

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 03/26/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, comfortable, and homelike environment on two of four nursing units (Nursing Units C, and F; Residents 1, 2, 3, 4, 5, and 6).</p> <p>Findings include:</p> <p>Observation of Nursing Unit C (second floor) on March 26, 2025, at 10:33 AM revealed the following findings:</p> <p>A wheelchair in the hallway with no resident identifier had a significant accumulation of crumbs and debris under the seat cushion on the chair. There was also an unidentified piece of metal on the seat of the chair. A concurrent interview with Employee 1, nurse aide, revealed the wheelchair belonged to Resident 1.</p> <p>Resident 2's wheelchair had an accumulation of crumbs and debris under the seat cushion on the wheelchair.</p> <p>Resident 3's wheelchair had an accumulation of crumbs and debris under the seat cushion on the wheelchair.</p> <p>Another wheelchair with no resident identifier had an accumulation of crumbs and debris under the seat cushion on the wheelchair. A concurrent interview with Employee 1 revealed it was unclear who the wheelchair belonged to.</p> <p>Observation of the Nursing Unit C shower room on March 26, 2025, at 10:53 AM revealed the following:</p> <p>There were multiple tears in the padding on the shower gurney exposing the underlying foam padding. One of the tears was six inches in length.</p> <p>A shower chair had five resident lift slings of various sizes piled on the seat. Another sling was draped over the backrest of the chair. There was a blue-colored padded foam heel boot amongst the slings.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A pink colored basin held various shower supplies that included skin moisturizer and soap. At least two different resident initials were noted on two of the items. One of the items had leaked. There was an unused, folded brief in the basin. The item had leaked onto several of the other items including the brief and the bottom of the basin.</p> <p>Observation of the Nursing Unit F (third floor) shower room on March 26, 2025, at 11:04 AM revealed the following:</p> <p>A bucket used for a bedside commode was on the floor in the shower stall partially full of a brownish-tinged liquid. The bucket contained a brown colored object that appeared to be from a bowel movement floating in the water.</p> <p>A black colored hair comb was located on a shelf above the sink. The teeth of the comb had a significant accumulation of white flakes and several strands of hair in it. The comb was placed with multiple other combs that appeared to be unused.</p> <p>Observation of Nursing Unit F on March 26, 2025, at 11:11 AM revealed the following:</p> <p>Resident 4's wheelchair was wet with an unidentified liquid under the seat cushion of the wheelchair. A concurrent interview with Employee 3, nurse aide, revealed that the wheelchair would be cleaned immediately.</p> <p>Resident 5's Geri-chair had plastic collapsible trays on bilateral sides of the chair. The edges of both trays were broken exposing jagged edges of plastic.</p> <p>Observation of Resident 6's wheelchair on March 26, 2025, at 2:58 PM revealed debris in the cupholder. There was a missing protective cap on the metal frame on the front left side of the wheelchair. There was an accumulation of dirt and debris in the missing cap. There was rust on the frame of the wheelchair.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and the Director of Nursing on March 26, 2025, at 3:20 PM.</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>		