

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
STATE LICENSE NUMBER: 233602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0812	Based on a Medicare/Medicaid Recertification Survey, State Licensure and Civil Rights Compliance Survey completed on December 4, 2024, it was determined that Lakeside at Willow Valley was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations for the Health portion of the survey process.	F 0812		
SS=E				

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)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
STATE LICENSE NUMBER: 233602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 1 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Deficiency - 483.35 Dietary Services, F tag 371- Store, prepare, distribute and serve food under sanitary conditions 1. Packages of frozen vegetables, frozen chicken and fresh kale were found in the walk-in freezer and cooler out of their original boxes. They were not properly labeled with the name of the product or the received date. - All Team members will receive mandatory training on properly labeling and dating all product, especially when it is removed from its original container. - Supervisors will complete a daily walk-thru inspection for 1 quarter to assure proper labeling practices are in place. -Team Members will be held accountable for any infractions noted. - Results of the daily walk-thru inspections will be monitored for trends and report in QI meeting 2.Sink and Surface Cleaner and	Completion Date: 01/29/2025 Status: APPROVED Date: 12/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024	
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY STATE LICENSE NUMBER: 233602		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 2	F 0812	<p>Disinfectant did not measure at the proper concentration.</p> <ul style="list-style-type: none"> - EcoLab was notified immediately and the pump for the product was fixed that afternoon. The product tested at the proper concentration after it was fixed. - While the pump was not working correctly, the Team members used the Sink and Surface Cleaner and Disinfectant from another dispenser located in the pantry on the 1st floor. - All Team Members will receive mandatory training on how to properly test the concentration of the Sink and Surface Cleaner and Disinfectant. This will include the proper action plan if the concentration is not at the proper level. - Supervisors will complete a daily walk-thru inspection for 1 quarter to assure the Sink and Surface Cleaner and Disinfectant is at the proper level and that it is being properly recorded on the log sheet. - Team Members will be held 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
STATE LICENSE NUMBER: 233602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 3	F 0812	accountable for any infractions noted. - Results of the daily walk-thru inspections will be monitored for trends and report in QI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024	
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY STATE LICENSE NUMBER: 233602		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 4 Based on review of facility policy, review of facility documentation, observations, and interview with staff, it was determined that the facility failed to store food and maintain appropriate sanitation in accordance with professional standards for food service safety. Findings included: Review of facility policy, "Food Storage", reviewed January 2024, indicated that all food items should be labeled, dated, and rotated to insure FIFO (first in, first out) method of storing and use and to prevent outdated food from being used. Review of facility policy, "Sanitation Process", revealed that sanitizer must be mixed at the proper concentration and checked at regular intervals with a test kit and logged on sanitizer log. Sanitizing solutions will be kept in clearly labeled red buckets of sufficient size and quantity to insure effective use. Review of the Three-Compartment Sink, Sink & Surface Cleaner & Sanitizer Concentration Log revealed that the concentration levels (ppm-parts per million) normal	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY STATE LICENSE NUMBER: 233602		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 5 range is between 704-1875 ppm. Observations on December 2, 2024, at 9:40 a.m. in presence of Employee E3 revealed three bags of pasta, one bag of mixed vegetables, two packages of chicken, and an opened bag containing cookie dough in the walk-in freezer. All had been removed from the shipping box and had no label or date. Observation on December 2, 2024, at 9:50 a.m. in presence of Employee E3 revealed the sanitizer concentration level in a red bucket was 170 ppm. An additional observation of the sanitizing solution received directly from the dispenser at the three-compartment sink revealed a concentration level of 170 ppm. Interview with Employee E3 confirmed that all items should be labeled and dated. Additionally, Employee E3 confirmed that the sanitizer concentration level did not meet the recommended range.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/04/2024	
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY STATE LICENSE NUMBER: 233602		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 6 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa Code 201.18(b)(3) Management	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395771	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/04/2024
NAME OF PROVIDER OR SUPPLIER: LAKESIDE AT WILLOW VALLEY STATE LICENSE NUMBER: 233602			STREET ADDRESS, CITY, STATE, ZIP CODE: 300 WILLOW VALLEY LAKES DRIVE WILLOW STREET, PA 17584		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0812 SS=E	Continued from page 7	F 0812			



Certified End Page

LAKESIDE AT WILLOW VALLEY
STATE LICENSE NUMBER: 233602
SURVEY EXIT DATE: 12/04/2024

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, 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