| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395167 | A. Building<br>B. Wing | 05/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Valley Manor Rehabilitation and Healthcare Center | 7650 Route 309<br>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) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review it was determined that the facility failed to develop and/or implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for one of three sampled residents. (Resident 1)<br><br>Findings include:<br><br>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (an irregular heart rhythm) and an infection in the skin. According to the Minimum Data Set assessment, dated April 18, 2025, the resident was dependent on staff for care, had multiple wounds, and had heart disease. On April 21, 2025, a nurse practioner noted that the resident has prior surgeries including the placement of an internal cardioverter/defibrillator (a device that administers a shock to correct certain abnormal rhythms). There was no documentation that the facility included interventions on the plan of care to monitor and care for this device.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. |

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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