STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey, and an Abbreviated Survey to review a Complaint, completed on April 14, 2025, it was determined that Valley View Haven, Inc., was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0641 SS=D		F 0641		

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:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	This Plan of Correction is submitted under Federal and state regulations and status applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Discharge MDS for Resident 105 was corrected on 4/10/2025 Discharge MDS' completed over the last 30 days will be reviewed to ensure accuracy of section A2105. Assessment Coordinators will be re-educated on ensuring the accuracy of assessments prior to	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 2	F 0641	submission. An audit of discharged MDS will be completed monthly for 3 months to ensure accuracy. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	**4702 E MAIN STREET BELLEVILLE, PA 17004**
STATE LICENSE NUMBER: **220402**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 3 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's discharge status for one of three residents reviewed (Resident 105). Findings include: Clinical record review for Resident 105 revealed a discharge MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) dated February 3, 2025, where facility staff assessed the resident's discharge status as being discharged to a hospital on that date. Further record review for Resident 105 revealed a discharge summary dated February 3, 3025, at 12:07 PM, and that the resident was discharged to home, not a hospital. The above information regarding Resident 105 was reviewed with the Nursing Home Administrator and Director of Nursing on April 10, 2025, at 2:30 PM.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 4 On April 11, 2025, at 11:58 AM facility staff provided evidence of a corrected MDS for Resident 105, indicating the residents discharge status was to reflect the resident was discharged to home and the prior MDS indicating the resident discharged to the hospital was coded in error. 28 Pa. Code 211.5(f)(iv)(xi) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0641		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 5 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident 150's wound continues to be assessed by Employee 1 during wound rounds. Staff present during clinical rounds on April 7, 2025 was educated on the action of the treatment ordered and assessing characteristics of a evaluation of wound odor only after the area is cleansed. The RN present during the dressing change to the wound on April 6, 2025 entered a late entry note with her assessment of the wound. The physician's assistant evaluated Resident 150's wound on 4/17/25 with Employee 1. New orders were received for testing and treatment of the sacral ulcer. Other residents with pressure injuries will continue to be evaluated by the wound nurse. Any concerns will be addressed with the provider. Any identified educational need from licensed nursing will be addressed by a Registered nurse. Licensed nursing staff will be educated on evaluation of wound	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 6	F 0684	characteristics and expected outcomes with a debriding agent. Nursing staff will also be educated on notification of the RN present in the facility when a wound concern arises, assessment of the concern by the RN and notification to the provider when the concern needs to be addressed. An audit of Residents with pressure injuries will be completed weekly for 6 weeks to ensure that any concern for healing is evaluated by the Registered Nurse and addressed by the provider. Results of this audit will be report to the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 7 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding a resident assessment for pressure ulcer concerns for one of 23 residents reviewed (Resident 150). Findings include: Clinical record review for Resident 150 revealed that they were admitted to the facility on March 29, 2025, with a sacral (triangular area at the bottom of the spine) ulcer. Facility staff completed an initial assessment of Resident 150's sacral ulcer with measurements noted as 10 cm (centimeters) long by 8 cm wide by no depth, with red, watery drainage. Staff ordered appropriate treatment. On April 6, 2025, at 3:55 PM staff documented that at 9:30 AM they went to change Resident 150's sacral dressing, however, there was no dressing on the wound. Staff cleansed and applied a new dressing, noting that they observed yellow slough (dead skin) on the wound bed (base of wound) with	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 8 a slight odor. On April 6, 2025, at 5:40 PM staff documented that they changed Resident 150's sacral dressing at 3:40 PM and noted a change/concern in the wound drainage (now with a tan/gray drainage) and an increase in depth near the top of the wound. Staff measured Resident 150's wound as 7.2 cm (centimeters) long by 5 cm wide by 1.5 cm deep in the center of the wound. At the top of the wound, staff measured a depth of 2.2 cm. Staff notified Employee 1, registered nurse, assistant director of nursing/infection preventionist, of the concern. On April 10, 2025, at 10:33 AM and 10:43 AM (3.75 days later) Employee 1 documented that they assessed Resident 150's sacral ulcer and observed the above noted slough. The slough was able to be moved with bone now visualized at the base of the wound. Employee 1 measured the wound as 7.2 cm long by 5 cm wide and 2.5 cm deep with no undermining or tunneling (wound channeling under tissue) with a mixture of purulent (pus like) and	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 9 serous (clear) drainage. Employee 1 determined the need to change/update the resident's sacral ulcer dressing order based on their assessment. Employee 1 did not assess Resident 150's sacral wound timely to identify potential wound and dressing changes. The above information was reviewed during an interview on April 15, 2025, at 10:40 AM with the Nursing Home Administrator. 