STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record and select facility policy review and staff interview, it was determined that the facility failed to provide effective pain management and administer pain medication as prescribed by the physician and failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication as prescribed for two resident out of 15 residents reviewed (Resident 10 and Resident 2). Findings include: A review of the facility's policy entitled Pain Management Policy with a policy review date of May 13, 2025, indicated that the physician will order appropriate nonpharmacological and medical interventions to address the individual's pain. A clinical record review revealed Resident 10 was admitted to the facility on February17, 2025, with diagnoses that include Spina Bifida, (a neural tube (the embryonic structure that develops into the brain and the spinal cord that forms the central nervous system) defect that occurs when the fetus's spine does not close completely during early development causing symptoms of incontinence, loss of feeling and leg paralysis) and Major Depressive Disorder (A mental health condition characterized by persistent feelings of sadness, loss of interest in activities and various emotional and physical problems). A review of Resident 10's quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 22, 2026, revealed that Resident 10 is 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 13-15indicates cognition is intact) A review of Resident 10's clinical record revealed physician's order for the resident to receive Oxycodone HCL oral tablet 15 mg. (Oxycodone HCL) (Oxycodone is a Schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) was initiated on November 24, 2025, with instructions to administer one tablet every 8 hours as needed for chronic severe pain. A review of Resident 10's electronic Medication Administration Record (eMAR - is used to document medications taken by each resident) from December 2025 to March 2026, revealed that Oxycodone 15 mg was administered without any documented attempts of nonpharmacological interventions one hundred and sixty-six times throughout December 2025, and March 2026. An interview was conducted with the NHA (Nursing Home Administrator) on March 12, 2026, at 2:00 PM, to review the above findings related to the facility failure to assure that licensed nursing staff attempted non-pharmacological interventions prior to administering analgesic pain medication that included opioids. A review of Resident 2's clinical record revealed admission to the facility on December 16, 2025, with diagnoses that included peripheral vascular disease (PVD is a progressive disorder that restricts blood flow to the arms, legs, or other body parts and occurs when blood vessels narrow, become blocked, or spasm), type 2 diabetes (T2DM occurs when the body cannot use insulin correctly and sugar builds up in the blood and occurs due to the pancreas not make enough of a hormone called insulin that helps sugar enter the cells) with diabetic neuropathy (is a type of nerve damage that can happen with diabetes due to prolonged high blood sugar levels resulting in nerve damage throughout the body, but most often damages nerves in the legs and feet), new right below knee amputation (a BKA involves the surgical removal of the leg below the knee, often due to severe injury, infection, or poor blood flow, and requires a comprehensive rehabilitation process), and chronic (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain. The resident was cognitively intact. A review of the resident's plan of care-initiated December 17, 2025, indicated the resident had chronic pain related to neuropathy and post right BKA with desired outcome for the resident to experience adequate relief of pain or ability to cope with incompletely relieved pain. Interventions/tasks included providing the resident with non-pharmacological interventions to treat pain as indicated, monitor/record pain characteristics: Quality (e.g. sharp, burning); Severity (mild, moderate, severe scale); Anatomical location; Onset; Duration (e.g. continuous, intermittent); Aggravating factors; relieving factors. A review of physician's orders dated December 18, 2025, at 2:45 PM, revealed an order for oxycodone HCL (an opioid pain medication used to relieve moderate to severe pain), give one table by mouth every 8-hours as needed (PRN) for moderate pain. A review of Resident 2's Medication Administration Record (MAR, or eMAR for electronic versions, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional and is a part of a patient's permanent record on their medical chart and the health care professional signs off on the record at the time that the drug or device is administered) dated December 2025 and January 2026 revealed PRN oxycodone HCL ordered to manage moderate pain was administered on the following dates and times without documented attempted non-pharmacological interventions prior to administration of an opioid: December 30, 2025, at 2:16 PM, December 31, 2025, at 11:30 AM, and December 31, 2025, at 9:00 PM, January 1, 2026, at 6:30 AM, January 1, 2026, at 9:33 PM, January 2, 2026, at 7:30 PM, January 4, 2026, at 3:00 AM, January 4, 2026, at 11:11 AM, January 4, 2026, at 9:30 PM, January 5, 2026, at 3:31 AM, January 6, 2026, at 11:50 AM, January 8, 2026, at 2:14 PM, January 9, 2026, at 8:25 PM, January 10, 2026, at 6:28 PM, January 14, 2026, at 9:21 PM, January 15, 2026, at 9:35 AM, January 15, 2026, at 8:57 PM, January 16, 2026, at 3:15 PM, January 16, 2026, at 11:30 PM, January 17, 2026, at 11:31 AM, January 17, 2026, at 8:41 PM, January 18, 2026, at 11:22 AM, January 19, 2026, at 12:58 PM, January 20, 2026, at 4:06 PM, January 21, 2026, at 1:33 PM, January 21, 2026, at 9:37 PM, January 23, 2026, at 1:51 AM, January 23, 2026, at 2:24 PM, January 23, 2026, at 11:23 PM, January 24, 2026, at 2:00 PM, January 24, 2026, at, 10:00 PM, January 25, 2026, at 11:56 AM, January 25, 2026, at 8:51 PM, January 26, 2026, at 12:00 PM, January 27, 2026, at 1:37 PM, January 27, 2026, at 8:23 PM, January 28, 2026, at 2:00 PM, and January 29, 2026, at 11:38 AM. The facility failed to ensure licensed nursing staff attempted and recorded non-pharmacological interventions prior to the administration of an opioid pain medication, oxycodone HCL, to manage Resident 2's pain. During an interview with the facility's Nursing Home Administrator (NHA) on March 13, 2026, at 10:00 AM, the above information was reviewed and confirmed. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to ensure that nursing services met professional standards of quality as required by the Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to ensure Licensed Practical Nurses (LPNs) administering intravenous (IV) therapy via a peripherally inserted central catheter (PICC) possessed the required education, competency, and supervision for one of 15 residents reviewed (Resident 63).Findings include: A review of the Pennsylvania Code, Title 49, Chapter 21.145 (Functions of the Licensed Practical Nurse), revealed that an LPN must perform nursing functions based on appropriate knowledge, skill, and competency, and may administer IV therapy only after completing the required IV therapy education and training. The regulation further requires that IV therapy be performed under the direction and supervision of a licensed professional nurse (RN) or other authorized health care provider. The regulation specifies that LPNs may only perform IV-related functions, including medication administration and flushing of IV access devices, when they have demonstrated competency and received appropriate training. A review of facility policies titled Medication Administration Policy 5.09: Intravenous Administration of Fluids and Electrolytes and Medication Administration Policy 5.10: Administering Medications Through Primary and Secondary Administration Sets, last reviewed May 13, 2025, revealed that intravenous medications and fluids are to be administered by nurses who are knowledgeable and competent in infusion therapy. The policy further indicated the facility would follow the Nurse Practice Act to ensure compliance with RN and LPN scope of practice requirements. Clinical record review revealed that Resident 63 was admitted to the facility on [DATE], with diagnoses including sepsis, unspecified organism (a serious, life-threatening condition caused by the body's response to infection, which can lead to organ failure). A review of Resident 63's significant change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 1, 2026, revealed that Resident 63 was severely cognitively impaired with a BIMS score of 3 (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 0 through 7 indicates significant difficulties with memory, orientation, and thinking). A review of Resident 63 clinical record revealed a physician's order dated December 27, 2025 for Ceftriaxone Sodium 2000 milligrams to be administered intravenously once daily for five days via a PICC line (a peripherally inserted central catheter, which is a long, flexible tube inserted into a vein in the arm and advanced into a large central vein near the heart to allow for long-term IV medication administration). Additional physician orders dated December 27, 2025, directed that the PICC line be flushed with 10 milliliters (mL) of normal saline (a sterile saltwater solution used to maintain patency, meaning to keep the line open and prevent blockage) before and after medication administration and during each shift Review of the Electronic Medication Administration Record (eMAR) (technology that automatically documents the administration of medication into the medical record) revealed the following: On December 28, 2025, and December 31, 2025, Employee 3 Licensed Practical Nurse (LPN) documented the administration of the normal saline solution to Resident 63 through the PICC line on day shift. On December 28, 2025, Employee 4, LPN, documented administration of normal saline via the PICC line during the evening and night shifts. On December 29, 2025, and December 31, 2025, Employee 5, LPN, documented administration of normal saline via the PICC line during the evening shift. On December 30, 2025, Employee 6, LPN, documented administration of normal saline via the PICC line during the evening and night shifts. Despite documentation that multiple LPNs performed IV-related care through a PICC line, further review of personnel records and facility-provided documentation failed to demonstrate that Employees 3, 4, 5, and 6 completed the IV therapy education required under Pennsylvania Code S21.145(b). There was no evidence of documented competency (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	validation (confirmation that staff demonstrated the ability to safely perform a skill), no evidence of supervision by a registered nurse as required, and no evidence of facility-based training specific to PICC line management and IV medication administration. During an interview on March 13, 2026, at 9:50 AM the Nursing Home Administrator confirmed the facility could not provide documentation that the LPNs administering IV therapy via PICC lines had completed the required IV therapy education or demonstrated competency. The administrator further confirmed the facility did not maintain documentation verifying compliance with State Board of Nursing requirements for LPN IV therapy practice. 