

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 09/11/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to implement interventions to decrease the potential for resident elopements for one of four residents reviewed (Resident 1). Findings include: Clinical record review for Resident 1 revealed a progress note date August 1, 2025, at 6:19 PM that indicated she was exit seeking twice during the shift. Clinical record review for Resident 1 revealed a nursing progress note dated August 17, 2025, at 10:11 PM that indicated Resident 1 was anxious and exit seeking. The physician was notified and a one time dose of Seroquel (a medication used to treat psychosis) 25 milligrams was ordered. A nursing progress note dated August 21, 2025, at 12:08 AM revealed that Resident 1 was pacing in the hallway and set off the wander guard system at the elevators once. A nursing progress note dated August 21, 2025, at 6:22 PM revealed that Resident 1 was restless and wandering. She wanted to leave. She was on the elevator twice and activated the alarm. Clinical record review for Resident 1 revealed a progress dated August 22, 2025, at 12:06 PM that indicated Resident 1 had eloped and walked out the front door of the building. Resident 1 was followed by staff and was on the grass at the right of the facility on the corner at the redlight near the highway. Staff redirected Resident 1 back into the facility. The note indicated that Resident 1's wander guard (a wearable bracelet that works with a wander guard system sounding an alarm to assist with elopement prevention) was working and sounded the alarm when she was brought back into the facility, and when she got off the elevator back onto the nursing unit. The note also indicated that Resident 1's physician was notified of the incident and new orders were received for lab work, an abdominal ultrasound, and urinalysis with culture and sensitivity. Review of the facility's investigation into Resident 1's elopement dated August 22, 2025, at 10:34 AM revealed that the facility initiated 15-minute checks on Resident 1 that would progressively lengthen in time over the weekend until they were hourly checks and then would remain in effect for 72 hours. Further clinical record review for Resident 1 revealed a progress note dated August 23, 2025, at 10:00 PM that indicated the alarm by the elevators activated and noted that Resident 1 was on the elevator as the elevator door closed. The nurse took the other elevator to the first floor and found Resident 1 near the front door with the wander guard alarm on that floor activated. Resident 1 was safely returned to her unit. The facility discontinued every one hours checks and initiated checks every 15-minutes. A nursing progress note dated September 1, 2025, at 9:49 PM revealed that Resident 1 attempted to leave the unit but was easily redirected. A nursing progress note dated September 3, 2025, at 2:29 PM revealed that Resident 1 attempted to get on the elevator one time that morning. A nursing progress note dated September 4, 2025, at 5:53 PM revealed that Resident 1 was exit seeking three times that shift. A nursing progress note dated September 6, 2025, at 3:23 PM revealed that Resident 1 was at the elevator with an arm full of clothes and pushed the elevator button and the alarm sounded, but the nurse intervened. A nursing progress note dated September 8, 2025, at 2:31 PM revealed that Resident 1 was walking down the hallway with some of her clothes towards the elevator and she was redirected by staff. A nursing progress note dated September 8, 2025, at 4:57 PM indicated that Resident 1 entered the elevator with visitors. The wander guard alarm activated. Resident 1 continued in the elevator and got off on the first floor where staff intervened as she was exiting the front of the building. Resident 1 was returned to the nursing unit and one-to-one was initiated. A progress note dated September 11, 2025, at 10:04 AM revealed that Resident 1 continued on 15-minute checks and she is also on one to one; however, that was discontinued at 10:00 AM. On September 11, 2025, at 9:00 AM the surveyor entered the facility and there was no receptionist at the front desk. The office doors in the general area were all closed. The surveyor waited from until 9:06 AM and then went to find staff. When the surveyor arrived back to the lobby area, there was still no receptionist. As the surveyor walked towards the front doors of the facility, they opened up allowing an exit from the facility without the assistance of staff. An interview with the Nursing Home Administrator on September 11, 2025, at 11:30 AM revealed that the wander guard system is not tied into the doors or the elevator. The NHA indicated that when a resident wearing a wander guard are near the wander guard system, it sets the alarm off but does not lock the elevator or doors. The NHA also indicated that the front doors of the facility are locked from 8:00 PM until 8:00 AM. He confirmed that if a resident with or without a wander guard bracelet came down in the elevator and staff were not there to intervene, that the resident could walk right out the front doors between the hours of 8:00 AM and 8:00 PM. The NHA also confirmed that if Resident 1 entered the elevator the alarm would go off but she could still get to the first floor and out the front doors if staff did not respond to the alarms timely</p>		