

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>MID-VALLEY HEALTH CARE CENTER</b>  STATE LICENSE NUMBER: <b>027502</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>63 STURGES ROAD PECKVILLE, PA 18452</b>
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F 0000	INITIAL COMMENT	F 0000		
F 0699 SS=D	<p>Based on a revisit survey completed on January 2, 2025, it was determined that Mid Valley Health Care Center failed to correct the deficiencies cited during the survey of October 18, 2024, and continued to be out of compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities, and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.</p>	F 0699		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0699  SS=D	Continued from page 1  483.25(m) Trauma Informed Care  §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.  This REQUIREMENT is not met as evidenced by:	F 0699	Step 1 Resident #2 was reevaluated by in-house Psych provider to accurately assess appropriateness of PTSD Diagnosis. In-house Psych Provider has provided a more appropriate diagnosis for Resident, plan of care has been updated to include same. Step 2 To identify others with the likelihood to be affected, all Residents identified with a current PTSD diagnosis were evaluated for appropriateness of diagnosis by in-house Psych provider, the DON/designee will audit care plans to ensure that the cause of trauma and triggers are identified with personalized interventions implemented to manage same or have diagnosis removed and plan of care updated if PTSD diagnosis was found to be inaccurate. Step 3 To prevent a future reoccurrence, DON/designee will educate the Interdisciplinary Team that Residents identified to have a PTSD	Completion Date: <b>01/08/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0699  SS=D	Continued from page 2	F 0699	<p>diagnosis will have their plan of care updated with the cause of trauma and potential triggers, with personalized interventions implemented.</p> <p>To prevent a future reoccurrence, the DON/designee will educate the Interdisciplinary Team that if a PTSD diagnosis is identified with no known trauma or triggers identified, the in-house Psych Provider will be consulted to evaluate the appropriateness of the diagnosis, providing documentation to support or refute PTSD diagnosis.</p> <p>Step 4 To monitor and maintain ongoing compliance the Social Worker/designee will audit all new admissions or any Resident obtaining a new diagnosis of PTSD to ensure, accuracy of the diagnosis and their plan of care contains the identified trauma and potential triggers with personalized interventions implemented to manage PTSD weekly x 4 and then monthly x 2. Results of audits will be forwarded to Facility QAPI</p>	

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F 0699  SS=D	Continued from page 3	F 0699	committee for further review and provide any necessary recommendations as needed.	

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F 0699  SS=D	Continued from page 4  Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized, person-centered plan of care to provide trauma-informed care for a resident with a diagnosis of Post-Traumatic Stress Disorder (PTSD), for one out of 6 residents reviewed (Resident 2).  Findings include:  A review of Resident 2's clinical record revealed the resident was admitted to the facility on August 11, 2022, with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that is often characterized by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event).  On January 2, 2025, the resident's current care plan was reviewed. It was determined the care plan did not address the resident's PTSD diagnosis.	F 0699		

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F 0699  SS=D	Continued from page 5  Specifically: There were no documented symptoms or identified triggers related to PTSD. The care plan lacked resident-specific interventions aimed at minimizing triggers and prevent re-traumatization.  An interview with the Director of Social Services on January 2, 2025, at 10:00 AM, confirmed the facility failed to demonstrate the provision of culturally competent, trauma-informed care. The facility did not adhere to professional standards of practice to address Resident 2's experiences and preferences to mitigate triggers and promote emotional safety.  28 Pa Code 211.12 (d)(3)(5) Nursing services.	F 0699		
F 0755  SS=D		F 0755		

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F 0755  SS=D	Continued from page 6  483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-  §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.  §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and  §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Step 1 Resident #1 had a head-to-toe assessment completed upon discovery of medication error, no adverse effects were identified, and MD/RP notification was completed. Step 2 To identify other Residents with the likelihood to be affected, the DON/Designee will audit Declining Count Narcotic logs of all controlled substances for the past 14 days to ensure all medications were administered and documented in the Emar logs as per physician orders, any medication found to be administered in error, will have a Medication Error event report completed with proper MD/RP notification. Step 3 To prevent a future recurrence, the DON/Designee will educate all licensed nurses on the 5 Rights of medication administration, including the proper procedure to follow if a change in direction sticker is present on a medication card or narcotic log. Step 4	Completion Date: <b>01/08/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0755  SS=D	Continued from page 7  This REQUIREMENT is not met as evidenced by:	F 0755	To monitor and maintain ongoing compliance, the DON/Designee will complete a Medication Pass competency on 5 Random licensed nurses weekly x 4 and then monthly x 2. To monitor and maintain ongoing compliance the NHA/Designee will interview 3 Random licensed nurses on proper procedure to follow during medication pass, if a change in direction sticker is present on a medication card or narcotic log, weekly x 4 and then monthly x2. To monitor and maintain ongoing compliance, the DON/designee will audit all Declining Count Narcotic logs to ensure the medication was documented in the Emar and on the log as per physician orders, 3x/week x 4 weeks, and then weekly x 8 weeks. Results of audits will be forwarded to Facility QAPI committee for further review and provide any necessary recommendations as needed.	