28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, facility policy, and staff interviews, it was determined that the facility failed to provide necessary care and services to ensure appropriate assessment and ongoing monitoring of a surgical wound in accordance with professional standards of practice for one of fifteen residents reviewed (Resident 2). Findings include: A review of the facility policy titled Skin Policy, last reviewed May 13, 2025, indicated that upon admission, licensed nursing staff complete a head-to-toe skin assessment and document all findings in the nursing clinical assessment. The policy indicated staff document all skin impairments and wounds in the Skin Assessment Section of the admission Screener and on the skin assessment forms, to include measurements (length, width, and depth, including tunneling or undermining, which refers to channels or areas of tissue destruction under the skin), and a detailed description of the wound bed (the visible tissue within the wound), including the presence of drainage (fluid coming from the wound), slough (dead tissue that appears yellow or white and may delay healing), eschar (dead tissue that appears black or brown and is typically dry and firm), odor, and pain. The policy further indicated that staff document all findings in the clinical record. The policy also indicated licensed nursing staff complete weekly skin assessments and document findings on the appropriate skin and wound assessment tool. A review of the clinical record revealed Resident 2 was admitted on [DATE], with diagnoses including peripheral vascular disease (a condition that reduces blood flow to the limbs), type 2 diabetes mellitus (a condition where the body cannot properly regulate blood sugar), diabetic neuropathy (nerve damage caused by prolonged high blood sugar, often affecting the feet), and a recent right below-knee amputation (surgical removal of the leg below the knee). A review of the admission assessment dated [DATE], at 4:49 PM, completed by Employee 1, Registered Nurse (RN), identified multiple pressure injuries to the resident's coccyx and other skin impairments left lower leg, left heel and groin. A nursing progress note completed by Employee 2 RN, dated December 16, 2025, at 6:53 PM, noted Resident 2 had an incision site to the stump with 26 staples on admission. A review of physician's orders dated December 16, 2025, directed licensed nursing staff to provide wound care (cleanse the right lower leg-stump with normal saline solution, pat dry, apply dressing, wrap with Kling and ace bandage to help reduce swelling, keep incision clean and dry) to the surgical site and to monitor and document the condition of the wound every shift, including the wound bed (the visible tissue within the wound), drainage (fluid from the wound), odor, surrounding skin, and any signs of infection. However, review of the clinical record from December 18, 2025, through February 6, 2026, revealed repeated documentation by licensed nursing staff indicating the surgical wound had not been evaluated. The facility failed to provide documented evidence that staff assessed and monitored the wound as ordered by the physician and required by professional standards of practice. Further review of the clinical record revealed a wound assessment completed by the facility's contracted wound care certified registered nurse practitioner (CRNP) dated January 6, 2026, at 9:28 PM. The assessment indicated Resident 2 had a surgical wound to the right below-knee amputation stump. The wound was identified as full thickness (involving all layers of the skin) and measured 0.1 centimeters in length, 17.0 centimeters in width, and 0.1 centimeters in depth, with a calculated area of 1.7 square centimeters. The wound bed (the visible tissue within the wound) consisted of 100 percent epithelial tissue (new skin-forming tissue), with stapled edges and intact surrounding skin. The assessment noted a light amount of sanguineous drainage (thin, red fluid primarily composed of blood), no odor after cleansing, and minimal pain reported by the resident. A review of a vascular surgeon follow-up dated January 7, 2026, at 8:30 AM indicated the surgical incision showed signs of necrosis (death of tissue due to lack of blood supply) and dehiscence (partial or complete reopening of a surgical wound) following removal of staples. The wound was cleansed and redressed, and new physician orders were issued for daily wound care and ongoing monitoring for signs of infection, worsening necrosis, or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further dehiscence, with instructions to transfer the resident to the emergency room if these conditions occurred. A follow-up evaluation was scheduled in one week. Despite these findings and physician orders, the clinical record continued to lack evidence that licensed nursing staff performed or documented routine assessments of the wound. A vascular consultation dated January 27, 2026, indicated delayed wound healing and noted the potential need for surgical debridement (removal of dead tissue to promote healing). On February 6, 2026, Resident 2 was transferred to the hospital due to poor wound healing and dehiscence. The resident required surgical debridement and placement of a wound vacuum device (a treatment that uses suction to promote wound healing). Resident 2's clinical record dated January 7, 2026, through February 6, 2026, revealed licensed nursing staff continued to repeatedly document skin issue had not been evaluated, located right below knee amputation site, issue type surgical wound present on admission. During an interview on March 12, 2026, at 10:45 AM the Director of Nursing and the facility's contracted wound care certified registered nurse practitioner confirmed that licensed nursing staff were responsible for monitoring and documenting the condition of Resident 2's surgical wound. Review of information provided by the contracted wound care provider included a photograph dated January 13, 2026, which showed blackened tissue (necrosis, or death of tissue due to lack of blood supply) along the surgical incision with surrounding redness, indicating deterioration of the wound. The facility provided evidence that licensed nursing staff completed wound treatments to the right below-knee amputation site as ordered. However, the facility failed to provide documented evidence that staff completed a comprehensive assessment of the surgical site upon admission or that staff monitored and documented the condition of the wound as ordered by the physician, including changes in the wound's appearance as it declined. During an interview on March 13, 2026, at 9:30 AM the above findings were reviewed with the Nursing Home Administrator. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f)(ix) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
