| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __--_____ B. WING: _____ | 03/12/2025 |

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| **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 |
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| E 0000 | INITIAL COMMENT<br><br>Based on an Emergency Preparedness Survey completed on March 12, 2025, it was determined that Valley Manor Rehabilitation And Healthcare Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73. | E 0000 | | |
| E 0036<br><br>SS=C | 483.73(d) EP Training and Testing<br><br>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency | E 0036 | Facility conducted an annual in-service for staff on the emergency preparedness plan and training program.<br><br>4/28/25<br><br>Staff will be educated annually to remain in compliance.<br><br>Director of maintenance will audit the emergency binder monthlyx3 to ensure it is up to date | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

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.

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| E 0036<br><br>SS=C | Continued from page 1<br><br>preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.<br><br>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). | E 0036 | | |

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| E 0036<br><br>SS=C | Continued from page 2<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.<br><br>This REQUIREMENT is not met as evidenced by: | E 0036 | | |

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| E 0036<br><br>SS=C | Continued from page 3<br><br>Based on documentation review and interview, it was determined the facility failed to provide documentation of the development and maintenance of emergency preparedness training program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan.<br><br>Findings include<br><br>Document review on March 12, 2025, at 3:15 p.m., revealed the facility failed to provide documentation of an emergency preparedness training program based on the Emergency Preparedness Plan, and to include initial and annual training of all staff.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the facility failed to develop an Emergency Preparedness Plan to include a training program. | E 0036 | | |

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| E 0037<br><br>SS=C | 483.73(d)(1) EP Training Program<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, | E 0037 | 1.Facility conducted an annual in-service for staff on the emergency preparedness plan.<br>2. 4/28/25<br>3. Staff will be educated annually to remain in compliance.<br>4.Director of maintenance will audit the emergency binder monthlyx3 to ensure it is up to date 8/25. Director will keep record in maintenance binder. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

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| E 0037<br><br>SS=C | Continued from page 5<br><br>consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. | E 0037 | | |

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| E 0037<br><br>SS=C | Continued from page 6<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures. | E 0037 | | |

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| E 0037<br><br>SS=C | Continued from page 7<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected | E 0037 | | |

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| E 0037<br><br>SS=C | Continued from page 8<br><br>roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br><br>This REQUIREMENT is not met as evidenced by: | E 0037 | | |

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| E 0037<br><br>SS=C | Continued from page 9<br><br>Based on document review and interview, it was determined that the facility failed to provide documentation of initial and annual Emergency Preparedness training for staff and individuals providing services to the facility including volunteers, in one of one facility.<br><br>Findings include:<br><br>Document review on March 12, 2025, at 3:15 p.m., revealed the facility failed to to provide the maintained annual documentation of Emergency Preparedness training of staff members demonstrating their knowledge of emergency procedures.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the facility failed to to provide annual records of employee training. | E 0037 | | |

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| E 0039<br><br>SS=C | 483.73(d)(2) EP Testing Requirements<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or | E 0039 | 1.Facility conducted a tabletop exercise on an active shooter event.<br><br>2.4/28/25.<br><br>3.The Director of maintenance will create schedule to have tabletop exercises annually.<br><br>4.Director of maintenance will complete random facility audits | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

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| E 0039<br><br>SS=C | Continued from page 11<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: | E 0039 | | |

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| E 0039<br><br>SS=C | Continued from page 12<br><br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem | E 0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __--_____ B. WING: _____ | 03/12/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| **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 |
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| E 0039<br><br>SS=C | Continued from page 13<br><br>statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a | E 0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| E 0039<br><br>SS=C | Continued from page 14<br><br>facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or | E 0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| E 0039<br><br>SS=C | Continued from page 15<br><br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based | E 0039 | | |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| E 0039<br><br>SS=C | Continued from page 16<br><br>or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or | E 0039 | | |