483.25 Quality of Care Previously cited 5/31/24 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0684		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 10 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Oxygen concentrator for resident 28 was removed from the room due to non-use. Residents utilizing oxygen will be reviewed to ensure the need for respiratory equipment in their room. Equipment not in use will be removed. Equipment being utilized will be checked to ensure that it is dated and bagged appropriately. Nursing and housekeeping staff will be educated on oxygen equipment dating and bagging will be completed. Staff will be further educated to remove medical equipment upon resident admission to the hospital. Clinical coordinators/ RN supervisors or designee will check rooms of residents that are transferred to the hospital to ensure no respiratory equipment that is not in use remains. This audit will be completed weekly for 4 weeks. Results of this audit will be reviewed by the Quality Assurance Committee	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 11	F 0695	to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 12 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of two residents reviewed (Resident 28). Findings include: According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. Clinical record review for Resident 28 revealed the following current physician orders: Oxygen at 2 liters per minute (LPM) via NC (nasal canula, tubing to deliver oxygen to the nose) to keep	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 13 SpO2 (oxygen saturations) greater than 91 percent as needed Further clinical review for Resident 28 revealed that they last utilized oxygen on March 28, 2025, at 6:02 AM. Observation of Resident 28's room on April 8, 2025, at 11:03 AM, and April 9, 2025, at 10:27 AM revealed that there was an oxygen concentrator beside his bed. Attached to the concentrator there was an undated humidification cannister that had an unbagged, undated nasal cannula tubing attached. The tubing was draped over the concentrator and onto the floor. Concurrent interview with Resident 28 on April 8, 2025, at 11:03 AM revealed that he had not utilized oxygen recently. The above information was reviewed with the Nursing Home Administrator during an interview on April 10, 2025, at 2:10 PM.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 14 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0726 SS=D		F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 15 483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 0726	Employee number 2 competency related to medication administration, the care and assessment of residents with indwelling urinary catheters and gastrostomy tubes will be completed. A baseline audit of nurses will be reviewed and ensure competencies are completed. Skills competency will be added to orientation checklist to be completed during orientation period. Registered Nurses will be educated on completion of the competency. An audit of newly hired nurses will be completed to ensure completion of competency monthly for 3 months. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 16	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 17 Based on a review of facility documentation, clinical record review, employee personnel record information, and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to medication administration, the care and assessment of residents with indwelling urinary catheters, and gastrostomy tubes for one of five employees reviewed for competencies (Employee 2; Residents 101 and 57). Findings include: The Centers for Medicare and Medicaid Services (CMS) QSO-24-13-NH memo dated June 18, 2024, noted that requirements specify that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 18 must provide. The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess to deliver the necessary care required by the residents being served. The facility assessment reviewed during the onsite survey last updated March 31, 2025, revealed that RN (registered nurse) competency and training would include catheter insertion and flushing (Foley, indwelling urinary catheters, flexible tubing inserted into the bladder to drain urine) and medication administration. The assessment stipulated that the lists were not all inclusive. Although the list of competencies and trainings did not refer to RN care and services for artificial feeding systems, the LPN (licensed practical nurse) competency and training list included enteral feeding (PEG, a flexible tube inserted through the abdominal wall and into the stomach for the purpose of administering nutrition, fluids, and medications) and use of pumps or feeding by gravity.	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 19 A review of the facility Resident Matrix (CMS-802, form used to identify pertinent care categories for residents who reside in the facility) documentation revealed that the facility had a total of nine residents with indwelling urinary catheters within the 107 resident facility census (8.4 percent). Clinical record review for Resident 101 revealed active physician orders for staff to irrigate a urinary catheter every eight hours as needed for blockages and to change a 16 French (The French scale, also known as the French gauge, is a widely used measurement system for the size of catheters) urinary catheter every 28 days and as needed for occlusion or leakage as needed. Clinical record review for Resident 57 revealed active physician orders to change an indwelling urinary catheter, size 16 or 18 French coude (A coude catheter is a type of urinary catheter that features a curved tip, designed to navigate around obstacles in the urethra, such as an enlarged prostate or strictures), monthly and as needed for	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 20 occlusion or leakage, and to irrigate the foley catheter with 60 milliliters (ml) of