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 policy, a review of clinical records, and staff interviews, it was determined the facility failed to monitor resident weights consistently and accurately to timely identify changes in nutritional parameters and implement nutritional interventions for one resident out of 15 residents reviewed (Resident 47).Findings include: A review of a facility policy entitled Resident Heights and Weight Policy last reviewed by the facility May13, 2025, indicated residents will be weighed upon admission to facility and on day two after admission. After the second day weight, all newly admitted residents will be weighed weekly for four weeks and then on a monthly basis unless otherwise specified. The resident weights will be recorded in the electronic medical record. Reweighs will be obtained for any residents whose weight fluctuates by plus or minus five pounds (lbs.) for those over 100 lbs. and plus or minus three pounds for those weighing less than 100 pounds. The licensed nurse will notify the Director of Nursing or designee, Physician, and Registered Dietitian of significant weight changes of 5 percent loss or gain in one month, or a 7.5 percent loss or gain in 3 months, or a 10 percent loss of gain in 6 months. The resident's representative will be notified of significant weight loss and any recommendations from the resident's provider and registered dietitian. The registered dietitian will notify the charge nurse of any significant weight changes and follow up with documentation in the resident's medical record. Clinical record review revealed Resident 47 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (a condition involving progressive decline in memory and thinking due to multiple causes), displaced intertrochanteric fracture of the left femur (a break in the upper portion of the thigh bone near the hip). A review of Resident 47's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 12, 2026, revealed Resident 47 was severely cognitively impaired with a BIMS score of 99 (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 99 indicates the resident was unable to complete the interview) was not on a therapeutic diet, and was able to feed self after set up. A review of Resident 47's comprehensive care plan, initiated June 17, 2025, identified the resident at risk for nutritional decline related to dementia, fracture of the femur, hypothyroidism (a condition in which the thyroid gland does not produce enough hormones, which can slow metabolism), and anemia (a condition in which the body lacks enough healthy red blood cells to carry adequate oxygen). The care plan identified the desired outcome that the resident would maintain adequate nutritional status, as evidenced by stable weight without significant weight changes. The care plan directed staff to monitor, record, and report to the physician signs and symptoms of malnutrition (a condition resulting from inadequate intake of nutrients necessary for health), including emaciation (extreme thinness due to loss of body fat and muscle), muscle wasting (loss of muscle mass and strength), and weight loss parameters of three pounds in one week, greater than five percent in one month, greater than 7.5 percent in three months, and greater than 10 percent in six months. Additional interventions included providing the diet as ordered and requiring the Registered Dietitian (RD, a licensed nutrition professional) to evaluate the resident and make dietary recommendations as needed. A nutritional assessment completed by the Registered Dietitian on July 24, 2025, documented the resident weighed 146.2 lbs. with a Body Mass Index (BMI, a calculation using height and weight to estimate body fat and assess weight status) in the overweight range. Despite this, the resident was identified as at risk for malnutrition due to underlying diagnoses and required continued monitoring. The record did not contain documented evidence that the physician or resident representative was notified of this risk. A review of a nutritional assessment completed by the facility's Registered Dietitian (RD) dated July 24, 2025, revealed the resident was ordered a regular diet with regular texture and thin liquids (standard food consistency and liquids that do not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	require thickening for swallowing safety), along with Prosource (a concentrated oral liquid protein supplement used to increase protein intake) twice daily and Ensure (a commercially prepared oral nutritional supplement used to provide additional calories and nutrients) twice daily. The RD documented the resident's height as 64 inches and weight as 146.2 pounds and calculated estimated daily nutritional needs of approximately 1700 calories (a measure of energy required by the body to maintain weight and bodily functions), 72 grams of protein (a nutrient necessary for tissue repair and maintenance), and 1700 milliliters of fluids (a measure of daily hydration needs), with staff instructed to encourage fluid intake. The assessment further documented