STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395787	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Haven, Inc	4702 East Main Street Belleville, PA 17004

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 18229 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to respect a resident's privacy for one of 25 residents reviewed (Resident 11). Findings include: The policy entitled Sound Monitoring, last reviewed without changes on May 22, 2024, revealed the facility may utilize a sound monitoring system in a resident's room to alert staff when a resident is attempting to rise without assistance. The sound monitoring system will only be used when other interventions have proven to be ineffective to prevent falls or injury. Permission for sound monitoring will be received from the resident or resident representative before sound monitoring is initiated. The consent will be documented in the resident's electronic medical record. Observation of the 700-nursing unit on May 28, 2024, at 11:42 AM revealed there was an audio monitor in the nurses' station. Resident 61 was in her wheelchair in the nurses' station at this time. There was a male and female voice coming from the audio monitor. The female voice was discussing toileting needs with Resident 11. Observation of the 700-nursing unit on May 29, 2024, at 9:12 and 11:07 AM revealed there were again voices on the audio monitor. Clinical record review for Resident 11 revealed the facility admitted Resident 11 on August 11, 2022. Further review of Resident 11's clinical record revealed no consent for Resident 11's audio monitor. A review of Resident 11's plan of care revealed the facility added a sound detection monitor to be utilized during sleeping hours to help alert the team when Resident 11 is rising on October 4, 2023. Interview with the Nursing Home Administrator and Director of Nursing on May 29, 2024, at 2:04 PM revealed the facility utilizes audio monitors in resident rooms and confirmed there was no evidence in Resident 11's clinical record that the facility obtained permission for the audio monitor. The Director of Nursing confirmed Resident 11's audio monitor was only to be used during sleeping hours. The facility failed to protect Resident 11's right to privacy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 19719 Based on clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to implement their abuse policy regarding completion of a thorough investigation of missing medications for one of three residents reviewed (Resident 21). Findings include: The policy entitled Abuse Prevention Program reviewed on May 24, 2024, indicates that the facility will develop investigation protocols for misappropriation of property. This surveyor attempted multiple times to obtain further facility policies and/or procedures regarding the investigation protocols for misappropriate of medications without success. The policy entitled Medication Error Guidelines reviewed on May 24, 2024, indicates that the facility will do a search for a missing medication. If the medication cannot be found, the responsible staff member may have to be suspended pending outcome of an investigation conducted by facility administration. Review of Resident 21's clinical record revealed nursing documentation dated April 27, 2024, at 4:56 AM that Resident 21's narcotic count was off. Resident 21's medication card was checked, and it was determined that one of her Phenobarbital (a medication used to treat seizures that has the potential for diversion due to its sedative and hypnotic properties) pills were missing and not signed out by the medication nurse. The documentation indicated that Employee 1, licensed practical nurse, did not know what happened to the pill and that it was unknown if she gave it to Resident 21 as an extra dose. Review of the facility's investigation into Resident 21's missing Phenobarbital revealed that the facility only determined that Employee 1 must have given Resident 21 an extra dose (possibly) and did not investigate the missing medication thoroughly to determine if misappropriation took place. The facility was not able to provide documented evidence that an investigation was initiated regarding Resident 21's missing phenobarbital, and its possible misappropriation. There were no witness statements from Employee 1, previous shift medication nurse, or the registered nurse supervisor on duty at the time of the findings. Interview with the Director of Nursing on May 30, 2024, at 2:30 PM confirmed the above findings for Resident 21. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital for three of five residents reviewed (Residents 56, 97, and 105). Findings include: Clinical record review for Resident 97 revealed that they were transferred to the hospital on April 26, 2024, after a change in their condition. There was no documentation that the facility provided written notification to the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred to, contact and address (mailing and email) information for the Office of the State Long-Term Care Ombudsman, and information (mailing and email address and telephone number) for the agency responsible for the protection and advocacy of individuals with developmental disabilities, and a statement of resident's appeal rights, including name, address (mailing and email) and telephone number of entity which receives requests. Clinical record review for Resident 105 revealed that they were transferred to the hospital on April 2, 2024, and April 27, 2024, after there was a change in their condition. There was no documentation that the facility provided written notification to the resident, or their responsible party as required regarding the transfer that included the required contents listed above. The surveyor reviewed the above information during an interview with the Director of Nursing on May 30, 2024, at 2:15 PM. Clinical record review 56 revealed that they transferred him to the hospital from April 9 to 11, 2024, after a change in his condition. There was no evidence to indicate that Resident 56's responsible party was provided written notification that included the above required contents. The Nursing Home Administrator and Director of Nursing confirmed these findings for Resident 56 regarding transfer notices on May 30, 2024, at 11:17 AM. 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/discharge Previously cited 6/9/23. 28 Pa. Code 201.14 (a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received written notice of the facility bed hold policy at the time of transfer for three of five residents reviewed for hospitalization s (Residents 56, 97, and 105). Findings include: Clinical record review revealed that Resident 97 was transferred to the hospital on April 26, 2024, after they had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital. Clinical record review revealed that Resident 105 was transferred to the hospital on April 2, 2024, and April 27, 2024, after they had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident's responsible party upon transfer out to the hospital. The surveyor reviewed the above information for Residents 97 and 105 during an interview with the Director of Nursing on May 30, 2024, at 2:15 PM. Clinical record review revealed that Resident 56 was transferred to the hospital on April 9, 2024, after he had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital. The Nursing Home Administrator and Director of Nursing confirmed these findings for Resident 56 on May 30, 2024, at 11:17 AM. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(f) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 19719 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 25 residents reviewed (Resident 37). Findings include: Review of Resident 37's clinical record revealed a Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated February 21, 2024, and May 14, 2024, that indicated the facility assessed him an having an active pneumonia infection and a sepsis (a life-threatening condition when the body responds to an infection) diagnosis. Resident 37 had not had an active pneumonia infection and/or sepsis since December 16, 2023. Interview with the Administrator on May 30, 2024, at 12:03 PM confirmed the above findings for Resident 37. 28 Pa. Code 211.5(f)(ix) Medical records 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. 29512 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered interventions and treatments for one of 25 residents (Resident 105). Findings include: Clinical record review for Resident 105 revealed a current physician order for staff to place a bilateral halo (circular) enabler bar on her bed. Observation of Resident 105's bed on May 28, 2024, at 12:01 PM revealed that the bed did not have bilateral halo bars on it. Clinical record review for Resident 105 revealed that she attended a podiatry appointment on April 24, 2024, for a right ankle fracture. Resident 105 was ordered a boot to the RLE (right lower extremity) as a result of the fracture. The podiatrist indicated to take the RLE boot off daily and wash the leg. When staff reapplied the RLE boot, they were to ensure that Resident 105 was wearing a sock, that the foot was flat in the boot, and the heel was in the back of the boot. Facility staff acknowledged the podiatrist's orders on April 24, 2024. Review of Resident 105's physician orders and treatment and task documentation revealed no indication that staff were removing, washing, ensuring proper placement of the RLE boot, and reapplying daily after April 24, 2024, until identified by the surveyor. The surveyor reviewed the above information during an interview on May 30, 2024, 1:02 PM with the Director of Nursing. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 29512 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to assess for the risk of side rail entrapment for two of four residents reviewed for accident hazards (Residents 97 and 106). Findings include: A Test Results Worksheet (form the facility used to document the assessment of entrapment risk zones) revealed that the facility only assessed zones one (within the rail), two (between the bottom of the rail and top of compressed mattress), and three (between the edge of the mattress and inside of the rail). The assessment did not capture zone four (between the top of the compressed mattress and the bottom of the rail at the end of the rail, zone five (between the split [head and foot] bed rails), zone six (between the end of the rail and the side edge of the head or foot board), or zone seven (between head or foot board and end of mattress). Observation of Resident 97's room on May 28, 2024, at 12:23 PM, and May 29, 2024, at 9:26 AM revealed that there were bilateral halo (circular) enabler bars observed on the bed. Clinical record review for Resident 97 revealed a Test Results Worksheet dated April 30, 2024, that revealed the facility measured, assessed, and passed the halo enabler bars for zones one, two, and three. Staff who completed the form indicated N/A (not applicable) for zones four, six, and seven. Zone five will not apply to this resident as they did not have head and foot split bed rails. Observation of Resident 106 on May 28, 2024, at 11:52 AM revealed that there was a halo enabler bar on the door side of the bed. There was no documentation that indicated the facility assessed Resident 106's halo enabler bar for entrapment zones six or seven. Zone five will not apply to this resident as they did not have head and foot split bed rails. The surveyor reviewed the above information during an interview with the Director of Nursing on May 30, 2024, at 2:25 PM. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service/storage equipment in a sanitary manner in the facility's main kitchen and five of five open nursing units (unit 200, 400, 500, 600, 700). Findings include: An observation in the facility's main kitchen on [DATE], at 10:00 AM with Employee 2, assistant director of nutrition services, revealed the following: The wall area to the right of the dish machine contained significant dried food splatter from ceiling to floor, which extended to a door in the area and the wall past the door towards the kitchen preparation area. The exterior of a large garbage can by the pot washing sink was covered with dried liquid spills and food. Vents along the front of the hood unit above the cooking area were covered in dust. A [NAME] by the food serving line stacked with racks of bowls and cups had a buildup of crumbs, dried food, and debris. An observation of the nourishment area on the 400 unit on [DATE], at 11:12 AM revealed a large brown water stain in the interior of the cabinet under the pipes of the sink, dried brown water stains were also present along a plastic tube extending across the interior of the cabinet. The interior of a drawer located beside the refrigerator with beverage mugs and thickening packets was significantly worn with the wipeable finish removed throughout most of the drawer exposing a paperboard surface with the potential to absorb liquid/contaminants. Another cabinet drawer located in the nourishment area contained several individual packs of peanut butter, two bags of ketchup packs, a bag of tartar sauce packets, and a bag of saltine cracker packets. There was no evidence of a date the packets were placed in the area or when they expired. An observation of the 500-unit nourishment area on [DATE], at 11:23 AM revealed a refrigerator/freezer in the nourishment room. The freezer had multiple ice cream cups in it also contained a folded towel on the lower shelf as several therapeutic ice packs. The bottom storage bins of the refrigerator contained dust, debris, and a dried brown substance covering the interior of one of the drawers. The wall beside and behind the trash receptacle located in the room contained dried liquid splatter, and large gauged areas of the drywall. An observation of the 200-unit nourishment area on [DATE], at 11:33 AM revealed a refrigerator/freezer unit in the room. Ice cream cups and bowls of ice cream were observed in the freezer. Multiple therapeutic ice packs were stored in the freezer with the ice cream. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the 600-unit kitchen area on [DATE], at 11:39 AM revealed a small upright freezer unit in which multiple packs of meat were stored including a bag of beef patties and a pan of fish. A box of ice cream sandwiches was stored touching the bags of frozen meat products on the same shelf. An observation of the 700-unit kitchen area at 11:46 AM on [DATE], revealed a small upright freezer with multiple packs of frozen meat products, and a plastic bag with packs of ice cream bars was stored on the same shelf and packed in with the frozen meat products. The above information was reviewed with the Director of Nursing on [DATE], at 1:30 PM and [DATE], at 12:00 PM. 483.60 (i)(2) Food storage safe and sanitary Previously cited [DATE] 28 Pa. Code 201.14(a) Responsibility of licensee