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F 0755  SS=D	Continued from page 8  Based on review of clinical records and controlled drug records, and staff interview, it was determined the facility failed to implement to ensure accurate accounting and administration of controlled medications and failed to properly document and account for the administration of a controlled substance for one resident of six sampled residents (Resident 1).  Finding include:  A review of Resident 1's clinical record revealed he was admitted to the facility on November 11, 2024, with diagnoses that included cervical spondylosis (is a general term for age-related wear and tear affecting the spinal disks in the neck and as the disks dehydrate and shrink, signs of osteoarthritis develop, including bony projections along the edges of bones resulting in bone spurs), history of falls, and transient ischemic attacks (is a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain).	F 0755		

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F 0755  SS=D	<p>Continued from page 9</p> <p>A review of the clinical record revealed Resident 1 revealed on December 12, 2024, a physician's order was received and verified by Employee 1, LPN, for Percocet (oxycodone-acetaminophen, narcotic medication) 5-325 mg, ½ tablet by mouth once daily at bedtime.</p> <p>A review of the controlled substance record (a controlled drug/medication is drug which has been declared by federal or state law to be illegal for sale or use but may be dispensed under a physician's prescription. The basis for control and regulation is the danger of addiction, abuse, physical and mental harm including death, the trafficking by illegal means, and the dangers from actions of those who have used the substance) accounting for the above narcotic medication indicated that on December 25, 2024, at 4:00 AM, Employee 2, RN (registered nurse), signed out a dose of Percocet (5-325 mg, ½ tablet) for Resident 1.</p> <p>However, a review of Resident 1's MAR for December 2024 revealed that Employee 2 failed to</p>	F 0755		

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F 0755  SS=D	<p>Continued from page 10</p> <p>document the administration of Percocet at 4:00 AM on December 25, 2024, as required.</p> <p>A review of a facility provided safety event report for a medication error completed by Employee 3, RN/former DON (director of nursing), dated December 26, 2024, at 2:25 PM, revealed that Employee 2, RN, administered the prescribed Percocet 5-325 mg at 4:00 AM on December 25, 2024, outside the prescribed bedtime schedule.</p> <p>The report further indicated that Employee 2 mistakenly administered the medication under the assumption it was a PRN (as needed) order, unaware the PRN order had been discontinued on December 12, 2024. Immediate interventions included a head-to-toe assessment of Resident 1, notification of the attending physician, and notification of the resident's responsible party (RP). No adverse drug reactions were noted.</p> <p>During an interview on January 2, 2025, at 10:25 AM, Employee 3 confirmed that Employee 2 failed</p>	F 0755		

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F 0755  SS=D	Continued from page 11  to ensure the narcotic medication was administered as prescribed and failed to record the administration accurately in the MAR (medication administration record). Employee 3 also verified that Employee 2 did not recognize the PRN Percocet order had been discontinued, leading to the medication error.  The facility failed to ensure adherence to procedures and protocols for the accurate administration and documentation of controlled substances. This practice compromised the integrity of the controlled medication records and increased the risk of medication errors.  28 Pa Code 211.5 (f)(x) Medical records.  28 Pa Code 211.12 (d)(1)(3)(5) Nursing services  28 Pa Code 211.9(a)(1)(k) Pharmacy services	F 0755		