the resident's Body Mass Index (BMI, a calculation based on height and weight used to screen for weight categories and potential health risks) was in the overweight range. Despite this classification, the RD identified the resident as at risk for malnutrition (a condition resulting from inadequate intake or utilization of nutrients necessary for health) due to underlying diagnoses and documented fair meal intake, with continued monitoring planned. The clinical record did not contain documented evidence that the physician or Resident 47's responsible party was notified of the identified nutritional risk or the interventions initiated. A review of the weight record revealed the following: On September 2, 2025, at 11:19 AM, the resident weighed 146.4 lbs. On October 8, 2025, at 2:30 PM, the resident weighed 139.4 lbs., reflecting a 4.7 percent weight loss. The facility did not obtain a reweight as required by policy. On October 23, 2025, at 12:47 PM (two weeks after previous weight), the resident weighed 120.2 lbs., reflecting a significant weight loss. The weight record revealed that on October 23, 2025, the resident's weight was 120.2 pounds, reflecting a loss of 19.2 pounds (approximately 13.8 percent) from the October 8, 2025, weight of 139.4 pounds, which met the facility's definition of significant weight loss. The facility did not obtain a reweight as required by policy to verify the accuracy of this significant change. No weight was documented for the month of November 2025. The next recorded weight was obtained on December 2, 2025, at 130.6 pounds. Due to the absence of a November weight and lack of required reweights, the clinical record did not demonstrate that the facility ensured the accuracy of the recorded weights or consistently monitored the resident's weight trends. A review of facility-provided documentation reports revealed significant gaps in meal and fluid intake documentation: September 2025: Breakfast intake was not documented for 17 of 30 days, and breakfast fluid intake was not documented for 18 of 30 days. Lunch intake and fluid intake were each not documented for 20 of 30 days. Dinner intake and fluid intake were not documented for 3 of 30 days. October 2025: Breakfast intake and fluid intake were not documented for 11 of 31 days. Lunch intake and fluid intake were not documented for 12 of 31 days. Dinner intake and fluid intake were not documented for 4 of 31 days. The clinical record did not contain evidence that the Registered Dietitian identified and addressed the significant weight loss between October 8, 2025, and October 23, 2025. A dietary note dated October 31, 2025, at 12:08 AM, eight days later, documented a change to feeding assistance to promote PO intake (PO, meaning by mouth). There was no documented evidence that the physician or resident representative was notified of the significant weight loss or intervention changes. The record did not demonstrate timely development or implementation of additional nutritional interventions following identification of significant weight loss. During an interview on March 13, 2026, at 10:45 AM, the above findings were reviewed with the Nursing Home Administrator. At that time, the facility did not provide additional documentation demonstrating consistent meals or fluid intake monitoring, timely weight monitoring, or reweights as required by facility policy for Resident 47. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to implement procedures to maintain accurate records of controlled drugs and ensure accurate drug administration for one of 15 residents reviewed (Resident 10). Findings include: A review of the facility policy titled Controlled Substances, last reviewed March 13, 2025, revealed the facility will comply with all applicable laws, regulations, and requirements related to the handling, storage, disposal, and documentation of Schedule II and other controlled medications (Schedule II controlled medications are drugs regulated by the federal government that have accepted medical use but a high potential for abuse and dependence, requiring strict tracking and accountability). A clinical record review revealed Resident 10 was admitted to the facility on February17, 2025, with diagnoses that include Spina Bifida, (a birth defect in which the spinal column does not close completely, which may result in paralysis, loss of sensation, and incontinence) and Major Depressive Disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest in activities and various emotional and physical problems). A review of the clinical record revealed a physician's order for Resident 10 to receive Oxycodone HCL oral tablet 15 mg (Schedule II opiate narcotic medication) was initiated on November 24, 2025, with instructions to administer one tablet every 8 hours as needed for chronic severe pain. A review of facility clinical records revealed the facility utilizes a Controlled Drug Receipt/Record/ Disposition Form to track, monitor, and reconcile each controlled medication. Review of facility documentation indicated the facility utilized a Controlled Drug Receipt/Record/Disposition Form to track, monitor, and reconcile controlled medications. The facility utilized a Medication Administration Record (MAR), which is a legal document used to record medications administered to a resident, including the date, time, medication, dose, administering staff, and clinical rationale. A comparison of Resident 10's Controlled Drug Receipt/Record/Disposition Form with the MAR from December 2025 through March 2026 revealed discrepancies between the two systems used to track controlled medications: Twelve entries were documented on the Controlled Drug Receipt/Record/Disposition Form indicating Oxycodone HCL 15 milligrams was removed or utilized; however, there was no corresponding documentation on the MAR to indicate the