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

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|---|---|---|---|---|
| E 0039<br><br>SS=C | Continued from page 17<br><br>an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at<br>least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may | E 0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| E 0039<br><br>SS=C | Continued from page 18<br><br>include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency | E 0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| E 0039<br><br>SS=C | Continued from page 19<br><br>events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br><br>This REQUIREMENT is not met as evidenced by: | E 0039 | | |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| E 0039<br><br>SS=C | Continued from page 20<br><br>Based on document review and interview, it was determined the facility failed to conduct the required annual-full scale exercise and additional exercise to test the emergency preparedness plan, affecting the entire facility.<br><br>Findings include:<br><br>Document review on March 12, 2025, at 3:15 p.m., revealed the facility failed to conduct the required annual-full scale exercise and additional exercise to test the emergency preparedness plan within the previous 12 months.<br><br>Exit interview with the Administrator, Director of Maintenance, and assistant on March 12, 2025, at 3:15 p.m., confirmed the lack of documentation. | E 0039 | | |

# Certified End Page

**VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**

**STATE LICENSE NUMBER: 480202**

**SURVEY EXIT DATE: 03/12/2025**

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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

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| K 0000 | INITIAL COMMENT<br><br>Facility ID# 480202<br>Component 01<br>Main Building (North & South Wings)<br><br>Based on a Medicare/Medicaid Recertification Survey conducted on March 12, 2025, it was determined that Valley Manor Rehabilitation And Healthcare Center was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).<br><br>This is a one-story, Type V (000), unprotected wood frame building, with a basement, that is fully sprinklered. | K 0000 | | |

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: |
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| K 0222<br><br>SS=E | NFPA 101 Egress Doors<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, | K 0222 | 1.Door # EM1 repaired and released on egress and requesting a TLW for EM4 as a door repair may be necessary to be made by an outside vendor.<br><br>2.4/28/25<br><br>3.Doors will be checked on a monthly basis.<br><br>4.Director of maintenance or designee will conduct monthly audits to ensure doors are released after 15 seconds of applying pressure | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**<br>STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309**<br>**COOPERSBURG, PA 18036** |

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| K 0222<br><br>SS=E | Continued from page 2<br><br>supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br><br>This REQUIREMENT is not met as evidenced by: | K 0222 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| K 0222<br><br>SS=E | Continued from page 3<br><br>Based on observation and interview, it was determined the facility failed to maintain exit egress doors equipped with delayed egress locking arrangements, affecting two of four smoke compartments..<br><br>Findings include:<br><br>Observation on March 12, 2025, at the following time and locations, revealed the exit door equipped with delayed egress locking arrangements did not release after 15 seconds of applying pressure against the crash bar.<br><br>a) 1:35 p.m., on the first floor, door # EM-1 Next to basement stairwell.<br>b) 2:15 p.m., on the first floor, door # E4 - Dining room.<br><br>Exit interview with the Administrator, Director of Maintenance, and Assistant on March 12, 2025, at 3:15 p.m., confirmed the doors did not release after 15 seconds of pressure against the crash bar. | K 0222 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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 |
|---|---|---|---|---|
| K 0222<br><br>SS=E | Continued from page 4 | K 0222 | | |
| K 0231<br><br>SS=C | NFPA 101 Means of Egress Capacity<br><br>Means of Egress Capacity<br>The capacity of required means of egress is in accordance with 7.3.<br>18.2.3.1, 19.2.3.1<br><br>This REQUIREMENT is not met as evidenced by: | K 0231 | The facility is requesting that the DOH Division of Life Safety perform an updated FSES. | Completion Date: **04/01/2025** Status: **APPROVED** Date: **04/02/2025** |

