

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 07/25/2024
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>45244</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain an effective pest control program in one of three nursing units. (North)</p> <p>Findings include:</p> <p>Observations on the North unit on July 25, 2024, at 10:42 a.m., revealed flies in the hallway, and in rooms 304, 308, 405, and 407. Observations again on July 25, 2024, at 11:38 a.m., revealed flies in the hallway, and in rooms 303, 304, 308, 405, and 407.</p> <p>In an interview on July 25, 2024, at 12:40 p.m., the Administrator confirmed there were flies on the North unit.</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1)Management.</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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