

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Delaware Valley Skilled Nursing & Rehabilitation C		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Rivers Edge Drive Matamoras, PA 18336	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on clinical record review, staff interview, and facility documentation, it was determined the facility failed to develop a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, mental, and psychosocial needs for one of 25 sampled residents (Resident 37), who expressed suicidal ideations.</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 37 was admitted to the facility on [DATE], with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities that interfere with daily functioning).</p> <p>A progress note dated April 2, 2025, at 11:45 a.m., documented that the resident expressed suicidal ideation, stating to a staff member that she wanted to kill herself. Following this, the resident was evaluated by the facility's social services department and placed on every 15-minute checks.</p> <p>However, a review of the resident's comprehensive care plan, in effect as of the survey ending May 1, 2025, revealed no evidence that the facility updated the plan of care to reflect the resident's expressed suicidal ideations or implemented new interventions to address the risk of self-harm. The care plan did not include the resident's psychosocial need related to mental health risk or outline strategies to monitor, support, and ensure the resident's safety.</p> <p>In an interview conducted on May 1, 2025, at 11:00 a.m., the Nursing Home Administrator confirmed the facility had not developed or updated a person-centered care plan to address the resident's suicidal ideation.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</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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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to review and revise the comprehensive care plan to reflect a significant change in condition related to weight loss for one of 16 residents sampled (Resident 2).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities that interfere with daily functioning).</p> <p>A review of the resident's documented weights revealed the following:</p> <p>On November 4, 2024, Resident 2 weighed 203.3 pounds.</p> <p>On December 4, 2024, the resident weighed 189.5 pounds, which represented a 6.8% loss of body weight in 30 days.</p> <p>A nutrition progress note dated December 6, 2024, indicated the registered dietitian (RD) assessed Resident 2 due to the identified weight loss and continued to recommend interventions. However, the resident's current care plan, which was originally developed on August 11, 2024, identified the resident as being at nutritional risk related to dementia and a mechanically altered diet, with interventions in place at that time.</p> <p>Upon review of the care plan during the survey conducted April 28 through May 1, 2025, there was no documented evidence the care plan had been reviewed or revised to reflect the resident's significant weight loss identified in December 2024. There were no new interventions added or existing interventions updated to reflect the change in nutritional status or to address the resident's ongoing weight trends.</p> <p>An interview was conducted with the Nursing Home Administrator on May 1, 2025, at 2:30 PM. The Administrator confirmed the facility failed to update Resident 2's care plan following the significant weight loss noted in December 2024 and acknowledged the resident's plan of care should have been reviewed and revised to reflect the change in condition and the resident's current needs.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306</p> <p>Based on a review of clinical records, facility policy, controlled drug shift count records, and staff interviews, it was determined the facility failed to implement procedures to ensure the timely acquisition and administration of a prescribed intravenous (IV) antibiotic for one of 16 sampled residents (Resident 34), and maintain accurate controlled drug shift count documentation on one of two medication carts reviewed, thereby failing to promote accountability and medication safety.</p> <p>Finding included:</p> <p>A review of a facility policy entitled Medication Availability last reviewed by the facility May 2024, indicated a procedure if a medication is not available the facility's procedure required staff to check the Cubex (is an automated medication dispensing machine system used for healthcare management that helps deter delayed medication administration and improve inventory management for healthcare facilities). If the prescribed medication was not available, staff were to contact the pharmacy for delivery status and request STAT (immediate) delivery and place a call into the satellite pharmacy (decentralized pharmacy program) and if the medication is unavailable notify the physician and obtain an order to hold until available or alternative medication is ordered, notify the RR (resident representative), and document outcomes in the nurses' notes.</p> <p>A clinical record review revealed Resident 34 was readmitted from the hospital to the facility on [DATE], at approximately 2:29 PM, with diagnosis that included, sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever) and UTI (urinary tract infection is a general term for infectious diseases in which bacteria enter the urethra, the passage through which urine passes, and propagate inside the body).</p> <p>Additionally, the resident returned to the facility with a PICC line (a peripherally inserted central catheter a long catheter introduced through a vein in the arm and passed through to the larger veins into the heart) for medication administration.</p> <p>A physician's order dated March 19, 2025, directed administration of Meropenem (antibiotic) 1 gram IV via PICC line every 12 hours for five days.</p> <p>A review of nurses' administration note dated March 19, 2025, at 9:28 PM, revealed that Meropenem was not available for administration to the resident.</p> <p>Further review of a nurses' administration note dated March 24, 2025, at 10:09 PM, revealed that Meropenem was not on unit for administration.</p> <p>Review of the Medication Administration Record (MAR) for March 2025 revealed missed doses of Meropenem on March 19, 2025, at 9:00 PM, and again on March 24, 2025, at 9:00 PM. Nursing notes documented that the medication was not available on both dates. The clinical record lacked documentation that the physician or resident representative was notified of the missed doses. As a result, the resident did not receive the full course of the prescribed antibiotic therapy.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Nursing Home Administrator (NHA) on May 1, 2025, at 10:30 AM, the NHA acknowledged the facility could not provide documentation confirming that the missed antibiotic doses were administered or that the physician had been notified. The NHA further confirmed the facility had backup pharmacy resources in place that should have been contacted to prevent a missed dose.</p> <p>A review of the facility policy titled Controlled Narcotic Sign-off Sheet, last reviewed in May 2024, indicated that Schedule II medications were to be counted and verified at each shift change by both oncoming and outgoing nurses, with signatures required on the shift count sheet to verify accuracy and completion.</p> <p>A review of the controlled medication shift change log for the 100-unit medication cart revealed missing signatures as follows:</p> <p>April 25, 2025: Third shift outgoing nurse failed to sign indicating the count was completed and accurate.</p> <p>April 26, 2025: Day shift oncoming nurse and outgoing nurse both failed to sign indicating the count was completed and accurate.</p> <p>An interview with Employee 1 Licensed Practical Nurse (LPN) on April 30,2025 at 8:35 AM confirmed the narcotic sheet was not signed off by the off going and oncoming nurses on the above dates.</p> <p>During an interview with Employee #1, Licensed Practical Nurse (LPN), on April 30, 2025, at 8:35 AM, it was confirmed that the shift count sheet had not been signed by the responsible nurses on the noted dates. In a separate interview conducted with the NHA on April 30, 2025, at 11:45 AM, the NHA confirmed that the facility failed to demonstrate consistent adherence to procedures for verifying and documenting controlled substance counts.</p> <p>28 Pa. Code 211.9 (f)(2) Pharmacy services</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.5(f)(x) Clinical records</p>		