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|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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|---|---|
| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**<br>STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309**<br>**COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0231<br><br>SS=C | Continued from page 5<br><br>Based on observation and interview, it was determined the facility failed to maintain the minimum required clearances along the means of egress, affecting two of two levels.<br><br>Findings include:<br><br>1. Observation on March 12, 2025, at 12:30 p.m., revealed the Northeast Stair Tower width was 33 in. The required width is 36 in.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the stair tower width.<br><br>2. Observation on March 12, 2025, at 12:45 p.m., revealed the Basement Level lacked acceptable headroom clearance along the exit access corridor. The headroom clearance was less than the required six feet, eight inches, (height was approximately six feet, six inches) from overhead sprinkler piping to finished floor level. | K 0231 | | |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**<br>STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309**<br>**COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0231<br><br>SS=C | Continued from page 6<br><br>Exit interview with the Administrator, Director of Maintenance, and Assistant on March 12, 2025, at 3:15 p.m., confirmed the headroom clearance. | K 0231 | | |
| K 0291<br><br>SS=E | NFPA 101 Emergency Lighting<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br><br>This REQUIREMENT is not met as evidenced by: | K 0291 | 1.Facility will resume testing monthly test and completed a 90-minute test.<br><br>2.4/28/25<br><br>3.The new director of maintenance will create a new PM binder. Maintenance staff educated on testing.<br><br>4.Audits will be conducted monthlyx3. | Completion Date: **04/28/2025**<br>Status: **APPROVED**<br>Date: **04/02/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
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|---|---|---|---|---|
| K 0291<br><br>SS=E | Continued from page 7<br><br>Based on observation, interview, and review of documentation, it was determined the facility failed to maintain that Emergency lighting of at least 1-1/2-hour duration was tested and inspected on one of two levels within this facility.<br><br>Findings include:<br><br>Review of documentation on March 12, 2025, between 9:15 a.m. and 12:30 p.m., revealed the facility lacked documentation verifying emergency backup lights were tested monthly and a 90 minute test was performed annually.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the facility lacked documentation verifying emergency backup lighting was tested. | K 0291 | | |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
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| K 0293<br><br>SS=E | NFPA 101 Exit Signage<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br><br>This REQUIREMENT is not met as evidenced by: | K 0293 | 1.Exit signage corrected and operable. The other exit sign removed.<br><br>2.4/28/25<br><br>3.Director of maintenance will check exit signs on monthly basis.<br><br>4.Audit will be conducted monthlyx3. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

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| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0293<br><br>SS=E | Continued from page 9<br><br>Based on observation and interview, it was determined the facility failed to ensure that exit signs were maintained, affecting one of two levels.<br><br>Findings include:<br><br>Observation made on March 12, 2025, at Great Room entrance from corridor, revealed that there were two exit signs ( One operable and another disabled ) that instructed conflicting instructions on nearest possible emergency exit through Great Room.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the disabled exit signage. | K 0293 | | |

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|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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|---|---|
| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| K 0321<br><br>SS=E | NFPA 101 Hazardous Areas - Enclosure<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br><br>This REQUIREMENT is not met as evidenced by: | K 0321 | 1.Soiled utility room door repaired to fully close and latch.<br><br>2.4/28/25<br><br>3.Staff education completed on regulation for NFPA 101 Standard (section 8.4) stating that "doors shall be self-closing or automatic closing ".<br><br>4.Director of maintenance will conduct audits monthlyx3. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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| K 0321<br><br>SS=E | Continued from page 11<br><br>Based on observation and interview, it was determined the facility failed to maintain a hazardous area enclosure on 1 of 2 levels of the facility.<br><br>Findings include:<br><br>Observation on March 12, 2025, at 1:00 p.m., on the first floor, at soiled utility across room 312, had paper towels stuffed into doorframe strike plate, preventing the door to latch.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the paper towels inside the strike plate. | K 0321 | | |
| K 0324<br><br>SS=F | | K 0324 | | |

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| K 0324<br><br>SS=F | Continued from page 12<br><br>NFPA 101 Cooking Facilities<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by: | K 0324 | 1.Kitchen suppression system will be tested again and two inspections completed for the year in June.<br><br>2.4/28/25<br><br>3.Maintenance staff will conduct quarterly inspections in the kitchen.<br><br>4.The Director of maintenance will keep inspection reports and conduct monthly audits x3. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

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| K 0324<br><br>SS=F | Continued from page 13<br><br>Based on document review and interview, it was determined the facility failed to ensure the kitchen suppression system was inspected and serviced at required intervals, for one of two required inspections.<br>Findings include:<br>Document review on March 12, 2025, between 9:15 a.m. and 12:30 p.m., revealed the facility could not produce documentation showing that the kitchen suppression system had been tested and maintained twice in the prior year. Only Inspection report 1/17/25 was provided.<br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the missing documentation. | K 0324 | | |
| K 0345<br><br>SS=F | | K 0345 | | |