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F 0757  SS=D	Continued from page 13  483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.  This REQUIREMENT is not met as evidenced by:	F 0757	Step 1 Resident #3 completed antibiotic course for UTI, appearing to suffer no ill effects prior to survey. Step 2 To identify others with the likelihood to be affected, the DON/designee will complete an audit of the Residents currently ordered antibiotic treatment to ensure McGeer's criteria was followed, any Residents identified to not meet McGeer's criteria will have documentation evaluated to ensure justification from the Clinician addresses specific reasoning for continued use of antibiotic therapy. Step 3 To prevent a future reoccurrence the DON/designee will educate all licensed nurses in the facility and Clinicians on McGeer's criteria, to ensure antibiotic initiations meet McGeer's criteria, and if the order does not meet McGeer's criteria that the Clinician was notified, and proper justification was provided from the Clinician indicating specific reasoning for same.	Completion Date: <b>01/08/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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F 0757  SS=D	Continued from page 14	F 0757	<p>Step 4 To monitor and maintain ongoing compliance, the DON/designee will audit all new antibiotic initiations to ensure new orders meet McGeer's criteria, or if the order does not meet McGeer's criteria a justification statement was provided from the Clinician regarding the specific reasoning of continued use of the antibiotic therapy, 3x/week x 4 weeks and then weekly x 8. Results of audits will be forwarded to Facility QAPI committee for further review and provide any necessary recommendations as needed.</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0757  SS=D	Continued from page 15  Based on clinical record and staff interview, it was determined the facility failed to assure the presence of documented evidence of clinical necessity for administration of an antibiotic resulting in the use of an unnecessary drug for one resident out of six sampled residents (Resident #3).  Findings included:  A review of Resident 3's clinical record revealed that the resident was admitted to the facility on April 19, 2024, with diagnoses that included dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities and the symptoms may interfere with individual's daily lives), dysphagia (difficulty swallowing), and history of UTI (urinary tract infection - is an infection in any part of the urinary system).  A review of a facility documentation entitled "Infection Control - Infection Tracker with McGeer's Criteria 2024 assessment (an algorithm that uses criteria to make an empiric diagnosis of	F 0757		

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F 0757  SS=D	<p>Continued from page 16</p> <p>UTI in nursing home residents. For resident's that do not have an indwelling urinary catheter and with at least three of the following signs and symptoms must be present prior to a practitioner prescribing antibiotic therapy include a fever (temperature of at least 38°C [100.4°F]), new or increased frequency, urgency, or burning on urination, new flank or suprapubic pain or tenderness, change in character of urine, and worsening of mental or functional status) form was completed by Employee 3, RN/former DON, dated December 12, 2024, at 10:40 AM, revealed that the form was initiated due to a suspected UTI.</p> <p>Resident #3 did not meet McGeer's criteria for initiating antibiotic therapy, as the resident exhibited only one symptom of dysuria (difficult urination) and no systemic additional urinary symptoms.</p> <p>A review of a physician's practitioner evaluation completed by Employee 4, certified registered nurse practitioner (CRNP for Resident 3's attending physician) dated December 20, 2024, at 12:20 PM,</p>	F 0757		

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F 0757  SS=D	Continued from page 17  revealed Resident #3 complained of urinary frequency. No other symptoms consistent with a UTI, such as burning, hematuria, fever, suprapubic pain, or mental status changes, were noted. A urinalysis and culture (culture and sensitivity - a urine culture is considered positive if it shows the presence of more than 100,000 colony-forming units (CFUs) of bacteria per milliliter of urine and indicates the presence of an infection), increase oral fluids, and to call if symptoms worsen or do not improve, was ordered.  Results dated December 26, 2024, revealed a urine culture showing 50,000-100,000 CFU/mL of Escherichia coli (bacteria from the intestines is present in fecal matter and trace amounts of fecal matter make their way into the urinary tract through the urethra opening and begin to multiply) which does not meet the threshold (?100,000 CFU/mL) for diagnosing a UTI per evidence-based guidelines. No other symptoms or indications of a UTI were documented in the clinical record.	F 0757		

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F 0757  SS=D	<p>Continued from page 18</p> <p>Asymptomatic bacteriuria (the presence of bacteria in the urine without symptoms) is generally not treated with antibiotics in most residents, especially in older adults in long-term care, unless there are specific exceptions (e.g., residents with indwelling catheters showing systemic symptoms or those undergoing urological procedures). Urine frequency does not meet criteria with absence of systemic or local symptoms (e.g., fever, pain, urgency).</p> <p>Documentation dated December 26, 2024, at 4:35 PM, indicated that new orders were obtained from Employee 4, CRNP, for Cipro (an antibiotic) 250 mg orally twice per day for five days due to UTI. Despite the absence of sufficient clinical indicators for a UTI, Resident #3 was prescribed and administered Cipro 250 mg twice daily for five days, completing all ten doses by December 2024.</p> <p>Documentation by Employee #3 on December 27, 2024, noted concerns which were relayed to the CRNP, about the appropriateness of the antibiotic therapy and reiterated the importance of adherence</p>	F 0757		

