

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 06/20/2024
NAME OF PROVIDER OR SUPPLIER Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 Warrentonville 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>36798</p> <p>Based on clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to ensure a resident was free from neglect resulting in injury for one of two residents reviewed (Resident 26).</p> <p>Findings include:</p> <p>Clinical record review for Resident 26 revealed a progress note dated May 24, 2024, at 6:00 AM that indicated she was being transferred in a mechanical lift when the top of the sling came loose, and she fell to the floor. She was noted to have bleeding from the back of her head. Assessment of her injuries indicated that she had a 2.5-centimeter (cm) x 0.3 cm laceration to the mid back of her head and a smaller laceration measuring 0.5 cm x 0.5 cm just above the other one.</p> <p>Review of the facility's investigation into Resident 26's fall revealed a statement from Employee 5, nurse aide, dated May 24, 2024, that indicated the lift slipped and Resident 26 slipped out of the sling onto the floor.</p> <p>Further review of the facility's investigation into Resident 26's fall revealed a statement dated May 24, 2024, at 9:00 AM from Employee 6, Registered Nurse, that revealed she checked Resident 26's mechanical lift sling after the fall and there were no cracks or defects noted in the hooks, and no tears noted in the sling.</p> <p>An email to the Director of Nursing (DON) from Employee 7, director of facility management, dated May 24, 2024, at 12:58 PM revealed the mechanical lift was checked by maintenance with no concerns.</p> <p>Further review of the facility's investigation into Resident 26's fall revealed an interview conducted on May 28, 2024, at 9:45 AM with Employee 5 by the DON. The written interview summary indicated that Employee 5 put the sling under Resident 26, and hooked her up to the lift, but when she went to move her, the wheels of the lift were sticking, and it was hard to move. Employee 5 had to move it by pushing the lift. She indicated that she possibly bumped the sling attachment at that time, and the right upper part of the sling came loose causing Resident 26 to slide to the floor. She also indicated that she did not have anyone else in the room with her when this occurred.</p> <p>Clinical record review of Resident 26's care plan revealed an intervention dated July 9, 2020, that indicated she was a full body mechanical lift with the assist of two staff.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395895
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A counseling action sheet dated May 28, 2024, revealed that Employee 5 was disciplined for neglect because she was operating a mechanical lift without a second person resulting in a resident falling from the lift to the floor. She received a final written warning, and any further incident would result in termination of employment.</p> <p>Review of the facility's corrective action was to conduct on the spot inservice to staff responsible for transferring residents with a mechanical lift. The inservice indicated that for the safety of the residents, when using a mechanical lift, two people must be present during the transfer, no exceptions. The inservice was a read and sign and was not initiated until May 30, 2024.</p> <p>Review of the signature sheets for the inservice revealed that only 46 staff members reviewed the information.</p> <p>Interview with the Director of Nursing on June 20, 2024, at 9:43 AM confirmed that as of this date all staff responsible for transferring residents with the mechanical lift did not acknowledge the information on the on-the-spot inservice.</p> <p>The facility failed to ensure that Resident 26 was free from neglect.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>29512</p> <p>Based on review of select facility policies, clinical record review, and staff interview, it was determined that the facility failed to develop and implement an abuse prohibition policy to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of 27 residents reviewed (Residents 79).</p> <p>Findings include:</p> <p>The current facility policy entitled Abuse Prevention/Elder Justice Act Suspicious Crime Reporting, last reviewed without changes on December 5, 2023, revealed that all residents of the facility have the right to live without fear of abuse. The facility will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported timely. The facility will prevent abuse and neglect through assessment and monitoring of residents, and educating employees, residents, and resident representatives. The facility will protect the rights of the residents, promptly report, and investigate incidents of alleged resident abuse,</p> <p>Clinical record review for Resident 79 revealed a care plan (a summary of resident's care needs) that identified as of April 22, 2021, Resident 79 utilizes two staff assistance for bed mobility.</p> <p>Resident 79's nursing documentation dated May 24, 2024, at 9:15 AM indicated that Employee 3, nurse aide, called staff to Resident 79's room. Employee 3 reported that while rolling Resident 79 to his left side to provide peri care, Resident 79 had a harsh coughing spell and rolled over off the bed to the floor. Resident 79 sustained 0.5 centimeters (cm) by 0.5 cm skin tear to the right elbow, a 1.5 cm by 1 cm abrasion on their right knee, and redness noted to their right side along the back and leg. Resident 79 indicated, I fell after coughing.