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|---|---|---|---|---|
| K 0345<br><br>SS=F | Continued from page 14<br><br>NFPA 101 Fire Alarm System - Testing and Maintenance<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This REQUIREMENT is not met as evidenced by: | K 0345 | 1.Tustin Fire Alarm will be scheduled to come to the facility and complete all testing.<br>A. Keys are now available for reset.<br>B. Tustin visited 3/31/25 and waiting on report for basement detectors.<br>C. Zone 4 was checked when Tustin came out. Waiting on report.<br><br>2.4/28/25<br><br>3.Maintenance staff educated on keeping up to date with the scheduling of the fire alarm system.<br><br>4.The Director of maintenance will keep all reports up to date. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

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|---|---|---|---|---|
| K 0345<br><br>SS=F | Continued from page 15<br><br>Based on document review and interview, it was determined the facility failed to maintain fire alarm system components in operable condition, affecting the entire facility.<br>Findings include:<br>1. Documentation reviewed on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed the fire alarm annual report dated 5/15/2024 listed the following:<br>a) The pull station at nurses station could not be tested due to no keys were available to reset;<br>b) The smoke detector sensitivity values documented on the device list (with the exception of the smoke detectors in the basement) were recorded during sensitivity testing.* Note: Customer needs to contact Simplex to acquire sensitivity values for the simplex smoke detectors in the basement;*<br>c) Zone 4 needs to be investigated to why detectors don't automatically reset.<br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at | K 0345 | | |

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| K 0345<br><br>SS=F | Continued from page 16<br><br>3:15 p.m., confirmed the fire alarm deficiency had not been resolved.<br>2. Documentation reviewed on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed the facility could not provide sensitivity testing on basement smoke detectors.<br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the lack of testing documentation. | K 0345 | | |
| K 0353<br><br>SS=F | | K 0353 | | |

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|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 17<br><br>NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This REQUIREMENT is not met as evidenced by: | K 0353 | 1.The Sprinkler system will be scheduled with Tustin for testing annually. Sprinkler heads will be adjusted. At time of survey the fire pump was in test mode and was discharging water and the facility ensures proper water is filled in the water tower. facility will inspect the external water tank at least quarterly<br>2. A. Facility will schedule replacement sprinkler with Tustin.<br>b. Facility will contact the fire department to get hydro test scheduled.<br>c. Report was from 2024. The temperatures were good during the site visit on 3/12/25.<br>d. Facility currently monitors the water tank daily.<br>e. Water was flowing during site visit on 3/12/25.<br><br>3.Tustin will be scheduled to come in and turn sprinkler heads downwards.<br><br>4.Fire alarm panel working properly and was completing a test which led to the low water notification. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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 |
|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 18 | K 0353 | The facility has a working heater that maintains adequate temperature throughout. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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

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|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 19<br><br>Based on document review and interview, it was determined the facility failed to maintain sprinklers affecting entire facility.<br><br>Findings include:<br><br>1. Docuemtnation reviewed on March 12, 2025, revealed the following:<br><br>a) Only record of two quarterly external water tank inspections dated 12/23/2024 and 5/15/2024 were provided.<br><br>b) Only record of two quarterly wet sprinkler inspections dated 12/23/2024 and 5/15/2024 were provided.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the missing report documentation.<br><br>2. Documentation reviewed on March 12, 2025, | K 0353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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 |
|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 20<br><br>revealed the 4th quarter sprinkler inspection dated 12/23/2024 reported the following:<br><br>a) Sprinkler in Dietary needs to be replaced due to corrosion per the state inspector(2/09/23);<br><br>b) At the time of inspection the fire department connection. Hydro test has not been performed. This needs to be performed as soon as possible;<br><br>c) Could not flow water for main drain or ITV's due to temperatures in fire pump room being below 40 degrees (32 degrees) with temperatures in the area being extremely low it is unknown if temperature has been below freezing where wet sprinkler piping is located. With water flowing there is a risk of broken pipes if ice is present. This area of the sprinkler system is required to to always be above 40 degrees fahrenheit and needs to be corrected as soon as possible (12/23/24);<br><br>d) The customer needs to monitor the water level in the tank and keep it filled at all times; | K 0353 | | |

