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Form Approved OMB
No. 0938-0391

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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at Penn Village, The	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)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on closed clinical record review, facility documentation, and staff interview, it was determined that the facility failed to develop and implement an effective discharge planning process for one of two residents reviewed (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed the resident was [AGE] years old and admitted to the facility on [DATE], from the hospital for rehabilitation following compression fractures of the spine and difficulty walking. Review of a five-day MDS (Minimum Date Set, an assessment completed at periodic intervals of time by facility staff to determined resident care needs) completed on July 7, 2024, by facility staff revealed staff assessed the resident of having a BIMS score (brief interview of mental status) of 12, indicating some cognitive impairment. Resident CR1 had a power of attorney listed as a responsible party with several other emergency contacts listed in the clinical record. Review of a social services assessment completed for Resident CR1 on July 8, 2024, indicated it was the resident's goal to return home with services. A care plan meeting note dated July 19, 2024, at 2:28 PM revealed Resident CR1 was alert with confusion and the resident's discharge plan continued to be a return to home. A care conference record of the same date revealed the resident and staff were present for the care plan meeting and no responsible party or family were present at the meeting. A physician's assistant visit dated August 8, 2024, noted Resident CR1 continued to have decline in function, continuing to lose weight, and becoming weaker. It was noted family (not POA) was present for the discussion. No discharge plans or discussion were noted. (continued on next page)

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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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review for Resident CR1 revealed the resident was on physical and occupational therapy case load from admission through August 12, 2024. Review of Resident CR1's physical therapy discharge summary dated August 12, 2024, revealed the resident had reached her maximum potential and still required minimum assistance of one person and cues for standing to sitting transfers, and moderate assistance of one and cues for standing pivot transfers. The resident's discharge destination was listed as home. Evidence indicated a Notice of Medicare Non-Coverage Part A (NOMNC) was completed by facility staff on August 8, 2024, for Resident CR1 and noted the resident's POA/responsible party was notified of the NOMNC and the resident's skilled services ending with a right to appeal and that the paperwork would be left at the facility's front desk for his signature. An updated copy of the NOMNC signed by the POA on August 9, 2024, was identified in the resident's record indicating the resident's last Medicare Part A covered day would be August 12, 2024. There was no evidence documented in Resident CR1's closed clinical record to indicate facility staff had any discussion with the resident and her POA/RP regarding the next steps to take in the resident's continued care process, if the resident was able to return home at her current level of care identified as her maximum potential by therapy, continue to reside in the facility, or transfer to another facility for continued care and services. In an interview with Employee 2, social services, on September 12, 2024, at 11:58 AM, Employee 2 indicated Resident CR1's family requested referrals to some other nursing facilities at the time the NOMNC was provided that were a better distance to family for the resident. Employee 2 confirmed there was no documentation of the discussion with the family as to whether the resident could return home with her level of function and condition, or if their wishes were for her to remain in the facility, or transfer to another nursing care facility. Review of additional documents in Resident CR1's closed record revealed copies of a faxed document dated August 20, 2024, with a cover sheet indicating it was faxed on August 20, 2024, addressed to another nursing facility for a referral for admission to the other facility. It was noted on the cover sheet that this was the second referral with the first being sent on August 9, 2024, 11 days prior. There was no other evidence provided at the time of the survey to indicate a fax/referral was sent to the facility for Resident CR1 on August 9, 2024. There was no documentation in Resident CR1's record to indicate the resident/POA requested that the facility start a referral to another facility on August 9, 2024, or anytime through August 20, 2024, at the time this fax referral was sent. Employee 1, social services, who was also present in the interview with Employee 2 on September 12, 2024, at 11:58 AM indicated the second referral to the other facility was sent on August 20, 2024, as the transfer facility stated they had not received the first referral that was alleged to be faxed on August 9, 2024. Employee 1 confirmed there was no documentation to indicate the facility staff reached out to the transfer facility prior to August 20, 11 days after the first referral was to be sent, as to why there was no response from the facility in that time frame, or that any communication was provided to Resident CR1 and the POA regarding any transfer status in that time frame. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was identified that another faxed document with a cover sheet to the same transfer facility was dated August 23, 2024, to the admission department, noting a first referral was sent on August 20, 2024, which was crossed out to indicate the August 20 date was a second referral and a first referral was sent on August 9, 2024. Employee 1 indicated the transfer facility indicated they had not received the fax from August 20, 2024. There was no documentation of this communication with the transfer facility or that any updates were provided to the Resident CR1 and the POA. A social service discharge plan document initiated on August 30, 2024, by Employee 1, indicated Resident CR1 was to be discharged on [DATE]. Employee 1 indicated in the interview on September 12, 2024, that the transfer facility did not have a bed prior to that. There was no evidence in Resident CR1's record to indicate communication occurred between the transfer facility or the resident and her POA of the bed availability at the transfer facility. There was no evidence to indicate Resident CR1 and her POA were communicated with during the process for discharge from the facility after the resident's skilled services were completed, or timely communication occurred with the transfer facility with updates to the Resident CR1 and her POA in the discharge planning process. Employee 1 did not indicate any reason as to why there was a delay in following up with the transfer facility from August 9 to August 20, 2024, before a second referral was sent, or to identify if the facility had not received the referral. The above information was reviewed with the Director of Nursing on September 12, 2024, at 3:00 PM. 28 Pa. Code 201.18 (3)(e)(1) Management 28 Pa. Code 211.10(a) Resident care plan

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on observation, clinical record review, review of facility documents, and resident and staff interview, it was determined the facility failed to investigate an incident of elopement and reassess and implement measures to ensure resident safety for one of five residents reviewed for resident safety (Resident 1). Findings include: Upon entrance to the facility on [DATE], at 9:00 AM a resident was observed sitting outside the facility's main entrance door on the patio smoking a cigarette. A bench seating area was also observed to the right of the main entrance of the facility. A parking lot was observed in front of the patio situated along a busy main road. In an interview with Employee 4, marketing, on September 12, 2024, at 11:45 AM who was working in an office located directly inside the main entrance of the building with windows facing the areas mentioned above indicated she observes many residents sitting outside the main entrance of the building. Employee 4 indicated there was a recent incident where the receptionist alerted Employee 4 along with another employee that a resident was heading across the parking lot area questioning if the resident was allowed to go there, and Employee 4 and another employee exited the building to retrieve the resident, identified as Resident 1, who was ambulating with a rolling walker in the main road. Employee 4 indicated she and the other Employee stopped traffic on the main road and retrieved the resident who was brought safely back into the facility and reported the incident to facility nursing administration. Employee 4 indicated Resident 1 was alert and stated she was going to the grocery store to purchase cigarettes. Clinical record review for Resident 1 did not reveal any recent documentation in August or September 2024, to indicate any incident had occurred where the resident ambulated with her rolling walker off facility property by herself and was retrieved from stopped traffic at the main road in front of the facility. In an interview with the Director of Nursing on September 12, 2024, at 12:30 PM she stated she was not aware of any recent elopements from the facility. When further information was requested regarding any information as to whether an incident did occur with Resident 1, Employee 6, assistant director of nursing, concurrently stated there was an incident with the resident, but it was not considered an elopement because staff had the resident in their vision the whole time and the resident is alert and oriented, but that she personally followed up with the resident but did not document it in the resident's clinical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing later provided staff witness statements dated September 4, 2024, from Employee 6, Employee 5, admissions, and a receptionist. Review of the staff witness statements indicated the receptionist observed Resident 1 going outside the building but instead of heading to the patio the resident headed toward the parking lot. The receptionist noted she asked Employee 4, and Employee 5 if the resident was allowed to be out on her own. Statements from Employee 4 and 5 indicated they were alerted to Resident 1 leaving the building with her rolling walker and calling to the resident to stop and she kept going, crossing the street towards the grocery store into traffic on the main road. Employees 4 and 5 stopped traffic and redirected the resident back across the street and back into the building where nursing took her back to her room. Review of a statement from Employee 6 also dated September 4, 2024, and not part of the resident's clinical record, noted she was made aware of the above incident at approximately 3:00 PM on September 4, 2024, regarding Resident 1 briefly leaving the building and being returned but she was witnessed the entire time. Employee 6 stated Resident 1 had a competent BIMS (brief interview of mental status) score of 13/15 at the time of the incident, and at the time the resident was walking out the door the receptionist yelled to the staff across the hall asking if the resident was allowed to go outside and at that time Employee 4 took direct visualization of the resident and was able to catch up to the resident as she was entering the road and vehicles did stop while the resident was approaching the road and Employee 4 assisted the resident back to the facility. Employee 6 stated an assessment was completed and no injuries were noted. Employee 6 also indicated she spoke with the resident after the incident and asked what she was attempting to do, and Resident 1 stated she wanted to go to the store to buy cigarettes because she would like to start smoking again. The statement noted Resident 1 does have visual impairments, which made it difficult for her to cross the road safely. The resident was told to notify staff when she would like to go on a leave of absence, the risks of