

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2140 Warrenton Road Montoursville, PA 17754	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>38839</p> <p>Based on clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to thoroughly investigate and notify the appropriate agencies of an identified incident of potential resident misappropriation of property (medication) for two of five residents reviewed (Residents 4 and 5).</p> <p>Findings include:</p> <p>In an interview with Employee 1, licensed practical nurse (LPN), on June 5, 2024, at 9:33 AM she stated she was aware of a recent discrepancy with Resident 5's liquid morphine in which the color of the medication was a dark purplish color and was normally blue. Employee 1 indicated the bottle had been opened.</p> <p>In an interview with Employee 2, LPN, on June 5, 2024, at 9:38 AM she stated there was a recent report of Resident 5's opened bottle of liquid morphine being a different color than others on the unit, where it appeared a grayish/brown color instead of blue and the bottle was discarded. Employee 2 also indicated there had been prior recent discrepancies in the controlled substance count of doses remaining of liquid Morphine for Resident 5, and Resident 4 who resided on the same hall and their counts on the controlled substance log were corrected.</p> <p>Clinical record review for Resident 5 revealed the resident was ordered Morphine Sulfate (concentrate) oral solution 20 milligrams/milliliter (mg/ml) to be given 0.25 ml (milliliters) by mouth every one hour as needed for pain or as needed for shortness of breath on January 19, 2024.</p> <p>A review of Resident 5's medication administration records for February through May 2024, revealed the resident was last documented as being administered the Morphine Sulfate on April 16, 2024, at 12:29 AM.</p> <p>Review of Resident 5's controlled medication record for the Morphine Sulfate revealed the bottle the dose was administered from on April 16, 2024, was received on January 20, 2024, with 15 ml as the amount received and the first dosage from the bottle was administered on February 2, 2024. The last dose was administered on April 16, 2024, and was documented on the controlled medication record as 0.25 ml given with 13.50 ml remaining in the bottle. No other doses were documented as administered after April 16, 2024. An April 20, 2024, entry on the same controlled medication log for Resident 5 noted count corrected with the amount on hand as 12 ml. A 1.5 ml (6 doses) decrease from the amount remaining logged on April 16, 2024, with a signature from a registered nurse and Employee 2.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 4 revealed the resident had an active order for Morphine Sulfate (concentrate) oral solution 20 mg/ml to be given 0.25 ml via PEG-Tube every one hour as needed for pain of seven to 10, or every hour as needed for dyspnea (shortness of breath).</p> <p>A review of Resident 4's controlled medication record for the Morphine Sulfate revealed a discrepancy was identified in April 2024, after a dose was documented as administered on April 11, 2024, at 11:22 AM with 11 ml remaining in the bottle. The next entry on the controlled medication record was dated April 20, 2024, noting the count was corrected to 9 ml remaining on hand. A 2 ml (8 doses) decrease from the amount remaining on April 11, 2024, with a signature from a registered nurse and Employee 2.</p> <p>A review of Resident 4's April 2024, medication administration record did not indicate any doses of the Morphine Sulfate were administered between April 11 and April 20, 2024, when the discrepancy in the count was noted.</p> <p>A review of the facility staff's investigation into the discrepancy in the Morphine Sulfate counts for Residents 4 and 5 documented on April 20, 2024, or an investigation into the discoloration of Resident 5's bottle of Morphine Sulfate mentioned in the above interviews revealed the following:</p> <p>A registered nurse, Employee 3's, statement dated April 20, 2024, noted the registered nurse counted the narcotic drawer with Employee 4, LPN, on the 6 AM - 2 PM shift identifying the levels on Resident 5's bottle as 12 ml when the sheet read 13.5 ml. A note was on the bottom of the sheet indicating a dose was not checked on April 16, 2024, which was the last known dose, and a second bottle for Resident 4 was found with a content of 9 ml. The narcotic sheet was showing 11 ml with the last known dose charted on April 11, 2024. The statement noted Employee 4 wrote a statement and was given permission to leave by the administrator.