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|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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

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|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 21<br><br>e) A full visual inspection was preformed 1/18/24 due to freezing outside air temperatures. No water was flowed;<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed records of repairs and mandatory sprinkler external water tank level inspections had not occurred.<br><br>3). Observation made on March 12, 2025 at 12:55 p.m., revealed two sprinkler heads, inside the basement laundry chute room, were recessed into the ceiling, which could prevent immediate water spread.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the impeded sprinkler heads in the basement.<br><br>4) Observation made on March 12, 2025 at 1:00 | K 0353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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

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|---|---|---|---|---|
| K 0353<br><br>SS=F | Continued from page 22<br><br>p.m., revealed the fire alarm panel had a supervisory with description of: 11:27 am 3/12/25 - Water Tower Low Water M1-8.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the low water in water tower indicated from notification of monitoring equipment. | K 0353 | | |
| K 0355<br><br>SS=E | | K 0355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0355<br><br>SS=E | Continued from page 23<br><br>NFPA 101 Portable Fire Extinguishers<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br><br>This REQUIREMENT is not met as evidenced by: | K 0355 | 1.The facility will replace the 15 fire extinguishers.<br><br>2.4/28/25<br><br>3.The maintenance director will be educated on tracking and replacing fire extinguishers as needed.<br><br>4.Monthly audits will be conducted on fire extinguisher expiration dates and that they are in good working condition. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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|---|---|
| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
| STATE LICENSE NUMBER: **480202** | |

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|---|---|---|---|---|
| K 0355<br><br>SS=E | Continued from page 24<br><br>Based on documentation review and interview, it was determined the facility failed to maintain portable fire extinguishers, affecting 15 of 32 portable fire extinguishers.<br><br>Findings include:<br><br>Document review on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed the facility provided documentation that an annual portable fire extinguisher inspection had been performed, on 1/17/25. Per report, 15 out of the 32 fire extinguishers needed to be replaced.<br><br>Exit interview with the Administrator, Director of Maintenance, and Assistant on March 12, 2025, at 3:15 p.m., confirmed the portable fire extinguishers have not been replaced at time of survey. | K 0355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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

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|---|---|---|---|---|
| K 0371<br><br>SS=C | NFPA 101 Subdivision of Building Spaces - Smoke Compar<br><br>Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING<br>Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2<br>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.<br><br>This REQUIREMENT is not met as evidenced by: | K 0371 | The facility is requesting that the DOH Division of Life Safety perform an updated FSES. | Completion Date: **04/01/2025**<br>Status: **APPROVED**<br>Date: **04/02/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
| STATE LICENSE NUMBER: **480202** | |

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|---|---|---|---|---|
| K 0371<br><br>SS=C | Continued from page 26<br><br>Based on observation, document review, and interview, it was determined the facility failed to provide adequate square footage of smoke compartments, affecting two of four smoke compartments.<br><br>Findings include:<br><br>Document review on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed smoke compartments 400 wing (zone two) and the First Floor (zone three), Rooms 101-111 and 101-302, had zones exceeding 22,500 square feet.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the size of the smoke compartments were larger than the maximum square footage permitted. | K 0371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0372<br><br>SS=E | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br><br>This REQUIREMENT is not met as evidenced by: | K 0372 | 1.Unsealed wire penetration was corrected and sealed using an UL approved stop gap penetration system for sealing the penetration.<br><br>2.3/13/25<br><br>3.The maintenance director will be educated on unsealed penetrations.<br><br>4.Audits will be conducted monthly random checks behind ceiling tiles to ensure any unsealed penetrations are not found. If found, they will be corrected at that time. | Completion Date: **03/13/2025** Status: **APPROVED** Date: **04/03/2025** |

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|---|---|---|---|---|
| K 0372<br><br>SS=E | Continued from page 28<br><br>Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls, affecting one of two levels.<br><br>Findings include:<br><br>Observation on March 12, 2025, at 3:00 p.m., revealed on first floor, above smoke barrier doors, next to Great Room, there was an unsealed MC wire penetration, .<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the penetration in the rated smoke wall. | K 0372 | | |
| K 0374<br><br>SS=E | | K 0374 | | |