smoking, and Resident 1 understood and verbalized back to Employee 6 that she would not leave the facility and cross the street unattended without notifying staff and that the resident stated she would be compliant with the leave of absence policy in the future. There was no evidence of any assessment of Resident 1 for any injuries as noted in the statement in the resident's clinical record, or any documented evidence of resident education as indicated in the statement as occurring on September 4, 2024. Further review of Resident 1's clinical record revealed the resident had resided at the facility since February of 2018. A review of the resident's physician orders revealed an order dated April 1, 2019, that the resident may go out with a responsible party and medications, and another order dated April 11, 2019, that the resident may go outside to smoke per facility policy. Review of Resident 1's active diagnosis revealed the resident has a diagnosis of repeated falls and unsteadiness on her feet added on January 31, 2020, and dementia added on October 4, 2022, after her admission. A review of Resident 1's active plan of care revealed a care plan for cognitive deficits was added on March 23, 2022, with an intervention noting the resident may go out with responsible party and medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident 1 on September 12, 2024, at 1:40 PM the resident stated she leaves the facility with her daughter and did try to go to the grocery store recently but they don't want me to do that. Resident 1 stated I made it to the middle of the street, and they saw me and came out and got me. Resident 1 stated she stopped smoking for a long time but decided she wanted to start again, and she was going to the store to get some cigarettes. Resident 1 stated she had got some cigarettes now from her daughter as she didn't really want her to smoke again but thought it was safer to get them for her than have her trying go across the road to get some. Resident 1 indicated she had cigarettes and a lighter in her pocket and had been out to smoke earlier in the day. Resident 1 also stated she had been outside to smoke the last couple days and pointed to her jacket on the bed stating she wore it the other day when she went out to smoke. Resident 1 did not wish to show the cigarettes in her pocket during the interview. An interview with Employee 3, licensed practical nurse, on September 12, 2024, at 1:45 PM indicated she was recently made aware Resident 1 was smoking again and that residents have smoking times for staff to take resident's out to smoke and cigarettes and lighters are kept at the nursing desk. Employee 3 stated she saw cigarettes at the desk for Resident 1 early in the week but could not locate them at the time of the interview. A concurrent visit to Resident 1's room with Employee 3 revealed Resident 1 did have a pack of cigarettes and lighter in her pocket in her room and Resident 1 became irritated when Employee 3 wanted to take them to keep them at the desk for safety. Employee 3 stated to the resident that someone needed to go out with her to smoke and Resident 1 repeatedly said she could and was allowed to go herself. Upon exiting the room Employee 3 stated she would have to follow up as to whether the resident was allowed to go outside herself to smoke as she was told the resident was to have someone with her. Employee 3 looked at another employee at the desk and asked if the resident was allowed and that staff member stated they believed the resident was to only go out with someone. Employee 3 indicated they would have to get it clarified if Resident 1 was allowed to go out herself. In an interview with multiple unidentified staff surrounding the nursing station on unit F located on the third floor of the facility where Resident 1 resides on September 12, 2024, at 1:50 PM, staff indicated there is a leave of absence book identified on the desk where residents are signed out by family/responsible party when leaving the facility and another book identified sitting on the desk for residents to sign out when they are leaving the unit to go outside or to another floor when they are not accompanied by staff. A review of the leave of absence book revealed Resident 1 was signed out by her family member last on September 2, 2024. A review of the resident sign out listing for leaving the unit unattended revealed no resident had signed out they were going off the unit unattended since August 30, 2024, and there was no evidence Resident 1 signed herself off the unit at any time in August or September 2024, as all the other sheets in the folder were blank. Review of Resident 1's medication administration record for September 2024, revealed the resident was documented as being on a leave of absence on September 6, 2024, although the resident was not signed out by a responsible party on the sheet since September 2, 2024. A quarterly MDS assessment (an assessment completed at periodic intervals of time to determine resident care needs) dated August 4, 2024, revealed facility staff assessed the resident as having a BIMS score of 13/15 (capable of normal cognition). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of any measures being put in place to prevent the resident from exiting the facility unattended or if she was assessed to safely do so after the incident on September 4, 2024, as the resident indicated she had been exiting the facility to smoke by herself since the incident. There was no evidence in Resident 1's clinical record indicating the incident on September 4, 2024, occurred with the resident being retrieved from a main road in front of the facility, that the resident was assessed after the incident, or reassessed for safety with smoking as the resident indicated she was going outside herself to smoke since the incident, or that the resident's cognitive status was reassessed after the incident until September 10, 2024, and no additional safety measures were implemented. The above findings were reviewed with the Director of Nursing on September 12, 2024, at 3:30 PM. 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 1/26/24, 5/1/24 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.10(d) Resident care policies