

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Manor at Penn Village, The		STREET ADDRESS, CITY, STATE, ZIP CODE 51 Route 204 Selinsgrove, PA 17870	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on clinical record review, review of facility investigations, and staff interview, it was determined that the facility failed to prevent and thoroughly investigate an elopement for one of one resident reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of Resident 1's clinical record revealed nursing documentation dated April 27, 2024, at 10:29 AM that indicated that the resident was admitted to the facility on [DATE], at 1:00 PM. The documentation further noted the resident was alert and oriented, and forgetful/confused at times.</p> <p>A Brief Interview for Mental Status (BIMS, an assessment tool to help determine the cognitive status of a person) evaluation for Resident 1 dated April 27, 2024, at 7:47 PM was completed by facility staff who assessed the resident as having a score of 14, which indicated the resident was cognitively intact.</p> <p>Nursing documentation for Resident 1 dated April 27, 2024, at 6:56 PM revealed that the resident was noticed to be missing when the food trays were being passed for dinner. The documentation further noted the nursing supervisor was notified that the resident was located at a nearby supermarket.</p> <p>A facility document regarding Resident 1 titled, Timeline, revealed documentation dated April 27, 2024, at 2:45 PM that noted that the registered nurse (RN) supervisor noted the resident was demonstrating odd behavior. The documentation further noted the resident was preoccupied with belongings and, .walking around unit looking for something. This was reported to the oncoming shift and, It was suggested at that time, that this was a change and to keep a close eye on her.</p> <p>Further review of this facility documentation revealed a note dated April 27, 2024, at 4:40 PM that the nurse aides began passing dinner trays and, Time of last resident visualization. At 4:45 PM, the resident was not in the chair at the nurse's station and a search of the immediate area began. At 4:55 PM, the facility received a call from the supermarket informing the supervisor that the resident was at the supermarket.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing (DON) on May 1, 2024, at 10:00 AM revealed that a pharmacist had called the nursing supervisor on the day of the elopement to inform the supervisor that the resident was at the supermarket. Facility staff then responded to the supermarket. Resident 1 was returned to the facility without incident and had no injuries.</p> <p>An observation and concurrent interview with the DON on May 1, 2024, at 10:16 AM of an egress area leading to the outside door adjacent to the Therapy Unit revealed that Resident 1 had eloped from the facility through this point. The door was controlled by a keypad and had a red alert device attached that activated with a loud siren-like, piercing sound if the door was opened. Once activated, it is turned off and reactivated with a key. The DON further noted that Resident 5 observed the elopement at the time of the event and this resident's room was in view of the egress point where Resident 1 had left the building.</p> <p>A review of the investigation revealed no statement from Resident 1 or witness statement from Resident 5. This was confirmed by the DON.</p> <p>A witness statement dated April 27, 2024, from a nurse aide noted, I found a door that was not armed properly. The door was identified in the witness statement as Station A therapy main exit door.</p> <p>An interview with Resident 5 on May 1, 2024, at 1:35 PM revealed he was familiar with the elopement that had occurred and stated he saw the female leave the therapy doors at the time of the event. Resident 5 further noted it was their (indicating the facility) fault because the doors were not latched correctly. Resident 5 further noted that the door alarm did not sound.</p> <p>Clinical record review for Resident 5 revealed an MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 27, 2024, that indicated the resident had a BIMS score of 15 that indicated the resident was cognitively intact.</p> <p>An interview with Resident 1 on May 1, 2024, at 2:22 PM revealed that the resident left the building. Resident 1 reported the alarm did not sound upon leaving the facility.</p> <p>An interview with the DON on May 1, 2024, at 3:00 PM revealed that the alarms at the egress points can be turned off with a key. The key for the therapy doors is located at the Station A nurse station where staff have access to it. However, it is kept out of the reach of the residents.</p> <p>A review of the investigation provided by the facility revealed no further investigative information as to why the doors were not armed properly as indicated in the witness statement and why the alarm did not sound as indicated by Resident 5 (i.e., were the alarm devices malfunctioning at the time, was the alarm silenced by staff, was the alarm disarmed at the time, did the alarm sound and staff did not respond to investigate, etc.).</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on May 1, 2024, at 4:10 PM.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p>		