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|---|---|---|---|---|
| K 0374<br><br>SS=E | Continued from page 29<br><br>NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br><br>This REQUIREMENT is not met as evidenced by: | K 0374 | 1.The Bari lift was removed doors close properly.<br><br>2.3/13/25<br><br>3.Staff educated on not blocking doors.<br><br>4.Director of maintenance will conduct a round audit to ensure doors are clear once a week for 2 weeks. | Completion Date: **03/13/2025** Status: **APPROVED** Date: **04/02/2025** |

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|---|---|---|---|---|
| K 0374<br><br>SS=E | Continued from page 30<br><br>Based on observation and interview, it was determined that the facility failed to ensure that smoke barrier doors are properly inspected and maintained to fully close and resist the passage of smoke in one of two wings within this component.<br><br>Findings include:<br><br>Observations made on March 12, 2025, at 2:50 p.m., revealed that on the first floor, the smoke barrier doors, next to room 508, failed to close tight due to being blocked by a berri lift.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the doors were blocked, inhibiting the ability to close smoke tight.. | K 0374 | | |
| K 0521<br><br>SS=E | | K 0521 | | |

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|---|---|---|---|---|
| K 0521<br><br>SS=E | Continued from page 31<br><br>NFPA 101 HVAC<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by: | K 0521 | 1.HVAC exhaust/ intake diffuser placed back in the ceiling.<br><br>2.4/28/25<br><br>3.Maintenance staff educated on ensuring exhaust system is back in place.<br><br>4.Director of maintenance will audit soiled utility rooms once a month. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/02/2025** |

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| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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|---|---|---|---|---|
| K 0521<br><br>SS=E | Continued from page 32<br><br>Based on observation and interview, it was determined that the facility failed to ensure HVAC exhaust diffusers are maintained on one of two levels within facility.<br><br>Findings include:<br><br>Observation made on March 12, 2025, at 1:35 p.m., revealed, on the first floor, inside the soiled utility room inside 500 wing, there was an HVAC exhaust / intake diffuser dislodged from the ceiling, powered, resting on top of wall mounted cabinets and sitting on intake side.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the HVAC intake diffuser was dislodged from ceiling grid and resting as described.<br>. | K 0521 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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 |
|---|---|---|---|---|
| K 0712<br><br>SS=F | NFPA 101 Fire Drills<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br><br>This REQUIREMENT is not met as evidenced by: | K 0712 | 1.The facility will conduct fire drills immediately on all three shifts. Going forward the facility will create a schedule for fire drills to ensure they are completed as required.<br><br>2.4/28/25<br><br>3.The Maintenance Director was educated on conducting the fire drills once per shift per quarter and intermittently throughout the year on different dates and times.<br><br>4.The Director of maintenance will complete random audits. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0712<br><br>SS=F | Continued from page 34<br><br>Based on document review and interview, it was determined the facility failed to conduct fire drills once per shift per quarter, affecting the entire facility.<br><br>Finding include:<br><br>Document review on March 12, 2025, between 9:15 a.m. and 12:30 p.m., revealed the facility could not produce accurate shift with staff participation documentation of monthly fire drills, for months March, May, June, August, October of 2024, and February of 2025.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the lack of accurate documentation. | K 0712 | | |

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|---|---|---|---|---|
| K 0741<br><br>SS=D | NFPA 101 Smoking Regulations<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br><br>This REQUIREMENT is not met as evidenced by: | K 0741 | 1.Cigarette butts were cleaned out of the mulch.<br><br>2.4/28/25<br><br>3.Staff were educated on cigarette smoking area. There are appropriate ashtrays and appropriate metal self-closing device to empty the ashtrays.<br><br>4.Director of maintenance will audit grounds 1x a week for 2 weeks. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |
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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |

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|---|---|---|---|---|
| K 0741<br><br>SS=D | Continued from page 36<br><br>Based on observation and interview, it was determined the facility failed to follow smoking regulations at one of one designated smoking area.<br><br>Findings include:<br><br>Observation on March 12, 2025, at 9:00 a.m., revealed the facility had an accumulation of cigarette butts inside the mulch beds, outside the resident room windows, along building's side driveway, outside the designated smoking area.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed discarded cigarette buts can accumulate in described area.. | K 0741 | | |
| K 0761<br><br>SS=F | | K 0761 | | |