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F 0757  SS=D	<p>Continued from page 19</p> <p>to McGeer's criteria and the facility's antibiotic stewardship program. However, Employee #4 confirmed the decision by the CRNP to continue Cipro, citing the resident's urinary frequency and positive urine culture as justification.</p> <p>Also, Employee 3 noted in a nursing progress note dated December 27, 2024, at 12:06 PM, further communication received from Employee 4, CRNP, that the antibiotic, Cipro, that was ordered was to be continue "due to patient's symptoms and positive urinalysis with positive urine culture the patient was placed on Cipro and was continue this treatment until complete."</p> <p>Resident #3's clinical record lacked evidence of sufficient symptomology to justify the administration of Cipro under the facility's infection surveillance protocols. The resident received ten doses of an unnecessary antibiotic.</p> <p>In an interview conducted on January 2, 2025, at 9:35 AM, Employee #3 confirmed that Resident</p>	F 0757		

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F 0757  SS=D	Continued from page 20  #3's medication regimen included an unnecessary antibiotic (Cipro) due to the lack of adherence to McGeer's criteria and absence of documented justification for its use.  However, Resident 3's clinical record failed to reflect documented evidence of symptomology associated with a UTI to meet the facility's algorithm (McGeer's Criteria) to justify the use of an antibiotic.  28 Pa. Code 211.2 (3)(5) Medical Director  28 Pa. Code 211.9 (k) Pharmacy Services  28 Pa. Code 211.12 (d)(1)(3) Nursing Services  28 Pa. Code 211.5 (f)(ix) Medical records	F 0757		

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P 5520		P 5520		

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

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P 5520	Continued from page 1  Nursing services.  (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.  This REGULATION is not met as evidenced by:	P 5520	PA 5520 Step 1. The facility cannot retroactively provide the minimum number of Nurse Aide hours for cited dates. Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated Nurse Aide ratio hours. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios.  Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of Nurse Aide for the facility. Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum Nurse Aide hours needed for the facility. Audits will be completed 3x/week weekly x 4 and	Completion Date: <b>01/08/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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P 5520	Continued from page 2	P 5520	then monthly x 2. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.		

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P 5520	<p>Continued from page 3</p> <p>Based on review of nursing time schedules and the resident census and staff interviews, it was determined the facility failed to provide a minimum of one nurse aide (NA) per 10 residents during the day shift, 1 nurse aide per 11 residents during the evening shift and one nurse aide per 15 residents during the night shift, for thirteen shifts out of 42 shifts reviewed (November 24, 2024, through November 30, 2024, and December 25, 2024, through December 31, 2024).</p> <p>Findings include:</p> <p>The facility census on November 24, 2024, was 36 residents, which required 3.60 nurse aides during the day shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the</p>	P 5520		

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P 5520	<p>Continued from page 4</p> <p>evening shift on November 24, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on November 25, 2024, was 35 residents, which required 3.50 nurse aides during the evening shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the evening shift on November 25, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on November 25, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.</p>	P 5520		

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P 5520	Continued from page 5  A review of the nursing time schedules revealed only 2.0 nurse aides worked the night shift on November 10, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  The facility census on November 26, 2024, was 35 residents, which required 3.18 nurse aides during the evening shift.  A review of the nursing time schedules revealed only 3.13 nurse aides worked the evening shift on November 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 6  The facility census on November 26, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.  A review of the nursing time schedules revealed only 2.13 nurse aides worked the night shift on November 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  The facility census on November 27, 2024, was 33 residents, which required 2.20 nurse aides during the night shift.  A review of the nursing time schedules revealed only 2.13 nurse aides worked the night shift on November 27, 2024.  No additional excess higher-level staff	P 5520		

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P 5520	<p>Continued from page 7</p> <p>were available to compensate this deficiency.</p> <p>The facility census on November 28, 2024, was 33 residents, which required 3.30 nurse aides during the day shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the evening shift on November 28, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on November 28, 2024, was 33 residents, which required 2.20 nurse aides during the night shift.</p> <p>A review of the nursing time schedules revealed only 2.00 nurse aides worked the</p>	P 5520		

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P 5520	<p>Continued from page 8</p> <p>night shift on November 28, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 25, 2024, was 35 residents, which required 3.50 nurse aides during the day shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the evening shift on December 25, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 25, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.</p>	P 5520		