</p> <p>Review of Resident 79's incident report dated May 24, 2024, confirmed the nursing documentation, but did not identify Resident 79's need for two staff members while moving in bed or the potential for neglect due to not having two staff members to assist Resident 79 in bed. The facility's intervention was to place a physical therapy screen. The facility provided Employee 3's statement with the incident report. There was no second staff statement involved with the incident provided.</p> <p>Review of Resident 79's May and June 2024, bed mobility documentation confirmed that staff only provided one staff assistance on May 24, 2024, day shift. Staff continued documenting one staff bed mobility assistance for 30 of the 74 shifts thereafter until identified by the surveyor.</p> <p>Review of a physical therapy screening completed on May 31, 2024, revealed that therapy staff determined that Resident 79 continues to be appropriate for assist x 2 (staff) for bed mobility.</p> <p>There was no documentation that indicated the facility identified the potential for neglect surrounding Resident 79's fall out of bed with only one staff present. The facility failed to report Resident 79's fall to the appropriate agencies. The facility failed to thoroughly investigate the incident to determine the presence of neglect, failed to complete a PB22 (abuse report), and failed to re-educate staff to utilize the correct number of staff either after the fall investigation and/or after therapy completed their screening.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This information was reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on June 18, 2024, at 10:50 AM.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 201.19 Personnel policies and procedures</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to maintain the highest practicable care for three of 27 residents reviewed (Residents 11, 116, and 119).</p> <p>Findings Include:</p> <p>Clinical record review for Resident 116 revealed that the facility admitted her on December 8, 2023, with a diagnosis of a prolapsed vaginal vault (the top of the vagina folds into the lower vagina) after a hysterectomy (a surgical procedure to remove the uterus).</p> <p>Clinical record review for Resident 116 revealed consultation reports dated March 13, 2024, and June 11, 2024, that indicated she was seen by a gynecology physician to have her pessary (a device that is inserted into the vagina to prevent or control a prolapse of the vaginal vault, bladder, or uterus) checked.</p> <p>Further clinical record review of Resident 116's care plan revealed the pessary was not noted on her plan of care.</p> <p>The Director of Nursing was made aware of the concern that there was no mention of Resident 116's pessary in her plan of care on June 18, 2024, at 10:45 AM.</p> <p>A care plan was provided to the surveyor on June 18, 2024, at 2:30 PM that revealed the facility added Resident 116's pessary use to her care plan on June 18, 2024, after the surveyor brought it to their attention.</p> <p>Clinical record review revealed the facility admitted Resident 11 on September 12, 2017. A review of Resident 11's current physician orders revealed an order dated January 13, 2021, indicating Resident 11's urine culture was positive for ESBL (extended-spectrum beta-lactamase, which is an enzyme found in some bacteria that makes them resistant to many antibiotics) and a new order to start contact precautions.</p> <p>A review of Resident 11's care plan on June 20, 2024, at 9:12 AM revealed there was no plan of care addressing Resident 11's ESBL in her urine or the need for contact precautions.</p> <p>Clinical record review revealed the facility admitted Resident 119 on September 23, 2023. A review of Resident 119's current physician orders revealed an order dated September 23, 2023, noting VRE (vancomycin-resistant enterococci, a type of bacteria that can cause serious infections in people who are already sick or have weakened immune systems) in Resident 119's urine and an order to start contact precautions.</p> <p>A review of Resident 119's care plan revealed there was no plan of care addressing Resident 119's VRE in her urine or the need for contact precautions.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 1 (infection preventionist) on June 20, 2024, at 12:52 PM confirmed the findings for Residents 11 and 119.</p> <p>The facility failed to implement person-centered care plans to maintain the highest practicable care for Residents 116, 11, and 119.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to identify and assess a resident's decline in activities of daily living (ADL) for two of two residents reviewed for an ADL decline (Residents 10 and 118).</p> <p>Findings include:</p> <p>A review of Resident 10's MDS (Minimum Data Set, assessment completed at specific intervals to determine care needs) assessment dated [DATE], noted nursing staff assessed Resident 10 as requiring the supervision of one staff for bed mobility. Resident 10's next quarterly assessment dated [DATE], revealed nursing staff assessed Resident 10 as declining and now requiring extensive assistance of one staff for bed mobility.</p> <p>There was no documented evidence in Resident 10's clinical record to indicate that the facility identified or assessed Resident 10's decline in her ability to perform this activity of daily living.