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|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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

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|---|---|---|---|---|
| K 0761<br><br>SS=F | Continued from page 37<br><br>NFPA 101 Maintenance, Inspection & Testing - Doors<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br><br>This REQUIREMENT is not met as evidenced by: | K 0761 | 1.Conducted rated fire door testing and inspection of fire doors.<br><br>2.4/28/25<br><br>3.Maintenance staff educated on completing rated fire door testing.<br><br>4.Director of maintenance will audit fire doors quarterly. | Completion Date: **04/28/2025**<br>Status: **APPROVED**<br>Date: **04/03/2025** |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
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|---|---|---|---|---|
| K 0761<br><br>SS=F | Continued from page 38<br><br>Based on document review and interview, it was determined the facility failed to ensure that rated fire door assemblies were inspected and tested annually, affecting the entire facility.<br><br>Findings include:<br><br>Document review on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed the facility could not provide documentation that rated fire door assemblies were inspected and tested within the previous 12 months.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the facility could not provide documentation that fire door assemblies were inspected and tested within the previous 12 months. | K 0761 | | |

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| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**<br>STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309**<br>**COOPERSBURG, PA 18036** |

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| K 0911<br><br>SS=E | NFPA 101 Electrical Systems - Other<br><br>Electrical Systems - Other<br>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Chapter 6 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by: | K 0911 | Order removed from the front of the main electrical panel.<br><br>A. Wires capped off and placed away from the dishwasher drying rack discharge on the same day.<br><br>Housekeeping director educated on not having janitorial equipment in front of electrical panels.<br><br>The Director of maintenance will conduct rounds to ensure nothing is covering the panels once a month. | Completion Date: **04/28/2025**<br>Status: **APPROVED**<br>Date: **04/03/2025** |

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| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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|---|---|---|---|---|
| K 0911<br><br>SS=E | Continued from page 40<br><br>Based on observation and interview, it was determined the facility failed to ensure that electrical panels were protected and accessible in accordance with NFPA 70 2011 Section 110.26; NFPA 70 2011 Section 314.23 (H)(1); and NFPA 99 2012 Section 6.3.2.1, affecting two of four zones within the facility.<br><br>Findings include:<br><br>1. Observation made on March 12, 2025, at 12:38 p.m., in the basement, at the outdoor dock area, revealed there was a large central supply order stored, leaning on, and in front the main electrical high voltage switch gear handles.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed storage blocking and leaning on high voltage electrical controls.<br><br>2. Observation made on March 12, 2025, at 3:10 p.m., inside kitchen, revealed an exposed 3 wire electrical conduit, coming from ceiling, not | K 0911 | | |

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|---|---|---|---|---|
| K 0911<br><br>SS=E | Continued from page 41<br><br>terminated into appliance, with wire nuts, electrical tape on three wires, and hanging above the dishwasher drying rack discharge.<br><br>Exit interview with the Administrator, Director of Maintenance, and Assistant on March 12, 2025, at 3:15 p.m., confirmed the exposed three wire conduit in kitchen.<br><br>3. Observation at 2:30 p.m., revealed, on the first floor, the mechanical room, across from room 330, had janitorial equipment in front of electrical panels.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the janitorial equipment in front of electrical panels. | K 0911 | | |

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| K 0918<br><br>SS=C | NFPA 101 Electrical Systems - Essential Electric Syste<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br><br>This REQUIREMENT is not met as evidenced by: | K 0918 | Director of maintenance working on finding an electrician to install a battery back-up light for the emergency generator.<br><br>4/28/25<br><br>Once electrician is scheduled, director of maintenance will continue to audit the emergency generator weekly. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

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|---|---|---|---|---|
| K 0918<br><br>SS=C | Continued from page 43<br><br>Based on observation and interview, it was determined the facility failed to maintain required emergency generator components, affecting the entire facility.<br><br>Findings include:<br><br>Observation made on March 12, 2025, at 12:45 p.m., revealed the emergency generator set (ATS) location, the electrical room in the basement , lacked battery back-up emergency lighting.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the back-up lighting was not installed. | K 0918 | | |