</p> <p>Review of a statement from Employee 4 dated April 20, 2024, noted when counting narcotics with the 10 - 6 nurse (name not noted) prior to starting the 6-2 shift Employee 4 noted the Morphine levels were not compatible to the countdown sheets verses the actual bottles for two residents. The licensed nurse noted immediately reporting the discrepancy to a registered nurse (only listed by first name) who came to the floor and looked at the bottles and noted they did not match and that she would take care of it, and that that another 10-6 nurse found an error where another nurse had not marked it down when a dose was given. Employee 4 noted that the registered nurse placed a sticky note for the missed dose to be signed by the nurse that failed to do so on the sheet and that all was ok. Employee 4 noted both nurses left the floor without the sheets being corrected or initialed by the registered nurse it was reported to. Employee 4 then made the 6AM-2PM registered nurse supervisor aware (noted as Employee 3) of the two bottles of Morphine that had not been corrected, by the 10 PM - 6AM registered nurse.</p> <p>There was no additional documentation provided at the time of the survey into the investigation of the discrepancy of the counts of the Morphine doses in the counts for Residents 4 and 5 identified on April 20, 2024. There were no additional staff interviews provided for any staff with access to the medications between the last confirmed counts and the discrepancy, or the registered nurse Employee 4 noted was first made aware of the discrepancies.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no evidence facility staff reported an alleged allegation of misappropriation with a completed investigation of Resident 4 or Resident 5's Morphine discrepancies to the Department of Health when the discrepancy in dosage counts were identified on April 20, 2024.</p> <p>A review of email communication between the Nursing Home Administrator and facility pharmacist dated May 23, 2024, at 12:22 PM revealed a discrepancy in the color of liquid Morphine Sulfate in a bottle was noted as brownish/clear instead of a light blue in color, and questioned if the color could change over time, and if it was safe to use. The pharmacist replied by email at 1:02 PM the same day noting the morphine concentrate should not change color over time, and the change in color reported likely indicates contamination and/or diversion and recommended a new supply be ordered for the resident, and to complete an investigation for possible diversion by inspecting the color of all morphine concentrate bottles in the facility, checking the controlled substance logs and signature sheets, monitor reports from residents of morphine doses being ineffective, document all findings and steps of the investigation, and contact authorities if indicated. In a follow up email to the pharmacist later the same day at 2:42 PM a picture of the discolored bottle beside five additional bottles was attached indicating the color is darker blue on the left, should we destroy? The pharmacist responded at 2:51 PM noting it may be destroyed per protocol once you have documented investigation findings to include the picture of the medication, lot number, expiration date, date opened, and any other notable aspects of the medication.</p> <p>An observation of the photo of the bottle of the discolored Morphine liquid was provided by the Director of Nursing with five additional bottles visible in the photo belonging to other residents on the same unit, which showed a discoloration compared to shades of light blue in the additional bottles. The date on the discolored bottle could be seen as 2/2 as the first parts of the date and the Director of Nursing confirmed the bottle belonged to Resident 5. There was no additional information provided as to any further investigation (i.e., staff interviews) to any prior notice of the resident's medication being a different color, or additional steps to the investigation as recommended by pharmacy prior to the disposal. Review of Resident 5's controlled medication record for the Morphine had not noted any entries of any administration of the medication since the dosage count was corrected as referenced above on April 20, 2024.</p> <p>In an interview with the Director of Nursing on June 5, 2024, at 2:30 PM the Director of Nursing indicated the discolored bottle of Morphine for Resident 5 was discarded and other than the photo comparing the color of the Morphine liquid to other bottles on the unit, there was no other investigation to rule out the potential diversion of the Resident's medication.</p> <p>In the same interview with the Director of Nursing on June 5, 2024, at 2:30 PM the Director of Nursing confirmed there were no additional staff interviews or investigation documentation available for the identified discrepancy in Morphine counts on April 20, 2024, for Resident 4 and Resident 5, to determine a justified reason for the discrepancy, or rule out misappropriation, or rule out potential diversion of the resident's medication. There was no rationale why the investigation was not conducted when it was first reported by Employee 5 to a prior shift registered nurse. The Director of Nursing stated the doses of Morphine liquid is hard to count due to the bottle being marked in 5 ml increments.</p> <p>The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 5, 2024, at 3:20 PM.</p> <p>(continued on next page)</p>		

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