</p> <p>A review of Resident 118's MDS assessment dated [DATE], noted nursing staff assessed Resident 118 as independent with bed mobility. A review of Resident 118's significant change MDS dated [DATE], revealed nursing staff assessed Resident 118 as declining and now requiring limited assistance of one staff for bed mobility.</p> <p>There was no documented evidence in Resident 118's clinical record to indicate that the facility identified or assessed Resident 118's decline in her ability to perform this activity of daily living.</p> <p>The surveyor reviewed the above findings for Residents 10 and 118 during an interview with Employee 4 (registered nurse assessment coordinator) on June 20, 2024, at 12:30 PM. The facility was unable to provide any further documentation that the facility assessed Residents 10 and 118's decline in bed mobility.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weights and feeding interventions for two of 27 residents (Residents 36 and 89).</p> <p>Findings include:</p> <p>Review of Resident 36's clinical documentation revealed the following physician orders:</p> <p>On January 17, 2024, and discontinued on March 1, 2024, staff were to complete a daily weight every day shift. Staff were to contact the physician if the weight increased by two-pounds in 24 hours or five-pounds in a week.</p> <p>On March 1, 2024, daily weights one time a day for CHF (Congestive Heart Failure, a heart condition that causes fluid build-up in the extremities and organs) for one week.</p> <p>On March 12, 2024, daily weights, make the physician aware if a two-pound weight gain in 24 hours or five pounds in one week, every day shift for CHF.</p> <p>Review of Resident 36's clinical documentation revealed no documented weights June 7, 2024.</p> <p>Further review of Resident 36's clinical documentation revealed that there was no physician notification regarding their weight change of two pounds in 24 hours or a five pounds in one week on the following dates:</p> <p>January 22, 2024, 161.8 pounds to January 23, 2024, 164.2 pounds, 2.4-pound increase</p> <p>May 7, 2024, 143.2 pounds to May 8, 2024, 145.4 pounds, 2.2-pound increase</p> <p>This information was reviewed during an interview on June 20, 2024, at 9:45 AM with the Director of Nursing.</p> <p>Clinical record review for Resident 89 revealed that she had a swallowing function study completed on June 12, 2024, at the request of her attending physician related to concerns with her reportedly choking often with eating and drinking. The results of the study indicated that the resident had mild dysphagia and her overall swallow was mildly unsafe.</p> <p>The recommendations related to the swallow study were for Resident 89 to sit fully upright for all intakes and at least 30 minutes after meals.</p> <p>There was no evidence in the clinical record to indicate that the recommendations from the swallowing evaluation were implemented.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing on June 20, 2024, at 11:15 AM revealed that the resident had remained on speech therapy services and that is why the recommendations were not implemented. She indicated that speech therapy was not present with Resident 89 at every meal and staff were feeding her the meals too.</p> <p>The facility failed to implement recommendations that were noted on the swallowing study completed on June 12, 2024, that would decrease the risk of choking for Resident 89.</p> <p>483.25 Quality of Care</p> <p>Previously cited 7/28/23</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>38839</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure each resident's medication regimen was free of adverse medication reactions for one of five residents reviewed for unnecessary medications (Resident 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 50 revealed a pharmacy note to the physician dated March 12, 2024, informing the physician that the resident's concurrent use of the medications Omeprazole (a proton-pump inhibitor used to treat reflux disease) and Clopidogrel (a platelet inhibitor used to reduce the change of blood clot formation), may decrease the efficacy of the Clopidogrel, thus increasing the risk for clots. The pharmacist note questioned if the physician would like to switch the resident's proton pump inhibitor from Omeprazole to Pantoprazole (another proton pump inhibitor).</p> <p>Resident 50's physician responded to the pharmacist note on March 18, 2024, in agreement to change the resident's Omeprazole to Pantoprazole, and noted once the Pantoprazole arrives to discontinue the Omeprazole.</p> <p>Further review of Resident 50's clinical record revealed the resident had been ordered Omeprazole and Clopidogrel since March 5, 2022. A new order for Resident 50 to receive Pantoprazole was made on March 18, 2024, as well as to discontinue the Omeprazole on the same date.</p> <p>Resident 50's new order of Pantoprazole was discontinued the next day on March 19, 2024, and Omeprazole was again reordered for the resident. There was no documentation in Resident 50's clinical record to indicate why the new medication was discontinued and the resident was placed back on the old medication. Resident 50's active medication orders on June 20, 2024, included both the Omeprazole and the Clopidogrel.