normal saline daily and as needed. Resident 57's active physician orders also instructed staff to flush his PEG tube two times a day with 240 ml of water and to assess his feeding tube placement every shift and with every use. Staff were also to flush the PEG tube as needed with 30 ml of water before and after medication administration with 10 ml between each medication as needed if Resident 57 was unable to take his meds orally. Review of Employee 2's (registered nurse) personnel records revealed that the facility completed new hire orientation training on September 17, 2024. The orientation training list provided did not include evidence of any competencies completed related to indwelling urinary catheters, PEG tubes, or medication administration. Email communication from the Nursing Home Administrator dated April 11, 2025, at 10:35 AM	F 0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0726 SS=D	Continued from page 21 confirmed that the facility had no evidence of Employee 2's competencies. The facility could only provide the RN orientation checklist that did not include the verification of competencies in medication administration, indwelling catheter care, or PEG tube care. 28 Pa Code 201.20(a) Staff development	F 0726		
F 0744 SS=D		F 0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0744 SS=D	Continued from page 22 483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 0744	The care plan for resident 27 was revised to reflect behavioral approaches related to cognitive loss and dementia. Other residents with dementia/cognitive loss care plans will be revised to reflect person center approaches to care. Staff will be educated on the implementation of person centered care plans for resident with cognitive loss/dementia. A random audit of residents with dementia/cognitive loss will be completed to ensure person centered care plans are implemented monthly for three months. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	Completion Date: 05/27/2025 Status: APPROVED Date: 04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0744 SS=D	Continued from page 23 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of three residents reviewed (Resident 27). Findings include: Clinical record review for Resident 27 revealed the facility admitted her on January 8, 2024, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 27's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated December 9, 2024, indicated that the facility assessed Resident 91 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.	F 0744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	4702 E MAIN STREET BELLEVILLE, PA 17004
STATE LICENSE NUMBER: 220402	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0744 SS=D	Continued from page 24 A review of Resident 27's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on April 10, 2025, at 2:00 PM. On April 11, 2025, at 10:23 AM the Nursing Home Administrator confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 27's dementia prior to surveyor's questioning. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services	F 0744		
F 0758 SS=D		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 25 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Resident 101 is no longer a resident of the facility. A baseline audit of residents utilizing psychotropic medications will be reviewed to ensure that care plans are in place to address target behaviors and non-pharmacological interventions. Nursing staff, Social Service, Assessment Nurses will be educated on implementation of care plans for residents utilizing psychotropic medications. An audit of residents with new orders for psychotropic medications will be reviewed to ensure the appropriate care plan is in place weekly for 4 weeks. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 26 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 27 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medication for one of five residents reviewed for medication regime concerns (Resident 101). Findings include: Clinical record review for Resident 101 revealed that the facility admitted her on March 14, 2025. An active physician order dated March 14, 2025, instructed staff to administer Lunesta (Eszopiclone, a sedative hypnotic medication used to induce and maintain sleep) 2 mg (milligram) by mouth at bedtime. An admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 19, 2025, identified that staff administered a hypnotic medication to Resident 101, and the facility would proceed to a care plan for the psychotropic	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 28 medication use. Review of care plans developed for Resident 101 did not include the use of a sedative hypnotic for sleep, did not include non-pharmacological interventions used, and did not identify target behaviors that the facility would monitor to support the rationale for the continued use of the medication. Interviews with the Nursing Home Administrator, Director of Nursing, and Employee 1 (assistant director of nursing/infection preventionist) on April 10, 2025, at 2:00 PM and with the Director of Nursing on April 11, 2025, at 9:30 AM confirmed that there was no plan of care or target behaviors identified or monitored for Resident 101's use of the sedative hypnotic. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0758		