medication was administered to Resident 10 on the following dates and times: January 14, 2026, at 5:30 PMJanuary 15, 2026, at 5:30 PMJanuary 27, 2026, at 5:00 AMJanuary 28, 2026, at 5:00 PMFebruary 7, 2026, at 5:30 AMFebruary 8 ,2026, at 6:30 AMFebruary 13, 2026, at 5:00 PMFebruary 14, 2026, at 6:00 AMFebruary 16, 2026, at 7:00 AMFebruary 18, 2026, at 5:15 PMMarch 8, 2026, at 6:00 PMMarch 8, 2026, at 5:45 AM One entry was documented on the MAR indicating Oxycodone HCL 15 milligrams was administered on March 7, 2026, at 6:03 PM; however, there was no corresponding documentation on the Controlled Drug Receipt/Record/Disposition Form to indicate the medication was removed or accounted for. These discrepancies demonstrated that the facility failed to ensure that controlled medication records were consistently reconciled and accurately reflected administration and disposition of a Schedule II controlled substance. An interview was conducted on March 12, 2026, at 2:00 PM with the Director of Nursing. The above findings related to discrepancies between the Controlled Drug Receipt/Record/Disposition Form and the MAR for Resident 10's controlled medication were reviewed. 28 Pa Code 211.5(f)(xi) Medical records. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa Code 211.10 Resident care policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and staff interview, it was determined the facility failed to ensure that psychotropic (medications that affect mood, behavior, or mental processes) medications were used in accordance with regulatory requirements by failing to implement and document non-pharmacological interventions and failing to ensure appropriate duration and rationale for as-needed (PRN) psychotropic medication orders for two of 15 residents reviewed (Residents 6 and 63).Findings include: A review of the policy entitled, Behavioral Assessment, Intervention, and Monitoring last reviewed May 13, 2025, indicated the facility will provide and residents will receive behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy statement indicated that the facility would adhere to regulatory requirements related to the use of medications to manage behavioral changes. Federal requirements for the use of psychotropic medications expect that these medications are used only when necessary to treat a specific, documented condition. These requirements further expect that individualized non-pharmacological interventions (approaches that do not involve medications, such as environmental adjustments, redirection, or comfort measures) are implemented and evaluated for effectiveness prior to the administration of as-needed (PRN) psychotropic medications, unless clinically contraindicated (not appropriate due to a medical reason). Additionally, these requirements limit PRN psychotropic medication orders to 14 days unless the prescriber documents a clinical rationale for continued use and specifies the duration of the extended order in the medical record. A review of Resident 63's clinical record revealed Resident 63 was admitted to the facility on [DATE], with diagnoses including sepsis, unspecified organism sepsis (a serious, body-wide infection that can lead to organ failure). A review of Resident 63's significant change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 1, 2026, revealed that Resident 63 was severely cognitively impaired with a BIMS score of 3 (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 0 through 7 indicates significant difficulties with memory, orientation, and thinking).A review of Resident 63's clinical record revealed a physician order dated December 26, 2025, for Ambien (drug used to help one fall and stay asleep) 5 milligrams (mg) every 24 hours, at bedtime as needed (PRN) for sleep. A review of Resident 63's electronic medication administration record (eMAR technology that automatically documents the administration of medication into the medical record) revealed the medication was administered on January 27, 2026, at 8:20 PM, February 25, 2026, at 7:31 PM, and February 27, 2026, at 8:53 PM. The record lacked documentation that non-pharmacological interventions were attempted prior to each administration.A review of Resident 63's clinical record revealed an order dated February 24, 2026, for Lorazepam (medication used to treat anxiety by producing a calming effect) 0.5mg every 12 hours as needed for anxiety. Review of the March 2026 eMAR indicated the medication was administered on March 1, 2026, at 11:30 PM, March 3, 2026, at 4:29 PM, and March 9, 2026, at 1:24 PM. The record lacked documentation that non-pharmacological interventions were attempted prior to each administration.Review of the February 24, 2026, Lorazepam order failed to identify a documented clinical rationale or specified duration extending the order beyond 14 days. The clinical record confirmed Resident 63 received the medication beyond the 14-day limit without required prescriber documentation of the justification for its use. A review of the clinical record revealed Resident 6 was admitted on [DATE], with diagnoses including gastrostomy (a surgically created opening into the stomach for nutrition or medication administration) and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior, often including hallucinations or delusions). A review of Resident 6's quarterly Minimum Data Set assessment dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], revealed that Resident 6 was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates intact cognition). A review of Resident 6's clinical record revealed a physician order dated January 3, 2026, for Lorazepam 1mg, apply topically (placed on the skin) every six hours as needed for agitation (a state of restlessness or emotional distress) and hallucinations (seeing or hearing things that are not present). Review of the January 2026 