STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395172	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at Penn Village, The	51 Route 204 Selinsgrove, PA 17870

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on observation and resident and staff interview, it was determined that the facility failed to provide a clean, comfortable, and homelike environment on three of four nursing units reviewed (Nursing Units A, B, and F; Residents 3, 4, 6, 8, and 7). Findings include: Observation of room [ROOM NUMBER] on May 30, 2024, at 10:22 AM revealed the room was currently empty and the previous resident had been discharged . The heating/air conditioning unit located on the wall had a significant accumulation of dust and debris located between the vents of the unit. Observation of room [ROOM NUMBER] on May 30, 2024, at 10:24 AM revealed the room was currently empty and the previous resident had been discharged . The heating/air conditioning unit located on the wall had a significant accumulation of dust and debris located between the vents of the unit. Observation of Resident 7 and Resident 8's room on May 30, 2024, at 10:30 AM revealed the heating/air conditioning unit located on the wall had a significant accumulation of dust and debris located between the vents of the unit. Observation of Resident 4's room on May 30, 2024, at 10:33 AM revealed the heating/air conditioning unit located on the wall had a significant accumulation of dust and debris located between the vents of the unit. There appeared to have been a brown colored liquid spilled on the vent at some point that was currently dried and crusted between a section of vents. Observation of Resident 6's room on May 30, 2024, at 10:40 AM revealed the heating/air conditioning unit located on the wall had a significant accumulation of dust and debris located between the vents of the unit. There was a significant accumulation of dust on all the vents. An interview and concurrent observation of the empty rooms [ROOM NUMBERS] with Employee 2, housekeeper, confirmed the observation that the vents were not cleaned on the heating/air conditioning units; however, should have been because both rooms were terminally cleaned at an earlier date. A slip of paper observed on the overhead table found in room [ROOM NUMBER] indicated the room was marked as cleaned on 5/15. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a common sitting area for residents and visitors on May 30, 2024, at 10:48 AM revealed two heating/air conditioning units. There was a significant accumulation of dust and debris located between the vents of the unit. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 30, 2024, at 5:15 PM. Observation of Resident 3's room on the F nursing unit on May 30, 2024, at 12:17 PM revealed a dead, black, insect on the floor with dust debris attached to it in front of her closet. Interview with Resident 3 at the time of the observation revealed that she believed that housekeeping had been in because the sign for the wet floor was in her doorway; however, her garbage had not been emptied. Observation of both trash cans in Resident 3's room revealed they were both one-half full of garbage. Interview with Employee 1 (housekeeper) on May 30, 2024, at 12:43 PM indicated that she performed housekeeping services in Resident 3's room, which included mopping the floor. Employee 1 stated that she would sweep the floor in Resident 3's room to rid the room of the dead insect. The surveyor reviewed the above concerns regarding housekeeping services for Resident 3 during an interview with the Nursing Home Administrator on May 30, 2024, at 1:44 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited deficiency 1/26/24 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on closed clinical record review and staff interview, it was determined that the facility failed to develop and implement a resident baseline care plan within 48 hours of the resident's admission for one of one resident reviewed (Resident CR1) Findings Include: Closed clinical record review for Resident CR1 revealed the resident was admitted to the facility on [DATE]. Further review of Resident CR1's closed clinical record revealed documentation titled, Baseline Care Plan and Summary, and dated May 2, 2024. The copy of the care plan was signed by the registered nurse and Resident CR1 on May 2, 2024. Review of the Baseline Care Plan and Summary revealed the following care plans marked by facility staff; however, there were no associated person-centered interventions marked on the document or identified. Discharge care plan was marked with a resident goal of will discharge to community. Resident's routine/activity preference with the following goals: Resident will self-direct activities of choice and will express feeling regarding routine preferences. Falls/Safety/Elopement with the goals of remaining free of injury and will not exit facility unassisted. Altered skin integrity/potential for with the goals of prevent any skin breakdown or injury and heal/improve current skin issues. Nutrition and hydration with the goals of maintaining a stable weight, consuming adequate fluids, and experiencing no other complications. Altered mood state and/or behavior with the goals of express/exhibit satisfaction and will have fewer episodes of depression. Psychosocial well-being with the goals of adjusting to current living situations and will verbalize emotions. Altered cognition/delirium with the goal of comfortable with surroundings. Altered communication with the goal of being able to communicate desires/needs. Altered vision/hearing with the goal of having optimal communication. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oral/dental status with the goal of maintaining appropriate oral hygiene and dental status. Altered cardiac/respiratory functioning with the goal of having no cardiac and/or respiratory complications. Altered elimination with the goal of being odor free without skin breakdown. Pain with the goal of maintaining comfort to the highest degree possible. Fracture with the goal of having maximum functional mobility and other marked as T9. Metabolic/diabetic with the goal of having no complications related to diabetes. A review of the electronic health record (EHR) for Resident CR1 revealed the following comprehensive care plans and the dates initiated: Resident has little or no community life involvement initiated May 6, 2024. ADL self-care performance deficits initiated May 7, 2024. Swallowing problem related to dysphagia (difficulty with swallowing foods or liquids) initiated on May 7, 2024. The facility failed to provide a baseline care plan within 48 hours for Resident CR1 that included instructions needed to provide effective and person-centered care that meets the professional standards of quality care. The above findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 30, 2024, at 5:15 PM. 28 Pa. Code 211.10(a)(c)(d) Resident care policies

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure dependent residents received assistance with bathing for three of five residents reviewed for bathing concerns (Residents 1, 2, and 3) and appropriate positioning for meals for one of five residents reviewed for nutritional concerns (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed a written physician telephone order that noted a diet of dysphagia advanced (difficulty swallowing food and liquids), thin liquids with aspiration precautions, and out of bed for meals as tolerated. A physician's order reviewed in the electronic health record for a diet dated May 4, 2024, that included a controlled carbohydrate diet, no added salt, dysphagia advanced texture, and regular/thin liquids consistency. The diet order did not note anything about the resident being out of bed for meals as tolerated. Further review of the physician orders for Resident CR1 revealed an order dated May 4, 2024, that indicated dysphagia treatment five times a week for four weeks, an analysis for swallow safety, function, diet modifications, and nutritional intake. A Medicare 5-day Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident CR1 dated May 8, 2024, noted facility staff assessed the resident as needing substantial/maximal assistance with transferring from chair/bed-to-chair. The care plan for Resident CR1 revealed a care plan that was initiated on May 7, 2024, that noted the resident had a swallowing problem related to dysphagia. Interventions included the following: diet to be followed as prescribed; monitor for shortness of breath, choking, labored respirations, lung congestion; monitor/document/report as needed any signs/symptoms of dysphagia; refer to speech therapist for swallowing evaluation; and Speech Therapy evaluation and treat as ordered. The care plan did not reveal any type of positioning needs for the resident. Speech Therapy documentation dated May 3, 2024, at 1:23 PM revealed under medical management that the resident reported new signs/symptoms. The documentation noted, communicated with nursing reference diet recommendations and precautions for out of bed for meals as tolerated and aspiration precautions. The documentation indicated this was also reported to the interdisciplinary team. Further review of the speech therapy documentation for Resident CR1 dated May 3, 2024, revealed a Speech Therapy SLP Evaluation. A new long-term goal identified: safely consumed regular consistency and thin liquids with functional oral phase and without pharyngeal signs/symptoms with mod I use of compensatory techniques. The baseline was noted as dysphagia advanced / thin with aspiration precautions (out of bed for meals and small controlled sips). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Speech Therapy SLP Evaluation for Resident CR1 revealed the clinical bedside assessment of swallowing noted Resident CR1 had reduced control of thin liquids. When out of bed in the chair, the resident consumed small sips of thin liquids via cup and straw with no overt signs/symptoms of aspiration. The resident was able to tolerate out of bed in the chair at lunch with improved swallow safety and nursing was aware per documentation. Further review of the speech therapy documentation for Resident CR1 dated May 9, 2024, at 10:48 AM revealed that the residents oral and pharyngeal abilities improve when out of bed and sitting upright. There was no documented evidence in the closed clinical record that the facility staff were getting Resident CR1 out of bed for meals as indicated by Speech Therapy. There were no notes under the diet order in the electronic medical record, recorded tasks, or person-centered care planned intervention that instructed staff that the resident was to be out of bed as tolerated for meals as indicated by Speech Therapy documentation. An interview with the Director of Nursing on May 30, 2024, at 5:00 PM confirmed there was no documented evidence in Resident CR1's clinical record to indicate that staff were getting the resident out of bed for meals or any instructions in the electronic health record to instruct staff to get the resident out of bed for meals as tolerated. The above information for Resident CR1 was reviewed with the Nursing Home Administrator and Director of Nursing on May 30, 2024, at 5:15 PM. Clinical record review for Resident 1 revealed a quarterly MDS assessment dated [DATE], that assessed her as needing substantial/maximal assistance with a shower/bathing. Review of Point of Care documentation (POC, electronic documentation by nurse aide staff of the performance of activities of daily living) dated May 2024 revealed that Resident 1 preferred a shower on Wednesdays and Saturdays on first shift; however, staff failed to document any bathing on Saturday, May 25, 2024. Staff documented that Resident 1 received a bed bath (not a shower) on Saturday, May 18, 2024, and only a partial bath (not a shower) on Saturday, May 4, 2024. Interview with the Director of Nursing on May 30, 2024, at 11:57 AM confirmed the above findings for Resident 1. The facility was unable to provide evidence that Resident 1 refused bathing assistance or preferred something other than her established shower schedule. Clinical record review for Resident 2 revealed a significant change MDS dated [DATE], that assessed her as needing substantial/maximal assistance with a shower/bathing. POC documentation dated May 2024 revealed that Resident 2 preferred a shower Tuesdays and Fridays on first shift; however, staff failed to document the assistance with a shower on the following dates: Tuesday, May 7, 2024, documented a partial bed bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Friday, May 10, 2024, documented a partial bed bath Friday, May 17, 2024, documented a partial bath Tuesday, May 21, 2024, documented a partial bed bath Friday, May 24, 2024, documented a bed bath Tuesday, May 28, 2024, documented as, response not required Clinical record review for Resident 3 revealed a quarterly MDS assessment dated [DATE], that assessed her as needing substantial/maximal assistance with a shower/bathing. POC documentation dated May 2024, revealed that Resident 3 preferred a shower on Tuesdays and Fridays on second shift; however, staff failed to document any bathing assistance on Friday, May 17, 2024. Interview with the Nursing Home Administrator and the Director of Nursing on May 30, 2024, at 3:30 PM confirmed the above findings for Residents 2 and 3. The facility was unable to provide evidence that either Resident 2 or Resident 3 refused bathing assistance or preferred something other than their established shower schedules. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 20725 Based on clinical record review and staff interview, it was determined that the facility failed to ensure staff with appropriate competencies and skills provided care for resident needs for nine of nine residents reviewed for activities of daily living concerns (Residents 7, 8, 9, 10, 11, 12, 13, 14, and 15). Findings include: Clinical record review of POC (Point of Care, electronic documentation completed by nurse aide staff upon completion of activities of daily living) documentation completed during the evening shift on May 4, 2024, revealed that Employee 4, administration, initialed completion of Resident 7's care for bed mobility, dressing, personal hygiene, toilet use, transferring, ambulation in the room and corridor, bowel and bladder functioning, eating, and restorative nursing programs for walking and range of motion. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 8's care for bed bath, bed mobility, dressing, personal hygiene, toilet use, transferring, ambulation in the room and corridor, bowel and bladder functioning, eating, and restorative nursing programs for range of motion and ambulation. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 9's care for bed mobility, dressing, personal hygiene, toilet use, transferring, ambulation in the room and corridor, bowel and bladder functioning, eating, oral hygiene, and restorative nursing programs for sitting, standing, and meals. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 10's care for bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, aspiration (choking) precautions, eating, bowel and bladder functioning, and feeding. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 11's care for bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, bowel and bladder functioning, emptying of suprapubic catheter (tube inserted through the abdomen into the bladder to drain urine), range of motion exercises, eating, and restorative nursing program for ambulation, toilet transfers, sit-to-stand transfers, and dressing/grooming. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 12's care for bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, oral hygiene, bowel and bladder functioning, eating, catheter care (flexible tube inserted through the penis into the bladder to drain urine), and restorative nursing program for lower extremity exercises. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 13's care for bed bath, bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, bowel and bladder functioning, eating, and restorative nursing programs for range of motion to bilateral upper and lower extremities. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 14's care for bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, bowel and bladder functioning, and eating. Clinical record review of POC documentation completed during the evening shift on May 4, 2024, revealed that Employee 4 initialed completion of Resident 15's care for bed mobility, dressing, personal hygiene, toilet use, transferring, walking in room and corridor, bowel and bladder functioning, eating, and restorative nursing programs for range of motion and ambulation. Interview with Employee 4 on May 30, 2024, at 5:30 PM confirmed that Employee 4 did not possess a nurse aide certification; or had completed any competencies pertinent to resident care such as bathing, personal hygiene, feeding, dressing, transferring, ambulation, or restorative nursing programs. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.20(a)(2) Staff development 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44738 Based on clinical record review and staff interview, it was determined that the facility failed to ensure the accurate acquiring and administration of medications to meet the needs for one of seven residents reviewed (Resident CR1). Findings include: Closed clinical record review revealed nursing documentation for Resident CR1 dated May 2, 2024, at 6:22 PM revealed the resident was admitted to the facility. Review of the physician documentation for Resident CR1 dated May 7, 2024, at 11:29 AM revealed the resident had a history of Crohn's disease (an inflammatory disease that impacts the digestive system). Physician orders for Resident CR1 revealed an order dated May 3, 2024, at 8:00 AM that instructed staff to administer Budesonide Extended-Release oral tablet (a medication used to treat inflammation of the digestive tract), give 3 mg (milligrams) by mouth one time a day. Review of the Medication Administration Record (MAR, tool to document the administration of medication) for Resident CR1 revealed that staff had not documented the resident as having received the medication as ordered on May 3, 5, 6, 7, 8, 10, 11, and 12, 2024. The medication was marked as administered on May 4, 2024, and May 9, 2024. Review of the clinical documentation for Resident CR1 revealed the following MAR notes for the Budesonide: May 5, 2024, at 9:26 AM revealed the medication was pending pharmacy arrival. The physician was made aware. May 6, 2024, at 3:13 PM revealed the medication was unavailable and staff were awaiting delivery from the pharmacy. Registered Nurse was made aware. May 7, 2024, at 9:12 AM revealed that staff will administer when delivered from pharmacy. May 8, 2024, at 11:10 AM revealed the medication is unavailable and staff were awaiting delivery from pharmacy. Registered Nurse was made aware. May 10, 2024, at 2:41 PM revealed the medication was unavailable and staff were awaiting delivery from pharmacy. Registered Nurse was made aware. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Employee 3 licensed practical nurse (LPN) on May 30, 2024, at 4:23 PM confirmed that her initials were noted as administering the Budesonide on May 4, 2024, and May 9, 2024. The LPN was unsure why the medications were marked as administered when other staff had documented the medication as being unavailable from pharmacy but reported that sometimes a packet with just a couple of meds is available for administration. An interview with the Director of Nursing (DON) on May 30, 2024, at 5:00 PM revealed that the medications usually arrive from the pharmacy within 24 hours. The DON further reported that the request for the Budesonide was submitted electronically twice, but there was no further follow-up with pharmacy regarding why the medication delivery was delayed or any documented evidence after May 5, 2024, that the physician was made aware that the resident was not routinely receiving the medication as ordered. The facility failed to obtain and maintain timely and appropriate pharmaceutical services that supported Resident CR1's healthcare needs, goals, and quality of life that are consistent with current standards of practice. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 30, 2024, at 5:15 PM. Further review of the MAR for Resident CR1 revealed the following medications with no documented administration, resident refusal, or indication that they were unavailable on May 3, 2024: Carbidopa-Levodopa Extended Release (a medication used to treat symptoms of Parkinson's Disease such as shakiness or problems with movement) 25-100 mg give 1.5 tablets by mouth in the afternoon. Carbidopa-Levodopa Extended Release 25-100 mg give two tablets by mouth one time a day. Cholecalciferol (a dietary supplement) oral tablet give 5000 units by mouth one time a day. Lidocaine External Patch (a patch placed on the skin to help relieve pain) five percent apply to back topically one time a day. Lisinopril (a medication used to treat high blood pressure) oral tablet 30 mg give one tablet by mouth one time a day. Metoprolol Succinate (a medication used to treat high blood pressure and various heart conditions) Extended Release oral tablet 24 hour 25 mg give one tablet by mouth one time a day. Terazosin Hydrochloride (a medication used to treat high blood pressure and prostate issues) 5 mg give two capsules by mouth one time a day. Venlafaxine Hydrochloride (a medication used to treat depression and anxiety) oral tablet 75 mg give three tablets by mouth one time a day. Vitamin B complex (a dietary supplement) tablet give one tablet by mouth one time a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ferrous Sulfate (a dietary supplement) oral tablet 325 (65 Iron) mg give one table by mouth two times a day. The 8:00 AM dose. Metformin hydrochloride (a medication used to treat high blood pressure) 1000 mg give one tablet by mouth two times a day. Acetaminophen Liquid (Tylenol, a medication used to treat pain and fever) 160 mg per five milliliters give 30 milliliters by mouth three times a day. Insulin Aspart (a medication used to treat high blood sugar) solution inject per the sliding scale. The 8:00 AM and 11:30 AM blood sugar documentation or medication administration. An interview with the Director of Nursing on May 30, 2024, at 1:15 PM revealed she believed the medications were not administered due to Resident CR1 just being admitted the day prior. However, the medications were not documented as such on the MAR. The facility failed to accurately document the administration, refusal, or unavailability of Resident CR1's medications. 28 Pa. Code 211.9(a)(1)(f)(2)(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(2)(3) Nursing services