</p> <p>Review of email communication between the Director of Nursing and the facility pharmacy dated June 20, 2024, revealed the pharmacy indicated that the Pantoprazole was ordered for Resident 50 on March 18, 2024, but was flagged as a drug/drug interaction (DDI), but the pharmacy still approved the order and on March 19, 2024, the facility cancelled the Pantoprazole and entered the order for the Omeprazole. The email from the pharmacy response noted the Omeprazole is a stock medication for the facility so it was only a profile prescription and no paperwork for a DDI was identified, that the DDI was ever faxed to the facility, and the pharmacy should have faxed it.</p> <p>There was no evidence to indicate Resident 50's physician further addressed the DDI between the resident's Omeprazole and Clopidogrel after the medication was reordered when the Pantoprazole presented a DDI and was discontinued. There was no evidence the physician addressed the risk/benefits of continuing the Omeprazole and the Clopidogrel despite a DDI. There was no evidence the pharmacist addressed the DDI on any visit/review since the March 12, 2024, review.</p> <p>The above information was reviewed with the Director of Nursing on June 20, 2024, at 9:44 AM.</p> <p>28 Pa. Code 211.9(k) Pharmacy services</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for one of five residents reviewed (Resident 89).</p> <p>Findings include:</p> <p>Clinical record review for Resident 89 revealed a note to the attending physician/prescriber dated January 12, 2024, indicating that the following orders are due for a gradual dose reduction review, Buspirone (a medication used to treat anxiety) 5 milligrams (mg) in the morning and bedtime and 2.5 mg in the afternoon and Citalopram (a medication used to treat depression) 20 mg daily.</p> <p>Resident 89's physician checked the box on the form to indicate that she is benefitting from therapy without adverse effects and that the benefits of continued use outweigh risks. The prescriber did not indicate whether they agreed or disagreed to the recommendation or what benefit outweighed what the risk. Review of Resident 89's current physician orders revealed that there have been no changes to either of the medications.</p> <p>Interview with the Director of Nursing on June 20, 2024, at 11:53 AM revealed that the facility was unable to provide documentation of a previous dose reduction that failed, or justification for the continued use of the medication.</p> <p>The facility failed to ensure Resident 89's medication regimen was free from potentially unnecessary medications.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>36798</p> <p>Based on observation, clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Residents 29 and 82).</p> <p>Findings include:</p> <p>The facility's medication error rate was 17.95 percent based on 37 medication opportunities with 7 medication errors.</p> <p>Observation of Employee 2, Licensed Practical Nurse (LPN), during a medication administration pass on June 17, 2024, at 8:32 AM revealed she poured and crushed both Metoprolol Tartrate (a medication used to treat high blood pressure) 12.5 milligrams (mg) by mouth and Potassium Chloride Extended Release (ER) 20 milliequivalent (mEq, a unit of measure used for electrolytes) one tab by mouth and attempted to administer them to Resident 29, who refused them.</p> <p>Observation of Employee 2 during a medication administration pass on June 18, 2024, at 8:48 AM revealed she poured and crushed Metoprolol Tartrate 25 mg, Paroxetine (a medication used to treat depression) 20 mg and Potassium Chloride ER and administered them in pudding to Resident 82.</p> <p>Review of the facility's Medication Management Do Not Crush or Chew list dated February 2024, provided by their pharmacy provider, noted that Metoprolol Tartrate, Potassium Chloride ER, and Paroxetine were all on the list as medications that should not be crushed.</p> <p>The facility policy entitled Specific Medication Administration Procedures Oral Inhalation Administration, last reviewed December 5, 2023, revealed the purpose was to allow for safe and effective administration of medication using an oral inhaler. The procedure indicated to wait 1-2 minutes in between puffs or before administering a different inhalation medication. For steroid inhalers, after administration, provide the resident with a cup of water and instruct him/her to rinse mouth and spit water back into the cup.</p> <p>Observation of Employee 2 during a medication administration pass on June 17, 2024, at 8:48 AM with Resident 82, revealed she administered Albuterol Sulfate Inhaler (an inhaled medication used to treat breathing problems), two puffs, without waiting 1-2 minutes in between puffs and immediately after the second puff, she administered Fluticasone-Salmeterol (a steroid inhaled medication used to treat asthma) inhalation 250-50 mcg (micrograms) one puff. She then provided Resident 82 with a glass of water and Resident 82 took a drink and swallowed the water. Employee 2 did not direct her to rinse mouth and spit the water back into the cup.</p> <p>Concerns with the medication administration pass observations with Employee 2 were reviewed with the Director of Nursing on June 20, 2024, at 9:55 AM. She confirmed that Employee 2 should not have crushed the above noted medications and that she should have waited in between puffs and in between the two different inhalers. She also confirmed that Employee 2 should have directed Resident 82 to rinse and spit after administration of the Fluticasone-Salmeterol inhaler.</p> <p>(continued on next page)</p>		

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 06/20/2024
NAME OF PROVIDER OR SUPPLIER Valley View Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 Warrentown 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.

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to ensure a medication error rate below 5 percent.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839</p> <p>Based on observation and staff interview, it was determined that the facility failed to store food in accordance with professional standards for food service safety and sanitation in the facility's main kitchen and three of seven nursing units (100, 300, 800).</p> <p>Findings include:</p> <p>An observation of the facility's main kitchen on [DATE], at 8:30 AM revealed the following:</p> <p>The coffee beverage station lower shelf contained several dried brown liquid spills along with dust and debris. A white blanket was balled up in the back corner of the shelf along the wall with dried brown and orange stains on it.</p> <p>The tubing on several flavors of bag in box juice concentrates connecting them to the juice dispenser were sticky and covered in dust.</p> <p>The flooring under the steam table, serving area, fryer, and cooking equipment contained dried food and debris.</p> <p>The wall area beside the plate warmers was covered in dried food splatter.</p> <p>The lower shelves of two production tables had dust and debris.</p> <p>The sides and control panel area of the steam kettle were covered in dried liquid spills.</p> <p>The lower shelves of the dry storage had a buildup of dust.</p> <p>An observation of the 100-hall nourishment area on [DATE], at 10:14 AM revealed a storage cabinet with small plastic containers filled with hot chocolate packets, peanut butter packs, jelly packs, tartar sauce packets, along with a basket of saltine cracker packets, and packs of microwave popcorn. Foam cups filled with additional condiments such as ketchup packets, mustard packets, more jelly packs, as well as cardboard trays of jelly and peanut butter packets were on the shelves. The refrigerator in the same area was observed to have a large bag of individual liquid coffee creamers, and a large bag of margarine packs. None of the items had any identification as to when they were placed there or when they expire.</p> <p>An observation of the 300-hall nourishment area on [DATE], at 1:45 PM revealed a cabinet containing plastic containers of mustard packets, saltine cracker packs, pancake syrup cups, peanut butter packs, and jelly packs as well as foam cups filled with cocktail sauce packets, honey packs, and cardboard trays of jelly packs and peanut butter packs. There was no date on any of the products to indicate when they were placed there or when they expired.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation of the 800-hall nourishment area on [DATE], at 1:56 PM revealed a cabinet containing packets of brown sugar topping, foam cups of tartar sauce packets, ketchup packets, mustard packets, jelly packs, peanut butter packs, pancake syrup cups, and a large plastic bag with a mix of cocktail sauce packs, and sweet 'n sour packs. None of the items were dated as to when they were placed there or as to when they expire.</p> <p>The above findings were reviewed with the Nursing Home Administrator on [DATE], at 2:02 PM.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		

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<p>F 0846</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully.</p> <p>18229</p> <p>Based on a review of facility policies and procedures and staff interview, it was determined that the facility failed to have a policy and procedure in place to address facility closure or termination of the facility's Medicare and/or Medicaid Provider Agreement.</p> <p>Findings include:</p> <p>During the entrance conference on June 17, 2024, at 8:35 AM the Nursing Home Administrator and Director of Nursing were asked to provide a copy of the facility's closure plan. The Director of Nursing revealed that the facility did not have a plan in the event of a facility closure. The Director of Nursing confirmed the facility was made aware of this during the previous full health survey in July of 2023.</p> <p>A follow-up interview with the Nursing Home Administrator on June 18, 2024, at 10:14 AM confirmed that the facility does not have a policy or procedure to address facility closure.</p> <p>28 Pa Code 201.23 (c)(1) Closure of facility</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36798</p> <p>Based on observation, review of a medication pass observation report, review of select facility policies and procedures, and staff interview, it was determined that the facility failed prevent the potential spread of infection during medication administration on 1 of 7 nursing units (600 hall, Resident 29).</p> <p>Findings include:</p> <p>The facility policy entitled, Specific Medication Administration Procedures Eye Drop Administration last reviewed on December 5, 2023, revealed the purpose was to administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner.</p> <p>Review of the medication pass observation report for Employee 2, Licensed Practical Nurse (LPN), dated April 30, 2024, revealed that for ophthalmic (eye) medications gloves should be worn and a separate tissue should be used for each eye.</p> <p>Observation of Employee 2 during a medication administration pass to Resident 29 on June 17, 2024, at 8:32 AM revealed she administered one drop of Systane eye drops (used to relieve and prevent dry eyes) to each eye. She held the eye drops in her ungloved hand and pulled down the lower eye lid with her ungloved hand, administered a drop into Resident 29's left eye, used a tissue to wipe the eye. She then used her ungloved hand, pulled down the lower eye lid of Resident 29's right eye, administered one drop into the right eye, and wiped the right eye with the same tissue she used to wipe Resident 29's left eye.</p> <p>The above noted infection control concerns with medication administration were discussed with the Director of Nursing on June 20, 2024, at 9:55 AM. She confirmed that Employee 2 should have utilized gloves and used a different tissue for each eye when administering Resident 29's eye medication.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>18229</p> <p>Based on a review of select facility policies and procedures, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure the administration of a COVID-19 immunization for four of five residents reviewed for immunization concerns (Residents 11, 109, 118, and 119).</p> <p>Findings include:</p> <p>The policy entitled COVID-19 Procedure for Testing, Quarantining, Source Control, and Vaccinations, last reviewed without changes on December 5, 2023, revealed the facility encourages everyone to remain up to date with all recommended COVID-19 vaccine doses. Residents, staff, and visitors will be offered COVID-19 vaccines through monthly booster clinics held at the facility.</p> <p>Clinical record review for Resident 119 revealed the facility admitted him on July 24, 2023. A review of Resident 119's immunization history information indicated that he received a COVID-19 immunization on March 4, 2021, April 1, 2021, and October 19, 2021.</p> <p>A review of facility documentation revealed that Resident 119's son gave permission on December 13, 2023, for the facility to administer the COVID-19 vaccination booster.</p> <p>There was no evidence in Resident 119's clinical record that he received a COVID-19 immunization booster. Further review of Resident 119's clinical record revealed nursing documentation dated February 9, 2024, at 10:43 AM indicating Resident 119 tested positive for COVID-19.</p> <p>Clinical record review for Resident 11 revealed the facility admitted her on September 12, 2017. A review of Resident 11's immunization history information indicated that she received a COVID-19 immunization on January 27, 2021, July 12, 2022, and March 21, 2023.</p> <p>A review of facility documentation revealed that Resident 11's responsible party gave permission on December 12, 2023, for the facility to administer the COVID-19 vaccination booster.</p> <p>There was no evidence in Resident 11's clinical record that he received a COVID-19 immunization booster. Further review of Resident 11's clinical record revealed nursing documentation dated February 21, 2024, at 8:55 AM indicating Resident 11 tested positive for COVID-19.</p> <p>Clinical record review for Resident 109 revealed that the facility admitted her on April 7, 2023. A review of Resident 109's immunization history information indicated that she received a COVID-19 immunization on March 9, 2023, and March 21, 2023.</p> <p>A review of facility documentation revealed that Resident 109's responsible party gave permission on May 10, 2023, for the facility to administer the COVID-19 vaccination booster.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no evidence in Resident 109's clinical record that she received a COVID-19 immunization booster. Further review of Resident 109's clinical record revealed nursing documentation dated February 14, 2024, at 10:55 AM noting Resident 109 tested positive for COVID-19.</p> <p>Clinical record review for Resident 118 revealed the facility admitted her on July 18, 2023. A review of Resident 118's immunization history information indicated that she received a COVID-19 immunization on March 4, 2021, April 1, 2021, and November 10, 2021.</p> <p>A review of facility documentation revealed that the facility sent Resident 118's responsible party an email on December 12, 2023, asking if they wished for Resident 118 to receive a COVID-19 vaccination booster. The facility did not receive a response to the email and did not attempt a follow-up call or email.</p> <p>There was no evidence in Resident 118's clinical record that she received a COVID-19 immunization booster. Further review of Resident 118's clinical record revealed nursing documentation dated February 12, 2024, at 1:49 PM indicating Resident 118 tested positive for COVID-19.</p> <p>An interview with Employee 1 (infection preventionist) on June 20, 2024, at 11:12 AM confirmed these findings.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		