

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2024
NAME OF PROVIDER OR SUPPLIER  Valley Manor Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7650 Route 309 Coopersburg, PA 18036	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>36935</p> <p>Based on clinical record review and facility policy review, it was determined that the facility failed to prevent resident to resident physical abuse by one resident (Resident 1) to ensure that each resident was free from abuse, for two of six sampled residents (Resident 2, 6). In addition, it was determined that the facility failed to report resident to resident abuse to the State Licensing Agency, Division of Nursing Care Facilities.</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Abuse, Neglect, Exploitation, Mistreatment of Resident/Patient, or Misappropriation of Resident/Patient Property, last reviewed September 2023, revealed the facility had designated and implemented processes, which strived to ensure the prevention and reporting of suspected, or alleged, abuse. The designated shift supervisor was responsible for immediate initiation of the reporting process and the Administrator, Director of Nursing, and Risk Manager were ultimately responsible for investigating and reporting abuse to the State Licensing Agency.</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included dementia with behavioral disturbance, anxiety, and depression. Review of nursing documentation and the care plan revealed that the resident had a history of behavioral disturbances, including yelling, screaming, and cursing at other residents and staff, and pushing others. Interventions included to refer to the psychiatrist/psychologist, as needed. On February 29, 2024, the psychiatrist noted that Resident 1 continued with agitated and aggressive behavior and at times he would yell at other residents and staff, slam his fists into walls/desks, and would occasionally pick up heavy furniture. The psychiatrist indicated that with his impaired judgement, Resident 1's behaviors were a safety concern to other residents, staff, and himself, and close nursing supervision was recommended. Nursing documentation, dated March 8, 2024, noted that Resident 1 was in the dayroom pushing Resident 6 against the soda machines. Staff had to stand between the two residents due to Resident 1 putting his fists up to hit Resident 6. There was no documented evidence that this incident was reported by the shift supervisor or investigated by the Administrator, Director of Nursing, or Risk Manager until March 19, 2024.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of nursing documentation and a facility incident report, dated March 14, 2024, revealed that Resident 1 was in the activity room with other residents for a baking activity. Resident 1 was observed and heard yelling at other residents and knocked over a table and chairs. As he was leaving the room, Resident 2 said the F word and Resident 1 pushed Resident 2 causing him to fall to the ground. Resident 2 stated, He hit me. There was no documented evidence that this incident was reported to the State Licensing Agency.</p> <p>In an interview with the Administrator and Director of Nursing on March 19, 2024, at 1:20 p.m., they confirmed that there was no documented evidence that the March 8, 2024, incident was reported by the shift supervisor and that the March 14, 2024, incident was reported to the State Licensing Agency.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		