F 0812 SS=F		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 29 483.60(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	All deficient items found in the kitchen, dishroom and pantries were corrected. Staff will be reeducated on proper food storage, dating and the daily, weekly and monthly cleaning list. Proper food storage, dating and labeling will be added to the closing list of each position to ensure each station is being checked before the employee leaves for the day. Kitchen walk throughs by management to ensure cleaning list are being completed and that dating and labeling of food is correct. A weekly audit for 4 weeks to ensure that employees are completing cleaning lists and storing food properly. Results of this audit will be reported to the Quality Assurance Committee.	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 30 Based on observation and staff interview, it was determined that the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen, and two of five nursing units (200 and 300). Findings include: An observation in the facility's main kitchen and the downstairs pantry and cold storage areas on April 8, 2025, at 10:09 AM with Employee 3, Assistant Director of Nutritional Services, revealed the following: The fryer had a moderate amount of black grease build up in the grease trap. Clean pans were stored on top of the oven where there was a considerable amount of dust buildup. The food warmer was observed with dried brown spills/splatters on the interior base of the warmer	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 31 and on three sheet trays that were holding pans of food inside the warmer. A windowsill in the dishwashing area was caked with white debris. The entire window was coated in a white substance. A box of hamburger patties was observed on a shelf in the walk-in freezer. The box was open, and a bag of hamburger patties was open to air inside the box. A box of chicken breasts was also observed open beside the box of hamburger patties, with a wide open bag of chicken sitting in the box exposed to air. Food debris was observed under the shelving units in the walk-in freezer. A piece of the metal wall covering on the interior back corner of the walk-in cooler was hanging off the wall. A stack of clean dish washing racks was observed	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	4702 E MAIN STREET BELLEVILLE, PA 17004
STATE LICENSE NUMBER: 220402	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 32 next to a shelving unit holding clean dishware. The racks contained pieces of dried food/debris built up in corners/indentations of the racks in several spots. An ice scoop was observed sitting directly on top of the ice machine uncovered. The flooring under the ice machine contained dust and debris. The downstairs dry storage was observed to have several brown stained ceiling tiles and dried liquid inside a ceiling light cover. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on April 10, 2025, at 2:25 PM. An observation of the 200-unit nourishment room refrigerator on April 9, 2025, at 10:05 AM revealed a shelf full of individual containers of juices in a variety of flavors such as apple, grape, and cranberry stored in the refrigerator. There was no evidence to indicate when the juices	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 33 were placed there, when they needed to be used by, or a manufacturer's expiration date on the containers. A concurrent observation of the 300-unit nourishment area refrigerator also revealed a shelf full of the same kind of juices stocked in the refrigerator. An interview with Employee 3 on April 9, 2025, at 10:05 AM revealed the juices are delivered to the facility frozen, and dietary staff pull the boxes from the freezer to thaw. Employee 3 indicated the staff date the box of juice when they pull it from the freezer, but once the containers are taken out of the box, such as for storing in the refrigerators on the nursing units, they would not be dated. Observation of a case/box of the individual juices with Employee 3 on April 9, 2025, at 12:05 PM revealed manufacturer instructions on the box indicating the product was to be used within 14 days once thawed.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 34 There was no evidence to indicate when the juices stored on the nursing units referenced above were pulled from the freezer, thawed, or when the 14-day expiration would occur. The above information regarding the juices was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on April 11, 2025, at 2:35 PM. 483.60(i)(2) Store, prepare, food safe and sanitary Previously cited 5/31/24 28 Pa. Code 201.14 (a) Responsibility of Licensee	F 0812		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 35 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Facility cannot retroactively correct implementation of signs for EBP for resident 101. Resident 101 discharged from facility. Transmission based precautions have been discontinued for residents 96 due to resolution of condition. Items stored on the floor for residents 62 and 77 were moved and appropriately stored. Signage for residents with EBP have been moved to the outside of the door. There are currently no other residents on contact precautions. Resident rooms will be checked to ensure proper storage of personal hygiene products. The policy for EBP will be updated to reflect the use of signage and its placement. Nursing staff will be educated on policy change, maintaining contact precautions and storage of personal hygiene products. An audit of sign placement for residents on EBP will be completed	Completion Date: **05/27/2025** Status: **APPROVED** Date: **04/30/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 36 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	weekly x 4 weeks. An audit for contact precautions compliance will be completed weekly x 4 weeks. Random audits of resident rooms for storage of personal hygiene products will be completed weekly x 4 weeks. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 37	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 38 Based on review of select facility policies and procedures, observation, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier precautions for one of 22 residents reviewed (Resident 101), implement appropriate transmission based precautions (TBP) for one of one resident reviewed on TBP (Resident 96), and ensure an environment free from the potential spread of infection with the storage of resident supplies on one of five nursing units (200; Residents 62 and 77). Findings include: The facility policy entitled "Isolation, Transmission Based Precautions," last reviewed without changes on May 22, 2024, revealed standard precautions will be used when caring for residents. Transmission based precautions will be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. If a resident is suspected of, or identified as having a communicable infectious	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 39 disease, the registered nurse supervisor will notify the infection control designee and the resident's physician for appropriate transmission-based precautions. Transmission based precautions will remain in effect until the physician or infection control designee discontinues them. Contact precautions will be used in addition to Standard Precautions for residents with specific infections that can be transmitted by direct and indirect contact. Clinical record review for Resident 96 revealed the facility admitted him on October 21, 2024. Review of Resident 96's physician orders revealed an order dated April 7, 2025, for contact isolation due to a shingles rash on his face and neck. Nursing documentation dated April 8, 2025, at 5:15 AM revealed Resident 96 began on the medication Valtrex (an antiviral medication) related to his diagnosis of shingles. Documentation revealed a pustule rash continues on Resident 96's face, and down the right side of his neck with pustules remaining intact. Contact precautions remain in	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 40 place. When the rash is still blistered and contains fluid in the blisters, the person is considered contagious if the rash comes in close contact to someone else, so it is best to keep the rash covered. Observation of Resident 96 on April 8, 2025, at 10:12 AM revealed he was in the dining/activity room seated at a table with 11 other residents making Easter eggs. The shingles rash was observed on his face and neck. The shingles rash on Resident 96's neck was exposed with pustules. Resident 96's rash was not covered. Observation of Resident 96 on April 9, 2025, at 10:25 AM revealed he was walking on the unit holding hands with another resident (Resident 96's wife). The shingles rash on Resident 96's neck was again exposed with pustules. Resident 96's rash was not covered. Observation of Resident 96 on April 9, 2025, at 12:29 PM he was in the dining room eating lunch, with two other residents seated at his table.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 41 Resident 96 was unable to be interviewed regarding any education he received regarding his rash and contact precautions due to his current cognitive status. Interview with Employee 1, infection control nurse, on April 10, 2025, at 2 PM confirmed these findings. She stated that staff should have covered Resident 96's rash on his neck with the exposed pustules. An observation of Resident 62's bathroom on April 8, 2025, revealed a bag of bladder pads stored directly on the floor beside the toilet. An observation of Resident 77's bathroom on April 8, 2025, revealed a plastic bag of maxi pads stored directly on the floor beside the resident's toilet. The above information regarding Residents 62 and 77 was reviewed with the Nursing Home Administrator and Director of Nursing on April 10. 2025, at 2:30 PM.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 42 Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, "Enhanced Barrier Precautions in Nursing Homes," dated March 20, 2024, revealed that CMS was issuing new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. In 2019, CDC (Centers for Disease Control) introduced a new approach to the use of personal protective equipment (PPE) called Enhanced Barrier Precautions (EBP). In July 2022, the CDC released updated EBP recommendations for "Implementation of PPE Use in nursing homes to prevent spread of MDROs." The CDC's, "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)," stipulated that, "When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 43 access to appropriate supplies. To accomplish this post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves." Nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of CDC guidance at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revealed that signs are intended to	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 44 signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure precautions are followed. CDC has created examples of signs that can be used by facilities to communicate information about Transmission-Based and Enhanced Barrier Precautions. Facilities can use these signs or modify them to create signs that work for their facility. Review of CDC guidance at https://www.cdc.gov/long-term-care-facilities/media/pdfs/Observations-Tool-for-Enhanced-Barrier-Precautions-Implementation-508.pdf, Enhanced Barrier Precautions (EBP) Implementation-Observations Tool (For use in Skilled Nursing Facilities/Nursing Homes only) reiterated that signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 45 the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. The EBP sign should also include a list of the high-contact resident care activities for which PPE (gown and gloves) should be worn. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure EBP are followed. Signs should not include information about a resident's diagnosis or the reason for the use of EBP (e.g., presence of a resistant germ, wound). A review of the CDC sign for EBP revealed that the first directive is that everyone must clean their hands, including before entering and when leaving the room. Review of the facility's policy entitled, "Enhanced Barrier Precautions," last reviewed without changes May 22, 2024, revealed that the compliance guidelines included that the facility would have the discretion on how to communicate to staff which residents require the use of EBP. The implementation of EBP included to make gowns and	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 46 gloves available near or outside the resident's room, ensure alcohol-based hand rub is in every resident room, position a trash can and linen cart inside the resident room near the exit, the infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education, and provide education to residents and visitors. The facility policy did not include the implementation of the placement of signage visible to individuals entering the room to signal the specific actions they should take to protect themselves and the resident. Clinical record review for Resident 101 revealed a physician's order dated March 28, 2025, for staff to implement enhanced barrier precautions related to an indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine). Observation of Resident 101's room on April 9, 2025, at 10:18 AM revealed that her door was partially shut. There was no signage or indication	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 47 before entering her room of the implementation of enhanced barrier precautions. Interview with Employee 2 (registered nurse) on April 9, 2025, at 10:33 AM revealed that the sign that indicated Resident 101 required EBP was positioned on the inside of Resident 101's door and was not visible to any person before entering her room. The interview confirmed that the sign positioned on the inside of Resident 101's door was the CDC Enhanced Barrier Precautions sign that included the directive that, "Everyone must clean their hands, including before entering and when leaving the room." Interview with the Nursing Home Administrator on April 10, 2025, at 10:00 AM confirmed that the facility's EBP policy did not include the necessity of signage to notify staff and/or visitors that EBP were necessary. Interview with the Nursing Home Administrator and the Director of Nursing on April 10, 2025, at 10:35	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 48 AM confirmed that the facility policy did not include an expectation that staff would post a sign visible to individuals entering the room to signal the specific EBP actions they should take to protect themselves and the resident. The interview also confirmed that the facility policy did not include how the facility would provide education to residents and visitors regarding EBP requirements. The interview indicated that "generally" Employee 1 (assistant director of nursing/infection preventionist) ensures that a sign is posted. The Director of Nursing stated that she believed that current nationally accepted standard guidance regarding EBP did not require the use of a sign. The surveyor referred the Director of Nursing and the Nursing Home Administrator to the CDC and CMS guidance noted above. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0883 SS=D	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 0883	Responsible party for resident number 4 was contacted and offered pneumonia vaccine, he initially consented, but due to residents decline in condition he has revoked his consent. An baseline audit of current residents was conducted, consents for those that are eligible this year will be sent to responsible parties/residents. Residents that consented for pneumonia vaccines will be scheduled based on eligibility date. An audit of eligible residents will be conducted to ensure administration of pneumonia vaccine as ordered monthly for 3 months. Results of this audit will be reviewed by the Quality Assurance Committee to evaluate the need for ongoing auditing or further education.	Completion Date: 05/27/2025 Status: APPROVED Date: 04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0883 SS=D	Continued from page 50 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0883 SS=D	Continued from page 51 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide recommended pneumococcal immunizations for one of five residents reviewed for immunizations (Resident 4). Findings include: The policy entitled "Pneumococcal Vaccination of Residents," last reviewed without changes May 22, 2024, revealed all residents of the facility and/or admissions to the facility will be offered the pneumococcal immunization. The resident and/or representative will receive information regarding the types of vaccinations available, and the benefits and potential side effects of the vaccine. Each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated or if they have already been immunized. Each resident's pneumococcal immunization status will be determined upon admission, or soon afterwards, and will be documented on the pneumococcal	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0883 SS=D	Continued from page 52 consent form and in the resident's medical record. The immunization/vaccine will be administered according to the standing physician order as per CDC (Centers for Disease Control) recommendations. Clinical record review revealed the facility admitted Resident 4 on February 1, 2022. Documentation in Resident 4's clinical record revealed she received two pneumococcal vaccines (Pneumovax 23 and Prevnar 13) prior to her admission in 2022. According to the CDC guidance entitled "Pneumococcal Vaccine Timing for Adults" dated October 2024, Resident 4's pneumococcal vaccinations would not be completed until she received a Prevnar 20 or Prevnar 21 at least five years after the last pneumococcal vaccine dose. There was no documented evidence to indicate that the facility offered Resident 4 an updated pneumococcal vaccination. Interview with Employee 1, infection control preventionist, on April 11, 2025, at 10:05 AM	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0883 SS=D	Continued from page 53 confirmed the above findings for Resident 4. Employee 1 stated at the time of sending Prevnar 20 consents (January 2024) Resident 4 was not yet eligible. Employee 1 indicated when Resident 4 became eligible the facility missed obtaining a consent and offering her the updated pneumococcal vaccination. Employee 1 contacted Resident 4's family and they indicated that they would like her to receive the vaccination. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management	F 0883		

Certified End Page

VALLEY VIEW HAVEN, INC.

STATE LICENSE NUMBER: 220402

SURVEY EXIT DATE: 04/14/2025

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