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P 5520	Continued from page 9  A review of the nursing time schedules revealed only 2.25 nurse aides worked the night shift on December 25, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  The facility census on December 26, 2024, was 35 residents, which required 3.18 nurse aides during the evening shift.  A review of the nursing time schedules revealed only 2.50 nurse aides worked the evening shift on December 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 10  The facility census on December 26, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.  A review of the nursing time schedules revealed only 2.13 nurse aides worked the night shift on December 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  The facility census on December 27, 2024, was 35 residents, which required 3.18 nurse aides during the evening shift.  A review of the nursing time schedules revealed only 3.00 nurse aides worked the evening shift on December 27, 2024.  No additional excess higher-level staff	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MID-VALLEY HEALTH CARE CENTER</b>  STATE LICENSE NUMBER: <b>027502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>63 STURGES ROAD PECKVILLE, PA 18452</b>		
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P 5520	<p>Continued from page 11</p> <p>were available to compensate this deficiency.</p> <p>The facility census on December 28, 2024, was 35 residents, which required 3.50 nurse aides during the day shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the evening shift on December 28, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 28, 2024, was 35 residents, which required 3.18 nurse aides during the evening shift.</p> <p>A review of the nursing time schedules revealed only 3.00 nurse aides worked the</p>	P 5520		

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P 5520	<p>Continued from page 12</p> <p>evening shift on December 28, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 29, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.</p> <p>A review of the nursing time schedules revealed only 2.13 nurse aides worked the night shift on December 29, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 30, 2024, was 35 residents, which required 3.18 nurse aides during the evening shift.</p>	P 5520		

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P 5520	Continued from page 13  A review of the nursing time schedules revealed only 3.06 nurse aides worked the evening shift on December 30, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  The facility census on December 30, 2024, was 35 residents, which required 2.33 nurse aides during the night shift.  A review of the nursing time schedules revealed only 2.02 nurse aides worked the night shift on December 30, 2024.  No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	<p>Continued from page 14</p> <p>The facility census on December 31, 2024, was 35 residents, which required 3.50 nurse aides during the day shift.</p> <p>A review of the nursing time schedules revealed only 3.0 nurse aides worked the evening shift on December 31, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>The facility census on December 31, 2024, was 36 residents, which required 3.27 nurse aides during the evening shift.</p> <p>A review of the nursing time schedules revealed only 3.00 nurse aides worked the evening shift on December 31, 2024.</p> <p>No additional excess higher-level staff</p>	P 5520		

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P 5520	Continued from page 15  were available to compensate this deficiency.  The facility census on December 31, 2024, was 36 residents, which required 2.40 nurse aides during the night shift.  A review of the nursing time schedules revealed only 2.13 nurse aides worked the night shift on December 31, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  An interview with the Nursing Home Administrator (NHA) on January 2, 2025, at 10:45 AM, confirmed the facility failed to provide a minimum nurse aide staffing ratios on the above shifts.	P 5520		

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P 5530	<p>Nursing services.</p> <p>(4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5530	<p>Step 1. The facility cannot retroactively provide the minimum number of LPN hours for cited dates.</p> <p>Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated LPN ratio hours. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios.</p> <p>Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of LPNs for the facility.</p> <p>Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum needed for the facility. Audits will be completed 3x/week weekly x 4 and then monthly x 2. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.</p>	<p>Completion Date: <b>01/08/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>01/08/2025</b></p>

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P 5530	Continued from page 17  Based on review of nursing time schedules and staff interviews, it was determined the facility failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift and failed to provide a minimum of one LPN per 30 residents during the evening shift and failed to provide a minimum of one LPN per 40 residents during the night shift on five out of 42 shifts reviewed (November 24, 2024, through November 30, 2024, and December 25, 2024, through December 31, 2024).  Findings include:  A review of facility census data indicated that on November 24, 2024, the facility census was 36, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed 0.5 LPNs worked on the night shift on November 24, 2024.  No additional excess higher-level staff were	P 5530		

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P 5530	<p>Continued from page 18</p> <p>available to compensate this deficiency.</p> <p>A review of facility census data indicated that on November 25, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 25, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>A review of facility census data indicated that on November 26, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 26, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p>	P 5530		

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P 5530	Continued from page 19  A review of facility census data indicated that on November 27, 2024, the facility census was 33, which required 1.10 LPNs on the evening shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on November 27, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on November 27, 2024, the facility census was 33, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 27, 2024.  No additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 20  A review of facility census data indicated that on November 28, 2024, the facility census was 33, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 28, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on November 29, 2024, the facility census was 33, which required 1.32 LPNs on the day shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the day shift on November 29, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on	P 5530		

