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	01/03/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide comprehensive skin assessments, and implement recommended interventions, that are consistent with professional standards of practice, to promptly identify and promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident CR1). Findings include: A review of the policy titled, Skin Evaluation, noted that, a licensed nurse will complete a total body evaluation on each resident weekly, and prior to a hospital or other facility transfer/discharge, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas, and skin problems. The policy further noted the licensed nurse will complete a total body evaluation on each resident weekly and document the observation on the skin evaluation form. If a resident is assessed as having a skin problem, the evaluating nurse will initiate the appropriate form. For pressure areas the staff will complete the Pressure Injury Record and for all other skin conditions the staff will complete the Non-Pressure Skin Condition Record. The licensed nurse will also complete a total body evaluation on each resident prior to a hospital or other facility transfer/discharge. The licensed nurse will document the observations on the skin evaluation form. A review of the policy titled, Skin and Wound, revealed that the policy will provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries. The policy further noted that staff are to document the presence of skin impairment(s)/new skin impairment(s) when observed and weekly until resolved. The staff will also, Monitor resident response to treatment, modify as indicated. The facility staff will evaluate the effectiveness of interventions and progress towards goals during the standard of care and care plan meetings. Closed record review for Resident CR1 revealed the resident was admitted to the facility on [DATE]. A physician's order for Resident CR1 dated November 15, 2024, instructed staff to perform weekly skin sweeps every evening shift on Wednesdays. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the physician orders for Resident CR1 revealed an order dated November 15, 2024, that noted, Zinc to buttocks with each incontinence. Care plan review for Resident CR1 revealed the resident had an activities of daily living (ADL) self-care deficit related to activity intolerance, a fracture (a broken bone), and osteoporosis (a condition that weakens the bones). The care plan noted that the resident was able to transfer to/from a chair with moderate to maximum assistance of two with a rolling walker. Further review of the care plan for Resident CR1 revealed the resident had a potential impairment to skin integrity related to fragile skin, comorbidities, and impaired mobility. One of the interventions included weekly skin integrity checks. The Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated November 21, 2024, revealed that facility staff assessed the resident as being at risk of developing pressure ulcers/injuries. An admission assessment for Resident CR1 dated November 15, 2024, at 3:51 PM revealed the skin assessment noted moisture associated skin damage (skin damage caused by irritation associated with prolonged exposure to moisture) to the bilateral buttocks with small scattered open areas. The size of the wound was not documented by staff. A nursing progress note for Resident CR1 dated December 19, 2024, at 3:16 PM revealed documentation of a worsened area on the sacrum (a bone at the base of the spinal column). The documentation noted the area is, .not new but worsened and had an optifoam (a type of wound dressing) over it. The documentation revealed, a six centimeter by six centimeter reddened area to sacrum, extending to right buttock with two open areas upper and lower both approximately two centimeters by two centimeters by 0.2 centimeters (cm). Wound bed pink/open with 10 percent slough (a non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture). Edges rolled. Noted Stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) depth at this time. The documentation further noted that a treatment was initiated, and staff will have the area assessed next week on wound rounds. The nurse was to notify the responsible party and physician. A wound evaluation (requested after staff identified the wound on the sacrum) for Resident CR1 from wound care (a third party wound management service that is contracted by the facility to perform various wound care needs/treatments/assessments) dated December 23, 2024, noted an end-stage skin failure sacrum full-thickness. The wound was measured as 2.5 x 3.6 x 0.3 centimeters (length x width x depth). It was assessed as having heavy serous exudate (a type of wound drainage), 50 percent thick adherent devitalized necrotic (dead) tissue, with a poor healing potential. An interview with Employee 1, registered nurse, on January 3, 2025, at 12:54 PM revealed that Resident CR1 was identified as having MASD on the buttocks area as noted in the documentation upon admission. A treatment of zinc was initiated at the time of this finding. Employee 1 confirmed that there were no further assessments or documentation that the facility could provide on the wound (such as exact measurements, healing progress, potential complications, presence of infection, pain, etc.) until a full-thickness wound was identified on the sacrum on December 19, 2024, and wound care was now requested to evaluate. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the clinical documentation for Resident CR1 revealed a nursing progress note dated November 22, 2024, at 10:29 PM that revealed a nurse aide found blood on the resident's bed after removal of their socks. Documentation noted that there was an open area to the left heel that measured 2 cm by 2 cm with a black area and bleeding. A dry dressing was applied. A wound evaluation for Resident CR1 from wound care dated November 26, 2024, revealed a Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer) pressure wound of the left heel full-thickness. The area was assessed as 3.5 x 4.0 x 0.3 cm in size. It was assessed as having heavy serous exudate, 75 percent thick adherent devitalized necrotic tissue, and 25 percent slough. Further assessment by wound care noted a wound duration greater than 10 days and, Noted to be present on admission per staff. Some treatment recommendations included elevating the leg(s), off-load the wound, float heels in bed, and a pressure off-loading boot. The facility could provide no further assessments of the skin prior to identification of Resident CR1's Stage 4 heel pressure ulcer until the nurse aide identified the wound on November 22, 2024. This wound was documented (as noted above) by wound care staff as having a duration greater than 10 days and, Noted to be present on admission per staff. There was no documentation in the clinical record that the facility identified any issues on Resident CR1's heels on admission. Employee 1 further noted during the interview on January 3, 2025, at 12: 54 PM that the recommendations initially made by wound care on November 26, 2024, related to Resident CR1's heel should be in the care plan. Further review of the resident's care plan, Kardex (documentation by nursing staff to note important information and care planning and facilitate resident care), tasks, and physician orders revealed no evidence that the recommendations made by wound care were put into place. The facility could provide no further documentation or evidence that the recommendations were initiated as recommended by wound care, documented as completed, or staff were aware of these recommendations. The facility failed to provide necessary monitoring (appropriate comprehensive assessments to initially identify a wound or response to treatments/interventions) and identify and implement specific recommended interventions upon finding the wound (as recommended by wound care for the resident's heel wound) for a resident who was identified (as noted in the MDS) to be at risk for developing pressure ulcers / pressure injuries. The above information for Resident CR1 was reviewed in a meeting with the Nursing Home Administrator, Director of Nursing, and Employee 1 on January 3, 2025, at 4:00 PM. 483.25(b)(1)(i)(ii) Treatment/svcs to Prevent/heal Pressure Ulcer Previously cited deficiency 4/9/2024 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services