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improvement as the infection resolved. The note further indicated the resident's prior weights had been variable and previously stabilized between 113 and 115 pounds. No dietary changes were recommended. A clinical record review at the time of the survey revealed no active physician orders for routine or increased weight monitoring for Resident 2. Following surveyor inquiry, a new physician order dated December 18, 2025, was placed for weekly weights. On December 18, 2025, Resident 2 was weighed at 105.6 pounds, reflecting a 15.4-pound weight loss, representing a 12.7 percent loss of body weight since September 23, 2025. An interview with the Registered Dietitian on December 18, 2025, at 10:40 AM, revealed he did not recommend nutritional supplements due to concern they could worsen gastrointestinal symptoms, such as loose stools, related to the resident's ongoing C. difficile infection, which he indicated had been present since September 2025. A review of the clinical record revealed no documented evidence that the attending physician or the resident was notified of the resident's significant weight loss. Additionally, there was no documentation to why interventions were not recommended by the RD and that the lack of nutritional interventions was reviewed with or agreed upon by the attending physician. During an interview on December 18, 2025, at 12:45 PM, the above information was reviewed with the Director of Nursing. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services		