STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395167	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor Rehabilitation and Healthcare Center	7650 Route 309 Coopersburg, PA 18036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to maintain resident environment and equipment in a sanitary and homelike manner on four of six nursing units. (Nursing unit 200, 400, 500, and 600) Findings include: Observation on February 24, 2026, from 10:05 a.m. to 2:20 p.m., and February 25, 2026, from 9:15 a.m. to 12:15 p.m., revealed the following: There was a block of floor tiles missing at the entrance to the main kitchen. The refrigerator in the nourishment room behind the nursing station of the central 200 nursing unit revealed that the shelves in the refrigerator were splattered with juice stains. In resident room [ROOM NUMBER], the over the toilet handrails in the bathroom were very loose and not sturdy. The shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] had black spots on the floor. The privacy curtain between beds in room [ROOM NUMBER] had a large stain. In room [ROOM NUMBER], the screws holding the window curtain rod in the wall were coming out and the curtain rod was partially hanging from wall. In room [ROOM NUMBER] next to bed B, there were yellow spots on the floor at the foot of bed, brown stains on the bottom of the tube feeding pole, the bedside nightstand had two drawers off track and on the ground beside the bed, and the dresser had two broken drawers. In room [ROOM NUMBER], the bathroom floor had dark brown spots with a dirty urine collection container on the floor. The room had unpainted spackle on the wall under the window and next to the sink. There were black marks on the ceiling at the entrance to the room. In room [ROOM NUMBER] the walls in resident room were marred and scratched near the window. In the 400-unit bathing suite, there were stains on two ceiling tiles, the bathtub had a brown and yellow substance near the drain, and the water was running continuously from the faucet. There was a hole in the wall between the tub and shower room. In the toilet room, the soap dispenser by the sink was empty and there were stains on the doorway privacy curtain. In the shower room, the privacy (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	curtain on one stall did not cover the opening fully and the second shower stall did not have a privacy curtain on it. The wall in the hallway between rooms [ROOM NUMBERS], had two holes and was marred. In room [ROOM NUMBER] bed B, there were stained ceiling tiles above the resident's bed. In room [ROOM NUMBER] bed A, there were brown stains at the base of the tube feeding pole. In an interview on February 26, 2026, at 10:35 a.m. the Administrator confirmed the environmental issues were present. CFR 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment. Previously cited 3/6/25 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide treatment and services as ordered by the physician to promote healing and prevent new pressure sores for two of three sampled residents who had pressure sores. (Resident 4, 10) Findings include: Clinical record review revealed that Resident 4 had diagnoses that included early onset of Alzheimer's disease. A review of a skin assessment dated [DATE], revealed that the resident had a pressure sore on her right buttock and a scar on her coccyx. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident required substantial assistance with overall care and that she had two pressure sores. A review of the care plan revealed that the resident had an actual wound on her right buttock and sacral slit. There was an intervention for staff to provide treatments as ordered by the physician. Review of a physician's order dated February 19, 2026, directed staff cleanse the sacral slit with soap and water and apply a cream for wound healing (Triad Paste) every day and evening shift. Review of the Treatment Administration Record (TAR) for February 2026, revealed that there was no documented evidence the treatment was completed on the day shift (7:00 a.m. to 3:00 p.m.) February 20 and 21, 2026, and on the evening shift (3:00 p.m. to 11:00 p.m.) February 22, 2026. Clinical record review revealed that Resident 10 had diagnoses that included a sacral pressure ulcer and diabetes. A review of a wound care note dated February 19, 2026, revealed that the resident had a pressure sore on the sacrum. The MDS assessment dated [DATE], indicated that the resident was dependent on staff for all care and had two pressure sores. A review of the care plan revealed that the resident had an actual wound on the bottom of the sacrum. There was an intervention for staff to provide treatments as ordered by the physician. Review of a physician's order dated January 29, 2026, directed staff to cleanse the sacrum with an antiseptic cleansing solution and apply a collagen dressing and a calcium alginate foam dressing every day and evening shift and as needed. Review of the TAR for February 2026, revealed that there was no documented evidence the treatment was completed on the day shift (7:00 a.m. to 3:00 p.m.) February 2, 5, 7, and 12, 2026, and on the evening shift (3:00 p.m. to 11:00 p.m.) February 2, 13, and 21, 2026. In an interview on February 26, 2026, at 9:32 a.m., and 12:53 p.m., the Director of Nursing stated that there was no documented evidence that the treatments had been completed to the wounds on the shifts listed above as ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for five of 33 sampled residents. (Residents 1, 66, 78, 86, and 118) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included hypotension (low blood pressure). A physician's order dated March 11, 2024, directed staff to administer a medication (midodrine) three times a day for hypotension. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 120 millimeters of mercury (mm/Hg). Review of Resident 1's January 2026 and February 2026 medication administration records (MARs) revealed that staff administered the medication 19 times in January and 10 times in February when the resident's SBP was greater than 120 mm/Hg. Clinical record review revealed that Resident 66 had diagnoses that included seizure disorder and traumatic subdural hemorrhage (a collection of blood between the brain and the outer covering due to ruptured veins from a head injury). Review of Resident 66's February 2026 MAR revealed that the resident received a medication for seizure disorder (levetiracetam) twice a day. A physician's order dated February 7, 2026, directed staff to obtain a lab test to check the blood level of levetiracetam. There was no documented evidence that the test was completed. Clinical record review revealed that Resident 78 had diagnoses that included hypertension (high blood pressure). A physician's order dated August 15, 2023, directed staff to administer a medication (amlodipine besylate) one time a day for hypertension. Staff were not to administer the medication if the resident's SBP was less than 110 mm/Hg. Review of Resident 78's January 2026 and February 2026 MARs revealed that staff administered the medication four times in January and three times in February when the resident's SBP was less than 110 mm/Hg. Clinical record review revealed that Resident 118 had diagnoses that included hypotension. A physician's order dated December 14, 2024, directed staff to administer a medication (midodrine) three times a day for hypotension. Staff were to administer the medication if the resident's systolic blood pressure SBP was less than 100 mm/Hg. Review of Resident 118's January 2026 and February 2026 MARs revealed that staff administered the medication 60 times in January and 30 times in February when the resident's SBP was greater than 100 mm/Hg. Clinical record review revealed that Resident 86 had diagnoses that included constipation and dementia. A physician's order dated August 12, 2024, directed staff to administer 30 milliliters of Milk of Magnesia (MOM) every 24 hours as needed and /or if no bowel movement in three days. A physician's order dated August 12, 2024, directed staff to administer a bisacodyl suppository rectally if there were no results from the MOM. A physician's order dated August 12, 2024, further directed staff to insert an enema if there were no results from the bisacodyl suppository. A physician's order dated May 30, 2023, directed staff to administer Dulcolax one tablet by mouth every 24 hours as needed for constipation. Review of bowel movement tracking documentation for Resident 43 revealed that there were no bowel movements recorded from February 17, 2026, at 2:07 p.m., through February 24, 2026, at 2:58 p.m. Review of the MAR for February 2026, revealed that the resident was not provided with any as needed medications for constipation until a Dulcolax tablet was provided at 2:58 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. on February 24, 2026, seven days after the last documented bowel movement. In interviews on February 26, 2026, at 10:17 a.m., 11:44 a.m., and 12:56 p.m., the Director of Nursing confirmed that the medications were administered outside established parameters for Residents 1,78, and 118, that the lab test for Resident 66 was not obtained and should have been, and that none of the as needed medications for constipation were administered for Resident 86, and should have been before seven days with no documented bowel movement. CFR 483.25 Quality of CarePreviously cited 3/6/25, 5/15/25 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to assess residents with a diagnosis of post-traumatic stress disorder (PTSD) and develop and implement an individualized person-centered care plan to render trauma informed care for three of five sampled residents diagnosed with PTSD. (Residents 4,16 and 77) Findings include: Clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD), schizoaffective disorder and early onset of Alzheimer's disease. The Minimum Data (MDS) assessment dated [DATE], indicated that the resident had some memory impairment and had a diagnosis of PTSD. There was no documentation to support that the resident was assessed for symptoms or triggers related to the diagnosis of PTSD. The care plan for Resident 4 did not include any measures to address the resident's history of trauma or identify triggers. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. Clinical record review revealed that Resident 16 was admitted to the facility on [DATE], with diagnoses that included PTSD and anxiety. The MDS assessment dated [DATE], revealed that the resident was cognitively intact and had a diagnosis of PTSD. There was no documentation to support that the resident was assessed for symptoms or triggers related to the diagnosis of PTSD. Resident 16's care plan did not include any measure to address the resident's history of trauma or identify triggers. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. Clinical record review revealed that Resident 77 was admitted to the facility on [DATE], with diagnoses that included PTSD and major depressive disorder. Review of the MDS assessment dated [DATE], revealed that the resident was cognitively intact and had a diagnosis of PTSD. On February 1, 2026, the nurse documented that the resident had previously reported that he suffers from bad PTSD from the Vietnam war, which gave him anxiety and triggered recurring episodes of vomiting. On February 2, 2026, the Nurse Practitioner documented that the resident was seen for follow up regarding nausea, vomiting, and PTSD. On February 20, 2026, the provider documented that the resident was evaluated for worsening cognitive and emotional symptoms, including increased difficulty with focus and concentration, escalating anxiety, and persistent insomnia. There was no documentation to support that symptoms or triggers were assessed related to the diagnosis of PTSD. Resident 77's care plan did not include any measure to address the resident's history of trauma or identify triggers. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization on the care plan. In an interview on February 26, 2026, at 9:32 a.m., the Director of Nursing confirmed that Residents 4, 16, and 77 were not assessed or care planned for PTSD. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on facility policy review, observation, and staff interview, it was determined that the facility failed to maintain accurate reconciliation records for controlled substances on one of seven medication carts. (400 Unit medication cart)Findings include:Review of the facility policy entitled, Controlled Medication Storage, last reviewed January 22, 2026, revealed that at shift change, a physical inventory of all controlled medications was to be conducted by two licensed nurses and documented on the individual resident's controlled medication accountability record. In an interview on February 26, 2026, at 1:30 p.m., the Director of Nursing stated that the nurse coming on duty and nurse going off duty were to count all controlled substances and other medications with the risk of abuse or diversion at the change of each shift and document on a Shift Count sheet that the count on the resident accountability card was accurate. The nurse coming on duty was responsible for the cart. This shift-to-shift count was to be completed at the same time by both nurses. Following shift to shift count, both nurses were to sign the Shift Count sheet. Any discrepancies of the controlled substances were to be immediately reported to the Director of Nursing.Observation of the medication cart on the 400 Unit, on February 26, 2026, at 8:15 a.m., revealed that the controlled substance log the facility used entitled, Shift Count, had missing signatures from licensed staff from the February 2026 log for various shifts. Review of the Shift Count log for the 400 Unit medication cart from January 5 through 24, 2026, and February 2 through 25, 2026, revealed the following number of missing licensed nursing signatures:Coming on duty at 7:00 a.m., 21 of 44 days reviewed.Coming on duty at 3:00 p.m., 28 of 44 days reviewed. Coming on duty at 11:00 p.m., 28 of 44 days reviewed. Going off duty at 7:00 a.m., 27 of 44 days reviewed.Going off duty at 3:00 p.m., 25 of 44 days reviewed.Going off duty at 11:00 p.m., 25 of 44 days reviewed. In an interview on February 26, 2026, at 1:30 p.m., the Director of Nursing confirmed that the signatures were not there at the previously mentioned times as per facility policy and should have been. 28 Pa. Code 211.9 (j.1)(5) Pharmacy Services28 Pa Code 211.12 (d)(1)(5) Nursing Services

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to provide copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman for five out of five residents who were transferred out of the facility. (Residents 6, 11, 14, 117, and 159) Findings include: Clinical record review revealed that Resident 6 was transferred to the hospital on January 31, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 11 was transferred to the hospital on February 6, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 14 was transferred to the hospital on December 22, 2025, January 5 and 16, 2026, after changes in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 117 was transferred to the hospital on October 9, 2025, and February 7, 2026, after changes in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 159 was transferred to the hospital on February 1, 2026, after a change in condition. There was no documented evidence to support that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. In an interview on February 26, 2026, at 10:30 a.m., the Director of Nursing confirmed that the written copies of the transfer notices were not sent to the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.