eMAR indicated the medication was administered to Resident 6 on January 9, 2026, at 1:32 AM, January 12, 2026, at 1:58 AM, January 14, 2026, at 8:39 PM, and January 21, 2026, at 1:32 PM. Review of the February 2026 eMAR indicated administration on February 7, 2026, at 10:06 PM, February 8, 2026, at 1:22 PM, February 10, 2026, at 4:18 PM, and February 13, 2026, at 10:48 PM. The record lacked documentation of non-pharmacological interventions prior to each administration. Review of Resident 6's January 3, 2026, physician order failed to identify a documented clinical rationale or specified duration extending the order beyond 14 days (after January 17, 2026). The clinical record confirmed the medication continued to be administered beyond the 14-day limit without required prescriber documentation or justification for its use.An interview was conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on March 12, 2026, at 1:30 PM to review the above findings related to the administration of as-needed psychotropic medications without documented non-pharmacological interventions and the continuation of these medications beyond 14 days. During a separate interview with the Nursing Home Administrator (NHA) on March 13, 2026, at 9:40 AM, the facility did not provide documentation demonstrating that non-pharmacological interventions were implemented prior to the administration of as-needed psychotropic medications or documentation supporting a prescriber rationale and specified duration for continuation of these medications beyond 14 days. 28 Pa. Code 211.2(d)(3)(5) Medical Director. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy and clinical record review, observation, and staff interview, it was determined that the facility failed to implement Enhanced Barrier Precautions (EBP) to prevent the spread of infection for one of 15 residents reviewed (Resident 3).Findings include: According to the Centers for Disease Control and Prevention (CDC) (2024), Enhanced Barrier Precautions are measures to reduce the spread of multi-drug-resistant organisms (MDRO) (bacteria that are resistant to multiple antibiotics and are difficult to treat) in nursing homes. Enhanced Barrier Precautions require gown and glove use during resident care activities that have been demonstrated to result in transfer of MDROs to the hands and clothing of healthcare personnel. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The CDC (2024) identifies residents who are considered at a higher risk of acquiring an MDRO and further explains that residents with chronic wounds are among those at higher risk. The CDC (2024) further elaborates regarding higher risk categories by providing examples of residents at higher risk including those with chronic wounds. Review of the facility policy entitled, Infection Control Program-Enhanced Barrier Precautions, last reviewed May 13, 2025, revealed that Enhanced Barrier Precautions were to be used with any high-risk resident such as residents with a wound or indwelling device. According to the policy, Enhanced Barrier Precautions are indicated during high contact care activities including during wound care, providing hygiene, and changing briefs and linens. EBP includes the use protective gowns and gloves during high-risk activities and is intended to remain in place for the entire duration of the resident's stay, devices are removed, or wounds heal. Clinical record review revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses that included orthopedic aftercare for surgical amputation (specialized care and rehabilitation provided to patients who have undergone surgical procedures, including surgical removal of a limb). A review of Resident 3's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 12, 2026, revealed that Resident 3 was severely cognitively impaired with a BIMS score of 3 (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 7 through 3 indicates significant difficulties with memory, orientation, and thinking). Clinical record review of a document entitled Wound Assessment Report revealed Resident 3 had six chronic, arterial wounds (open skin areas caused by reduced blood flow leading to tissue damage and delayed healing) located on the left lateral foot, left foot, great toe, left heel, right lateral foot, right metatarsophalangeal joints (the joint area between the toes and the foot), right lower leg, and Achilles region. On March 10, 2026, at 1:45 PM, observation of Resident 3 in the resident room revealed no evidence that Enhanced Barrier Precautions were implemented. Protective gowns and gloves were not readily available for staff use upon entry to the room for high-contact care activities, including wound care. Clinical record review failed to identify a physician order for Enhanced Barrier Precautions. The resident's comprehensive care plan did not include Enhanced Barrier Precautions as an intervention to address the resident's multiple chronic wounds and increased risk for transmission of infection. An interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on March 11, 2026, at 1:45 PM. The above information was reviewed at that time. The facility did not demonstrate that Enhanced Barrier Precautions were implemented for Resident 3. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of employee personnel records, review of facility policies and procedures, and staff interviews, it was determined the facility failed to develop, implement, and maintain an effective training program to ensure licensed nursing staff possessed the knowledge and competencies necessary to safely manage a peripherally inserted central catheter (PICC line) for 1 resident (Resident 63) of 15 residents reviewed.Findings include:Federal regulation requires that a facility develop, implement, and maintain an effective training program for all new and existing staff. The facility must use the facility assessment, which is an evaluation the facility conducts to identify the resident population served to determine the amount and types of training necessary to ensure staff competencies meet the needs of the residents as identified in their care plans and the facility assessment. A review of the facility policies entitled Medication Administration. Policy 5.09 Intravenous Administration of Fluids and Electrolytes and Medication Administration. Policy 5.10, Administering Medications Through Primary and Secondary Administration Sets last reviewed May 13, 2025, reveals intravenous fluids, electrolytes, and medications will be administered by nurses knowledgeable and competent in infusion therapy to ensure proper assessment and monitoring. The general guideline of the policies indicates the facility will verify with the Nurse Practice Act regarding RN/LPN scope of practice for intravenous therapy. Clinical record review revealed Resident 63 was admitted on [DATE], with diagnoses including sepsis (a serious infection that can spread throughout the body and lead to organ failure). A review of Resident 63's significant change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 1, 2026, revealed that Resident 63 was severely cognitively impaired with a BIMS score of 3 (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 0 through 7 indicates significant difficulties with memory, orientation, and thinking). Resident 63 returned from the hospital with a Peripherally Inserted Central Catheter (PICC) line in the right upper arm. A PICC line is a long, flexible tube inserted through a vein in the arm and advanced into the larger veins near the heart. It allows medications, such as intravenous antibiotics, to be delivered directly into the bloodstream for extended periods. A review of physician orders dated December 27, 2025, required administration of Ceftriaxone Sodium (an intravenous antibiotic used to treat serious bacterial infections) daily for five days through the PICC line. The orders also required the PICC line to be flushed with 10 milliliters (mL) of normal saline (a sterile saltwater solution used to keep the catheter open and prevent blockage) before and after medication administration and during each shift. A review of Resident 63's December 2025 electronic Medication Administration Record (eMAR, serves as the legal record used to document medications administered) revealed the antibiotic was documented as administered four times, and normal saline flushes were documented 14 times through the PICC line by licensed nursing staff.Further review of the eMAR revealed the following licensed nurses documented accessing the PICC line to administer normal saline flushes:On December 28, 2025, and December 31, 2025, Employee 3 Licensed Practical Nurse (LPN) documented administering a normal saline flush through the PICC line.On December 28, 2025, Employee 4 LPN documented administering a normal saline flush through the PICC line. One December 29, 2025, and December 31, 2025, Employee 5 LPN documented administering a normal saline flush through the PICC line.On December 30, 2025, Employee 6 LPN documented administering a normal saline flush through the PICC line.Review of personnel records revealed the following:Employee 3, LPN, hired April 9, 2021, with most recent annual education dated April 9, 2025, had no documented education, training, or competency validation related to PICC line management.Employee 4, LPN, hired November 7, 2023, with most recent annual education dated May (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Skilled Nursing & Rehabilitation C	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)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2, 2025, had no documented education, training, or competency validation related to PICC line management.Employee 5, LPN, hired October 5, 2022, with most recent annual education dated November 11, 2025, had no documented education, training, or competency validation related to PICC line management.Employee 6, LPN, hired September 19, 2024, with most recent annual education dated October 30, 2025, had no documented education, training, or competency validation related to PICC line management.There was no evidence that the facility provided a structured training program, competency validation (a process used to confirm a staff member can safely and correctly perform a task), or ongoing education specific to PICC line care for licensed nursing staff. During an interview on March 13, 2026, at 9:50 AM, the surveyor requested documentation from the Nursing Home Administrator demonstrating education and competency validation for licensed nursing staff providing care to residents with PICC lines. The Nursing Home Administrator confirmed the facility could not provide evidence of such training or competency validation and confirmed the facility had not developed or implemented a training program specific to PICC line management. Pennsylvania State Board of Nursing regulations (Title 49, Chapter 21) require Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) performing intravenous therapy, which includes administration of medications and care involving PICC lines, to complete a board-approved education program, receive supervised clinical instruction, and undergo ongoing competency assessments. LPNs may perform only those intravenous therapy functions for which they have documented knowledge, skills, and abilities under appropriate supervision.The facility failed to develop, implement, and maintain an effective training program based on its facility assessment to ensure licensed nursing staff possessed the knowledge and competencies necessary to safely provide care to residents requiring PICC line management.Cross refer F 65828 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.