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P 5530	Continued from page 21  November 29, 2024, the facility census was 33, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 29, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on November 30, 2024, the facility census was 33, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on November 30, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 25, 2024, the facility census was 35,	P 5530		

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P 5530	<p>Continued from page 22</p> <p>which required 1.17 LPNs on the evening shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on December 25, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>A review of facility census data indicated that on December 25, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 25, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>A review of facility census data indicated that on December 26, 2024, the facility census was 35, which required 1.17 LPNs on the evening shift.</p>	P 5530		

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P 5530	Continued from page 23  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on December 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 26, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 26, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 27, 2024, the facility census was 35, which required 1.17 LPNs on the evening shift.	P 5530		

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P 5530	Continued from page 24  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on December 27, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 27, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 27, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 28, 2024, the facility census was 35, which required 1.40 LPNs on the day shift.  A review of the nursing time schedules, and time	P 5530		

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P 5530	Continued from page 25  punch documentation revealed 1.00 LPNs worked on the day shift on December 28, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 28, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 28, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 29, 2024, the facility census was 35, which required 1.40 LPNs on the day shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked	P 5530		

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P 5530	Continued from page 26  on the day shift on December 29, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 29, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 29, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 30, 2024, the facility census was 35, which required 1.40 LPNs on the day shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the day shift on December 30, 2024.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MID-VALLEY HEALTH CARE CENTER</b>  STATE LICENSE NUMBER: <b>027502</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>63 STURGES ROAD PECKVILLE, PA 18452</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	<p>Continued from page 27</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>A review of facility census data indicated that on December 30, 2024, the facility census was 35, which required 1.17 LPNs on the evening shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on December 30, 2024.</p> <p>No additional excess higher-level staff were available to compensate this deficiency.</p> <p>A review of facility census data indicated that on December 30, 2024, the facility census was 35, which required 1.0 LPNs on the night shift.</p> <p>A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 30, 2024.</p>	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5530	Continued from page 28  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 31, 2024, the facility census was 35, which required 1.40 LPNs on the day shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the day shift on December 31, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  A review of facility census data indicated that on December 31, 2024, the facility census was 36, which required 1.20 LPNs on the evening shift.  A review of the nursing time schedules, and time punch documentation revealed 1.00 LPNs worked on the evening shift on December 31, 2024.  No additional excess higher-level staff were	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5530	Continued from page 29  available to compensate this deficiency.  A review of facility census data indicated that on December 31, 2024, the facility census was 36, which required 1.0 LPNs on the night shift.  A review of the nursing time schedules, and time punch documentation revealed zero (0) LPNs worked on the night shift on December 31, 2024.  No additional excess higher-level staff were available to compensate this deficiency.  An interview with the Nursing Home Administrator (NHA) on January 2, 2025, at 10:33 PM, confirmed that the facility did not meet the state minimum nursing ratios for LPNs required.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5640	Continued from page 30  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	Step 1. The facility cannot retroactively provide the minimum number of general nursing care hours for cited dates. Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated general nursing hours of 3.20 hours of general nursing care to each resident. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios.  Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of direct care nursing hours per resident. Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds	Completion Date: <b>01/08/2025</b> Status: <b>APPROVED</b> Date: <b>01/08/2025</b>

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P 5640	Continued from page 31	P 5640	the minimum of 3.20 hours needed for the facility. Audits will be completed 3x/week weekly x 4 and then monthly x 2. The results of the audits will be forwarded to the facility QAPI committee for further review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395644</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5640	Continued from page 32  Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily.  Findings include:  A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.20 hours of general nursing care to each resident:  December 31, 2024 - 2.92 direct care nursing hours per resident  The facility's general nursing hours were below minimum required levels on the above date.  An interview with the Nursing Home Administrator (NHA) on January 2, 2025, at 11:00 AM, confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640			



# Certified End Page

**MID-VALLEY HEALTH CARE CENTER**

**STATE LICENSE NUMBER: 027502**

**SURVEY EXIT DATE: 01/02/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

Handwritten signature of Jeanne Parisi in black ink.

*Jeanne Parisi*  
Deputy Secretary for Quality Assurance

Handwritten signature of Debra L. Bogen MD in black ink.

*Debra L. Bogen, MD, FAAP*  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY