STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on March 6, 2025, it was determined that Valley Manor Rehabilitation and Healthcare Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1.Rooms were addressed during the visit. 2.The maintenance Director and Housekeeping Director will conduct environmental rounds together to ensure room issues are rectified and addressed. 3.The maintenance director will create a painting schedule for each room and coordinate with nursing and housekeeping until completion. Housekeeping will provide deep clean/target room schedules. Staff will be educated on utilizing maintenance work order forms to report any issues identified. Maintenance director will address work order forms as received. 4.Administrator or designee will conduct weekly audits on room rounds to ensure progress is being made in rooms and issues corrected. Data will be reviewed at QAPI.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 3 Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on one of three nursing units. (Central) Findings include: On March 4, 2024, from 9:30 a.m. to 1:15 p.m., the following was observed: In room 103, the doorknob to the bathroom was broken. There were no paper towels in the dispenser for residents or staff to dry their hands. In room 105, the transition was loose between the bathroom and the resident room, and the walls were heavily marred. In room 106, the window curtain was off the rod, and the walls were heavily marred with chipped paint throughout the room. In room 107, the bottom of the closet door was	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 4 peeling and separating, and the walls were marred with chipped paint. In rooms 111, 113, 205 and 207, the walls are marred with chipped paint throughout the rooms. In room 201, the bottom of the wall had a large hole along the baseboard near the bathroom, and the walls were marred with chipped paint throughout the room. In room 202, the window curtain was off the rod, and the walls were marred with chipped paint throughout the room. In room 209, the right side closet door was off the track and on the floor, the bottom of left closet door was peeling and separating, and the walls were marred with chipped paint throughout the room. In room 211, the privacy curtain was covered in dried pink and light brown stains, the window curtain was off the rod, and the walls were marred	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 5 with chipped paint throughout the room. In room 213, the bottom of closet door was peeling and crumbling, there was broken tile on the left side between the bed and the window with loose pieces scattered on the floor, tile missing in front of the bathroom door, and walls marred with chipped paint throughout the room. In room 215, there was tile missing in the bathroom, and marred walls with chipped paint throughout the room. CFR: 483.10(i) Safe, Clean, Comfortable, and Homelike Environment Previously cited 2/14/24. 28 Pa. Code 201.18(b)(1)(e)(2.1) Management.	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 6	F 0584		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1.Resident 49 fingernails were cut during survey. Resident 63 fingernails were cut, and his beard was trimmed on evening shift on 3/5/25. 2.DON/ADON did a house-wide audit on current residents listed as dependent with ADL. 3.Educated Unit managers on ADL care policy, as well as CNA's and LPNs. 4.DON or designee will conduct weekly audits during rounds to sample five dependent residents on each unit to ensure they receive nail care and facial hair grooming on shower days. Audits will be conducted weeklyx3 for two weeks, and then weeklyx4. Results will be reviewed at QAPI.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 7 Based on and staff and resident interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for two of 28 sampled residents. (Residents 49, 63) Findings include: Clinical record review revealed that Resident 49 had diagnoses that included dementia, diabetes mellitus, and polyneuropathy. According to the Minimum Data Set (MDS) assessment dated December 18, 2024, the resident was able to clearly communicate his needs and required extensive assistance from staff for personal hygiene. Review of the care plan revealed that the resident required assistance with activities of daily living (ADLs) with an intervention for staff to trim nails on shower days. On March 4, 2025, at 10:44 a.m., the resident was observed out of bed in his wheelchair. Resident 49's fingernails were long and dirty; there was a dark colored substance underneath the nails. The resident stated that his fingernails needed to be cut. On March 5, 2025, at 11:24 a.m., the resident was observed in	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 8 bed; his fingernails remained long and dirty. Clinical record review revealed that Resident 63 had diagnoses that included stroke, chronic pain, and depression. According to the MDS assessment dated February 4, 2025, the resident was able to clearly communicate his needs and required extensive assistance from staff for personal hygiene. Review of the care plan revealed that the resident required assistance with ADLs with an intervention for staff to trim nails and facial hair grooming on shower days. On March 4, 2025, at 11:30 a.m., the resident was observed out of bed in his wheelchair. Resident 49's fingernails were long and dirty; there was a dark colored substance underneath the nails. The resident stated that his fingernails needed to be cut, and he wanted his beard shaved. On March 5, 2025, at 11:24 a.m., the resident was observed in bed, his fingernails remained long and dirty and beard not shaved. In an interview on March 6, 2025, at 9:16 a.m., the Director of Nursing confirmed that the residents'	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 9 fingernails and beard should have been trimmed and cleaned with bathing and as needed. CFR 483.24(a)(2) ADL care provided for Dependent Residents Previously cited 2/14/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1.Wound care was completed for resident 249 on 3/4/25. Nurses on assignment were re-educated. Wound doctor assessed residents wound on 3/5/25 and there were no signs of an infection, or any harm caused to the resident. 2.DON/ADON conducted an audit on all wounds in-house to ensure they were completed and orders followed on 3/4/25. 3.IDT reviewed and updated the facility wound care policy. DON/designee provided education on the updated wound policy to licensed nursing staff. 4.DON or Designee will complete weekly wound audits to ensure wound care is being provided as ordered. Audits will be conducted weeklyx2, and monthlyx1. Results will be reviewed at QAPI.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 480202	7650 ROUTE 309 COOPERSBURG, PA 18036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 11 Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 28 sampled residents. (Resident 249) Findings include: Clinical record review revealed that Resident 249 had diagnoses that included atrial fibrillation, chronic obstructive pulmonary disease, and diabetes mellitus. Review of the Minimum Data Set assessment revealed that the resident had cognitive impairment. Review of Resident 249's skin assessment dated February 26, 2025, revealed that the resident had multiple bilateral lower extremity wounds from frost bite. In an interview on March 4, 2025, at 1:30 p.m., Resident 249's responsible party stated that she was concerned about the resident's wounds becoming infected because wound care was not being done daily. A physician's order dated February 20, 2025, directed staff to soak bilateral feet in lukewarm soapy water, pat dry, apply betadine to scattered open wounds and	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 12 toes and leave open to air, cover left medial ankle with abdominal dressing pad (ABD) pad and wrap in Kerlix (cotton gauze bandage rolls). A review of the February and March 2025 Treatment Administration Records revealed that the wound care was not done as ordered on February 21 and 28, 2025, and March 1 and 4, 2025. In an interview on March 6, 2025, at 08:43 a.m., the Nursing Home Administrator confirmed that the wound care was not done as ordered. CFR(s) 483.25 Quality of Care Previously cited 2/14/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the	F 0758	1.Orders for resident 47, resident 106, and resident 128 were reviewed by the physician and end dates for PRN psychotropic medications were applied on 3/6/25. 2.DON/ADON will audit all PRN psychotropic medication orders to ensure end dates are in place. 3.DON or Designee will educate nurses on PRN end dates and reassessment after 14 days. Education will be given to provider to document rationale for any continuation for PRN psychotropic medication. 4.DON or designee will complete audit on PRN psychotropic medication orders weeklyx3, and monthlyx2. Results will be presented at QAPI.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 480202	7650 ROUTE 309 COOPERSBURG, PA 18036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 14 attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 15 Based on clinical record review and staff interview, it was determined that the facility failed to document the rationale for the continued use of as needed (PRN) anti-anxiety medications for three of five sampled residents who were on psychotropic medications. (Residents 47, 106, 128) Findings include: Clinical record review revealed that Resident 47 had diagnoses that included anxiety, major depressive disorder and end stage renal disease. The Minimum Data Set (MDS) assessment dated February 15, 2025, indicated that the resident had minimal memory impairment, and had been administered an anti-anxiety medication within the seven-day assessment period. A review of the care plan revealed that the resident utilized psychotropic medications due to anxiety. On January 13, 2025, a physician ordered for staff to administer an anti-anxiety medication (Ativan) every 12 hours PRN for anxiety. Review of the	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 16 Medication Administration Records (MARs) revealed that Resident 47 received the prn Ativan four times in January 2025, twice in February 2025, and once in March 2025. There was no documentation in the resident's clinical record from the physician for the rationale to extend the PRN Ativan beyond the 14 days from the original order on January 13, 2025. Clinical record review revealed that Resident 106 had diagnoses that included peripheral vascular disease, diabetes mellitus, and bipolar disorder. On August 20, 2024, a physician ordered for staff to administer a psychoactive medication (Ativan) every 6 hours as needed for anxiety and/or agitation. Review of the MARs revealed that resident 106 received the prn Ativan six times in January 2025, and three times in February 2025. There was no documentation in the resident's clinical record from the physician for the rationale to extend the PRN Ativan beyond the 14 days from the	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 17 original order on August 20, 2024. Clinical record review revealed that resident 128 had diagnoses that included major depressive disorder, metabolic encephalopathy, Parkinson's disease, type 2 diabetes mellitus, anxiety, and unspecified dementia. The MDS assessment dated January 29, 2025, indicated that the resident had severe memory impairment, and had been administered an anti-anxiety medication within the seven-day assessment period. A review of the care plan revealed that the resident utilized psychotropic medications due to depression and anxiety. On November 10, 2024, a physician ordered for staff to administer an anti-anxiety medication (Ativan gel) every four hours as needed for anxiety. Review of the Medication Administration Records (MARs) revealed that resident 128 received the prn Ativan four times in November 2024, once in December 2024, six times in January 2025, twelve times in February 2025, and five times in March 2025.	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 18 There was no documentation in the resident's clinical record from the physician for the rationale to extend the PRN Ativan beyond the 14 days from the original order on November 10, 2024. On January 28, 2025, a physician ordered for staff to administer to resident 128 an anti-anxiety medication, lorazepam (generic Ativan), every four hours as needed for anxiety. Review of the MARs revealed the resident had been administered the PRN lorazepam medication once in January 2025, 20 times in February 2025, and three times in March 2025. There was no documentation in the resident's clinical record from the physician for the rationale to extend the PRN lorazepam beyond the 14 days from the original order on January 28, 2025. In an interview on March 6, 2025, at 9:27 a.m., the Administrator stated that there was no documentation to support the rationale to extend the PRN psychotropic medications beyond the 14 days	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 19 from the original order for the aforementioned residents. Pa. Code 211.12(d)(1)(5) Nursing services.	F 0758		
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 0880	1.DON/Admin rounded the facility to ensure all staff were wearing proper PPE. Signage applied to identified rooms. 2.Educated staff on donning and doffing PPE. 3.Full house re-education will be provided to all staff on the proper usage of PPE, infection control, donning and doffing PPE. 4.DON or designee will complete audits weeklyx2 to ensure appropriate signs are displayed outside of resident rooms and staff are wearing proper PPE while providing care. Results will be reviewed at QAPI.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: 480202	7650 ROUTE 309 COOPERSBURG, PA 18036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 20 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER	**7650 ROUTE 309 COOPERSBURG, PA 18036**
STATE LICENSE NUMBER: **480202**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 21 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 22 Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for five of 28 sampled residents (Residents 12, 19, 49, 86, 131) on two of three nursing units. (North and Central) Findings include: Review of the facility policy entitled, "Transmission Based Precautions," last reviewed November 25, 2024, revealed that transmission based precautions (TBPs) may include contact precautions, droplet precautions, and airborne precautions that vary with how restrictive they were in requiring certain personal protective equipment (PPE). If a resident was identified as having a communicable disease, then TBPs were to be initiated. Staff were to post a sign on the door that all personnel and visitors entering the room must first see the nurse to obtain additional information before entering the room as part of maintaining the specific TBP and PPE	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 23 protocol. Review of the facility policy entitled, "Droplet Precautions," last reviewed November 25, 2024, revealed that droplet precautions were to be implemented for residents documented or suspected to be infected with microorganisms transmitted by droplets generated by the individual coughing, sneezing, talking, or by the performance of such procedures such as suctioning. An infection requiring Droplet Precautions includes influenza. Staff was to wear cleanable or disposable eye wear, non-sterile, disposable isolation gowns, face masks, and gloves, which were donned and doffed when entering and exiting patients' rooms and were not to be reused. Clinical record review revealed that Resident 12 tested positive for influenza A on March 1, 2025. Observation on March 5, 2025, at 8:50 a.m., revealed an environmental services worker (EVS 1) in Resident 15's room without any PPE. EVS 1 exited the room at 8:59 a.m. and went directly into the next resident room. On March 5, 2025, at 9:00	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 24 a.m., Registered Nurse (RN 1) was observed entering Resident 15's room for eight minutes wearing a surgical face mask. RN 1 did not have on the additional required PPE. RN 1 was observed giving the resident her medications and exiting the room at 9:08 a.m. At 9:10 a.m., RN 1 re-entered Resident 12's room to give additional medication wearing only a surgical mask. RN 1 did not have on the required PPE. RN 1 did not remove her face mask when she exited the room. In an interview at that time, RN 1 stated that she didn't see the sign outside the door and did not know why Resident 12 was on Droplet Precautions. Review of the facility policy entitled, "Enhanced Barrier Precautions," last reviewed November 25, 2024, revealed that Enhanced Barrier Precautions (EBPs) are used to help reduce the transmission of Multi-Drug Resistant Organisms (MDROs) by requiring the use of gowns and gloves during specific high contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of acquiring an	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 25 MDRO. Residents at risk include but are not limited to those with feeding tubes, indwelling urinary catheters, central vascular lines, tracheostomy tubes, and wounds. Clinical record review revealed that Resident 19 had diagnoses that included a history of an open wound of the abdominal wall as well as sacral and right lower extremity pressure wounds. On March 5, 2025, at 9:20 a.m., a nurse aide (NA 3) was observed entering Resident 19's room to provide care. NA 3 did not use a protective gown in accordance with facility policy. There was no sign indicating that the resident was on EBPs. Clinical record review revealed that Resident 49 had diagnoses that included a history of neuromuscular dysfunction of the bladder with a suprapubic catheter. On March 4, 2025, at 11:45 a.m., a nurse aide (NA 2) was observed entering Resident 49's room to provide care. NA 2 did not use a protective gown in accordance with facility policy. There was no sign indicating that the resident was on	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 26 EBPs. Clinical record review revealed that Resident 86 had diagnoses that included end stage renal disease with a right chest permanent catheter (a flexible tube inserted into the vein in the neck, chest, or groin, used for dialysis). On March 5, 2025, at 10:30 a.m., a nurse aide (NA 1) was observed entering Resident 86's room to provide care. NA 1 did not use a protective gown in accordance with facility policy. There was no sign indicating that the resident was on EBPs. Clinical record review revealed that Resident 131 had diagnoses that included a history of neuromuscular dysfunction of the bladder with an indwelling catheter. On March 5, 2025, at 1:37 p.m., a licensed practical nurse (LPN 1) was observed entering Resident 131's room to provide care. LPN 1 did not use a protective gown in accordance with facility policy. There was no sign indicating that the resident was on EBPs.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 27 In an interview on March 6, 2025, at 8:45 a.m., the Director of Nursing confirmed that Droplet and Enhanced Barrier Precautions should have been implemented and the policies were not being followed by staff. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309 COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 28	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1.The facility staffs the facility to at least meet the required staffing ratios of NAs, including the use of agency staff if necessary. When there are staff callouts, the facility attempts to call other staff in and notify agency staff as well. Facility continues to focus on recruitment and retention activities. 2.Valley Manor will hold staffing meetings throughout the week to monitor staffing ratio compliance. 3.NHA or designee will educate DON/ADON/ and Nursing Supervisors on state ratio staffing regulation. 4.To monitor the corrective action and ensure that it does not recur, the DON will audit nursing staff to resident ratios weekly X4; bi-weekly X 2 and monthly X 1. The results will be reviewed at the QAPI meeting.	Completion Date: **04/01/2025** Status: **APPROVED** Date: **03/21/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395167	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER STATE LICENSE NUMBER: **480202**	**7650 ROUTE 309** **COOPERSBURG, PA 18036**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Continued from page 1 Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for three of 21 days reviewed. Findings include: Review of nursing schedules for 21 days from February 13, 2025, to March 5, 2025, revealed the following: The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on February 16, 2025, and February 23, 2025. The facility failed to meet the minimum NA to resident ratio of one NA for 11 residents on evening shift (3:00 p.m. to 11:00 p.m.) on March 3, 2025.	P 5520		

Certified End Page

VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 480202

SURVEY EXIT DATE: 03/06/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY