

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  08/28/2024
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 14599</p> <p>Based on clinical record review, policy review, review of facility documentation, observation, and staff interviews, it was determined that the facility failed to provide necessary supervision to monitor a resident's whereabouts and prevent an elopement (unauthorized departure from the facility) by one of 16 sampled residents at risk for elopement. (Resident 1) This failure resulted in an Immediate Jeopardy situation. The incident has been identified as past non-compliance.</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Elopement, last reviewed on September 28, 2023, revealed that staff was to monitor residents' whereabouts who were at risk for unsafe wandering and elopement.</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included dementia (impaired cognition, or a disease that causes progressive cognitive impairment that includes memory loss and personality changes), depressed mood, anxiety, and difficulty walking. According to the Minimum Data Set assessment (a periodic evaluation of resident care needs), dated May 21, 2024, the resident was cognitively impaired and could walk without assistance. According to the comprehensive care plan, the facility identified that the resident was at risk for elopement since admission to the facility, and that he liked to walk around the facility. An elopement risk evaluation, dated June 3, 2024, identified that the resident was at high risk for elopement.</p> <p>On August 25, 2024, a nurse noted that at approximately 7:00 a.m., the nurse aide assigned to Resident 1 notified her that she could not locate the resident when she came to work. The nurse noted that at 8:30 a.m., a staff member saw the resident while driving to the facility and returned him to the facility. According to the facility investigation into the incident, the resident was last seen at approximately 5:00 a.m. wandering about the facility. He was located approximately 5.5 miles away and had been missing for over three hours until he was returned by the staff member in their car. The investigation indicated that the resident had walked across a four-lane highway and on unlit rural roads before being found.</p> <p>In a interview on August 28, 2024, at 9:00 a.m., the Administrator stated that the resident pushed open the front door of the facility, and that staff failed to respond to the alarm to see if a resident was attempting to leave the facility. As a result, the resident was able to leave the facility unattended.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On August 28, 2024, at 11:37 a.m., the Administrator was notified that the failure to provide adequate supervision to prevent elopement constituted an Immediate Jeopardy situation at F689-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required.</p> <p>The facility identified the jeopardy at the time of the incident, August 25, 2024, at 8:35 a.m., and implemented the following corrective action plan:</p> <ol style="list-style-type: none"> <li>1. Resident 1 was to receive constant direct supervision by staff at all times.</li> <li>2. The facility conducted an immediate head count of all residents in the facility to ensure that facility accounted for all residents.</li> <li>3. All safety devices were checked to ensure they were in place, including electronic devices applied to residents to prevent doors from opening (Wanderguard).</li> <li>4. All doors were checked by maintenance and were found to be in good working order. Additionally, the vendor for the alarm system also immediately checked all alarms in the building for proper function.</li> <li>5. The facility educated all staff in the facility on the facility's procedure for finding a missing resident and conducted elopement drills on each shift. Staff was also educated to immediately respond to any door alarms.</li> <li>6. The facility audited all residents' records to ensure their elopement risk assessments were current and accurately reflected resident risk.</li> <li>7. The facility trained all staff that they should visually check on their resident at minimum at the start and end of each shift, during meals, during care, and more often if required by the plan of care.</li> <li>8. The facility scheduled a staff member to be present at the front door at all times.</li> <li>9. All staff members were required to be trained on this plan before being permitted back to work.</li> </ol> <p>On August 28, 2024, a review was conducted to verify the complete implementation of the facility corrective action plan. Licensed employees RN 1, LPN 1, LPN 2, and LPN 3, non-licensed employees NA 1, NA 2, NA 3, and NA 4, activity staff E 1, housekeeper E 2, and receptionist E 3, were all interviewed regarding education provided. All staff interviewed confirmed that they received the training described in the facility action plan. All nursing staff were aware of the requirements for supervising residents who were at risk for elopement. All facility doors and safety devices (Wanderguards) were checked and were functioning properly. Resident 1 was observed walking throughout the facility under direct supervision by a staff member assigned to him. All sampled resident were being supervised by staff when needed.</p> <p>(continued on next page)</p>		

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