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| K 0920<br><br>SS=E | NFPA 101 Electrical Equipment - Power Cords and Extens<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6.<br>Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br><br>This REQUIREMENT is not met as evidenced by: | K 0920 | Extension cords removed from both locations.<br><br>3/13/25<br><br>Staff educated on extension cords in facility.<br><br>The Director of maintenance will conduct random facility audits. | Completion Date: **03/13/2025** Status: **APPROVED** Date: **04/03/2025** |
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| K 0920<br><br>SS=E | Continued from page 45<br><br>Based on observation and interview, it was determined the facility failed to ensure that electrical wiring and equipment was maintained and the improper and unauthorized use of power strips, extension cords and outlet multipliers were prohibited on 1 of 2 levels within this component.<br><br>Findings Include:<br><br>Observations on March 12, 2025, revealed between 12:30 p.m. and 3:15 p.m.:<br><br>a) In the basement, the Resident Storage- Dehumidifier plugged into extension cord that is powered from ceiling receptacle;<br>b) Admissions Office- Microwave, mini-fridge and toaster plugged into a power strip.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the unauthorized use of devices to power motorized appliances. | K 0920 | | |

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|---|---|---|---|---|
| K 0920<br><br>SS=E | Continued from page 46 | K 0920 | | |
| K 0921<br><br>SS=F | NFPA 101 Electrical Equipment - Testing and Maintenanc<br><br>Electrical Equipment - Testing and Maintenance Requirements<br>The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time | K 0921 | Facility will conduct annual receptable testing in resident care areas.<br><br>4/28/25<br><br>Maintenance staff educated on receptable testing.<br><br>The Director of maintenance will conduct random facility audits. | Completion Date: **04/28/2025** Status: **APPROVED** Date: **04/03/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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 |
|---|---|---|---|---|
| K 0921<br><br>SS=F | Continued from page 47<br><br>to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.<br>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on documentation review and interview, it was determined the facility failed to maintain required inspections of electrical wiring and receptacle systems, affecting all resident bed locations.<br>Findings include:<br>Review of documentation on March 12, 2025, between 9:15 a.m., and 12:30 p.m., revealed the required annual inspection of receptacles in resident care areas was not performed.<br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the testing was not performed. | K 0921 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: 01<br>B. WING: | 03/12/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**<br>STATE LICENSE NUMBER: **480202** | **7650 ROUTE 309**<br>**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 |
|---|---|---|---|---|
| K 0923<br><br>SS=E | NFPA 101 Gas Equipment - Cylinder and Container Storag<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) | K 0923 | Propane tank removed from being stored in front of main electrical panel.<br><br>4/28/25<br><br>Staff educated on not storing propane tanks in front of electrical panels.<br><br>The director of maintenance will conduct random facility audits. | Completion Date: **04/28/2025**<br>Status: **APPROVED**<br>Date: **04/03/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

| 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** | |

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|---|---|---|---|---|
| K 0923<br><br>SS=E | Continued from page 49<br><br>This REQUIREMENT is not met as evidenced by: | K 0923 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395167 | A. BLDG: __01_____ B. WING: _____ | 03/12/2025 |

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| **VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER** | **7650 ROUTE 309 COOPERSBURG, PA 18036** |
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|---|---|---|---|---|
| K 0923<br><br>SS=E | Continued from page 50<br><br>Based on observation and interview, it was determined the facility failed to ensure portable gas cylinders were secured from unauthorized access, affecting 1 of 2 levels within the facility.<br><br>Findings include:<br><br>Observation made on March 12, 2025, at 12:35 p.m., in the basement, at outdoor dock area, revealed there was a full, unsecured propane tank being stored in front of the main electrical high voltage switch gear.<br><br>Exit interview with the Administrator, Director of Maintenance and Assistant on March 12, 2025, at 3:15 p.m., confirmed the portable tank was not protected. | K 0923 | | |

# Certified End Page

**VALLEY MANOR REHABILITATION AND HEALTHCARE CENTER**

**STATE LICENSE NUMBER: 480202**

**SURVEY EXIT DATE: 03/12/2025**

**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