

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/05/2025
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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and staff and resident interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on one of three open nursing units (Unit F and Residents 44 and 91) and failed to maintain the facility environment to protect the health and safety of residents, personnel and the public (two of two elevators, the area outside the elevators, and the main hallway after the lobby entrance). Findings include: Observations of Resident 44's room on December 3, 2025, at 11:06 AM revealed multiple light tan and brown colored stains on the privacy curtain in the resident's room. Observation of Resident 91's room on December 3, 2025, at 11:18 AM revealed the privacy curtain had brown colored stains and what appeared to be dried liquid on the privacy curtains. Observations of Elevator 2 on December 4, 2025, at 8:15AM revealed that the carpet on the floor had 2 areas of rippling/bubbling, causing the carpet to be elevated at the elevator door entrance. Further inspection revealed that there were many fraying fibers around the edge of the carpeting near the elevator walls. Concurrent observation revealed that Elevator 1 also had elevated carpet areas where the carpet appeared to have bubbles. Elevated carpet areas were also noted immediately after the lobby area at the hallway intersection, leading to the Kitchen and the Recreation room. The carpet outside of the elevators on the first floor had an 8-inch, round stain with a brown center measuring 1.5 inches, to the left of the elevator doors and near the wall when facing the doors. The above information was relayed to the Nursing Home Administrator and the Director of Nursing on December 4, 2025, at 12:30 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited deficiency 3/26/2025 28 Pa. Code 201.18(b)(3)(e)(2.1) Management		

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide respiratory care consistent with professional standards of practice for two of two residents reviewed for respiratory concerns (Residents 5 and 54). Findings include: Clinical record review revealed the facility admitted Resident 5 on November 6, 2025. A physician's order initiated on November 7, 2025, instructed staff to administer Resident 5 continuous oxygen at three liters per minute (LPM) by nasal cannula (medical tubing that delivers supplemental oxygen directly to the nose). Observations of Resident 5 on December 3, 2025, at 10:53 AM, and 2:17 PM, and December 4, 2025, at 9:59 AM revealed she was receiving supplemental oxygen via nasal cannula. Each observation revealed the oxygen was being administered at one LPM, not three LPM as ordered by her physician. Interview with Resident 5 on December 3, 2025, at 10:53 AM revealed that she doesn't know why they keep putting the oxygen on her. She stated that she did not use any oxygen at home, and that she is not short of breath. The findings for Resident 5 were reviewed during a meeting with the Nursing Home Administrator and Director of Nursing on December 4, 2025, at 11:30 AM. Observation of Resident 54's oxygen tubing on December 3, 2025, at 10:46 AM revealed that there was no date on the oxygen tubing to indicate when the tube was last replaced. Observation of Resident 54's oxygen tubing on December 4, 2025, at 8:13 AM revealed there was still no indication of when the oxygen tubing was last changed located on the tubing. A concurrent observation of the nebulizer machine (specialized compressor utilized to administer aerosolized medication through specialized tubing, a medication cup, and a mask) located on a table next to the bed revealed a nebulizer mask, tubing, and medication cup that remained connected to the machine. The medicine cup and mask appeared cloudy, with droplets of clouded liquid dried inside the medicine cup. The nebulizer tubing was dated November 24, 2025. A bag containing a new mask and tubing was located beside the nebulizer machine and dated November 30, 2025. A concurrent interview with Resident 54 revealed that she had left the nebulizer mask there after her last treatment, which she indicated she uses only as needed. The resident stated that staff did not throw away her old mask when they brought in her new mask. Review of Resident 54's clinical record revealed the last administered dose of medication that required the nebulizer machine was November 29, 2025, at 7:18 PM. A review of Resident 54's clinical record revealed a current physician's order dated August 23, 2025, that stated change tubing, mask and/or nasal cannula weekly, may change sooner as needed. as needed for hygiene AND every night shift every Sat. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on December 4, 2025, at 12:36 PM. 483.25(i) Respiratory Care Previously cited 2/4/25 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. Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents who utilize a gastric tube for two of two employees reviewed for competencies (Employees 7 and 8). Findings include: A review of the facility documentation revealed that the facility had a total of 2 residents with a feeding tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications; also known as a PEG tube). A request for nursing staff competencies for G-tubes revealed the facility was unable to provide any competencies in this area for Employees 7 (licensed practical nurse), and 8 (registered nurse). The findings were reviewed with the Nursing Home Administrator on December 5, 2025, at 1:30 PM. On December 8, 2025, at 10:40 AM the Nursing Home Administrator confirmed the facility could provide no documentation that ensured Employees 7 and 8 had specific competencies and skill sets to care for the residents needs listed above. Cross reference F0693 Tube Feeding mgmt./Restore Eating Skills 28 Pa. Code 201.20 (a) Staff Development		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on employee personnel record review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 9, 10, and 11). Findings include: The facility noted the following hire dates for three employees reviewed for performance evaluations (EPR, employee performance review): Employee 9's hire date of November 2, 2021. Employee 10's hire date of August 9, 2023. Employee 11's hire date of April 30, 2024. The annual performance evaluations for Employee 9, 10, and 11, revealed EPRs dated as completed on December 5, 2025. Further requests to view the previous EPRs completed prior to December 5, 2025, revealed no documented evidence that the facility completed performance evaluations for Employees 9, 10, and 11 (nurse aides) at least once every 12 months. Interview with the Nursing Home Administrator on December 5, 2025, at 12:19 PM confirmed that performance evaluations were not completed annually on the three employees requested. 28 Pa. Code 201.19 (2) Personnel policies and procedures		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff and resident interview, it was determined that the facility failed to implement a comprehensive, person-centered care plan regarding a cardiac pacemaker for one of 32 residents reviewed (Resident 24). Findings Include: Clinical record review for Resident 24 revealed a diagnosis list that included the presence of a cardiac pacemaker (an electronic device to help regulate the beating of the heart) and complete atrioventricular block (a disorder of the heart that impacts the electrical signals between the upper and lower chambers). Hospital documentation for Resident 24 dated July 29, 2025, at 7:16 AM revealed that the resident's electrocardiogram (EKG, a test to measure the electrical rhythm of the heart) had a ventricularly (referring to the lower chambers of the heart) paced cardiac rhythm. An interview with Resident 24 on December 5, 2025, at 11:30 AM confirmed that the resident had a pacemaker and an electronic transmittal device on the bedside dresser the resident reported was for remote monitoring. Review of Resident 24's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker, any pertinent assessments related to the pacemaker and/or clinical care, precautions, or the transmittal device care. An interview with Employee 2, licensed practical nurse, on December 5, 2025, at 12:12 PM confirmed that there was no comprehensive, person-centered care plan associated with Resident 24's pacemaker. The above information for Resident 24 was reviewed with the Nursing Home Administrator and Director of Nursing on December 5, 2025, at 2:15 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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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. Based on clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to implement interventions to aid in fall prevention for one of five residents reviewed for falls (Residents 69). Findings include: Clinical record review for Resident 69 revealed the resident had a history of falls in the facility. A review of Resident 69's active plan of care for the risk of falls revealed an intervention listed was to keep the resident's bed in low position when in bed, bilateral body pillows when in bed, floor mats on the right side of the bed, left side of the bed against the wall, and the bed needs to be locked down, with a date initiated of November 22, 2025, and revision date of November 23, 2025. Further review of resident 69's fall risk plan of care intervention above revealed a history of changes to the above intervention, but bilateral body pillows were listed as part of the intervention since August 18, 2024. Clinical record review for Resident 69 revealed a progress note dated November 22, 2025, that indicated the resident was not moving her left arm or shoulder and also had complaints of left hip pain with movement and due to the timing for a mobile x-ray the resident's responsible party wanted the resident sent to the emergency room. Transportation was arranged at that time. A progress note dated November 23, 2025, at 7:21 AM for Resident 69 by Employee 6, registered nurse, noted the nurse was on the unit and heard a scream coming from the resident's room and noted the resident was found lying on the floor on her left side between the dresser and floor mat. It was noted two skin tears were identified on the resident's left arm, and the resident was not able to perform range of motion on her left arm having severe pain when moving it. The physician was made aware, and the oncoming registered nurse would continue to assess and call for an x-ray. Facility staff indicated this note was in reference to Resident 69's fall that occurred on November 22, 2025, but due to change of shift it did not get documented until November 23, 2025, by Employee 6. Review of a progress note for Resident 69 dated November 23, 2025, at 6:31 AM revealed facility staff had contact with the hospital, and the resident was noted to have sustained a fracture of her left humerus (arm), and a fracture of an iliac bone that extends to the left hip socket. Review of a facility fall report for Resident 69 dated November 22, 2025, at 8:55 PM revealed the resident was found on the floor in her room at the end of the bed noting the resident got out of bed and walked over her fall mats and then fell. The report noted the resident's left shoulder and arm pain and that the resident's responsible party wanted the resident sent to the hospital. The report also indicated that the resident got out of bed unassisted and was in a low bed with a right fall mat and no body pillow, noting it was sent to laundry due to soiling. Review of a statement by Employee 12, nurse aide, regarding Resident 69's fall noted above dated November 22, 2025, revealed that a fall mat and slippers were in place at the time of the fall, but the body pillow was taken down to wash. Review of an additional statement dated November 22, 2025, for Resident 69's fall, with the author not identified on the statement noted slippers and fall mats were in place but the body pillow was in laundry. The above information regarding Resident 69's fall risk intervention of a body pillow not being present at the time of the fall sustained on November 22, 2025, was reviewed with the Nursing Home Administrator and Director of Nursing on December 5, 2025, at 9:30 AM. On December 5, 2025, at 11:00 AM the Director of Nursing provided an additional statement from Employee 6, dated December 5, 2025, noted a clarification to the employee's observation of Resident 69 at the time of the November 22, 2025, fall to now add that there were pillows on the resident's bed at the time of the fall. In a follow up interview with Employee 6, on December 5, 2025, at 11:24 AM Employee 6 stated Resident 69's fall happened at the end of her shift and she was the one who initially assessed the resident and knew that when she and the other staff who assisted her put the resident back into her bed there was not a body pillow on the bed, but there were other regular pillows, which she used to position under the resident. Employee 6 could not confirm if staff had utilized pillows to function in place of the required body pillow to extend down the resident's side as she only saw the resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the fall and knew that regular pillows were on the bed when she helped position the resident. Employee 6 indicated that the body pillow is a long pillow, which extends down the side of the resident and is not the same as regular pillows. Employee 6 indicated the facility has a supply of body pillows and could obtain another pillow if one was being laundered. Resident 69 did not have a body pillow per her plan of care at the time of the fall on November 22, 2025, in which the resident sustained an injury. The above findings for Resident 69 were reviewed with the Director of Nursing on December 5, 2025, at 12:15 PM. 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 2/4/25, 9/11/25 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide appropriate treatment and services for a resident who is fed by enteral means to prevent potential complications for one of one resident reviewed for tube feeding concerns (Resident 6). Findings include: Observation of Resident 6 On December 3, 2025, at 3:24 PM revealed the presence of a feeding tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications; also known as a PEG tube) connected to a feeding pump (a mechanical device used to pump a specialized liquid nutrition source referred to as feed, through a G-tube at a pre-set rate). A concurrent observation of the feeding pump revealed that the pump rate was set to administer 50 milliliters (ml) of feed per hour. Clinical record review revealed that Resident 6 had a physician's order written on November 20, 2025, stating 42ml/hr continuous feed via PEG- until (4) 250ml container received x 24 hours via PEG. Observation on December 5, 2025, at 7:45 AM revealed that the feeding rate remained at 50ml/hr. A concurrent interview with Employee 5, licensed practical nurse, confirmed that the feeding rate set on the pump did not match the physician's order in Resident 6's chart. A request for the nursing competencies for Employee 7, licensed practical nurse, and Employee 8, registered nurse, were requested on December 4, 2025, at 12:30 PM. The nursing competencies specifically related to G-tubes were requested from the Nursing Home Administrator for Employees 7 and 8 on December 5, 2025, at 9:15 AM, 12:45 PM. On December 8, 2025, at 10:40 AM the Nursing Home Administrator confirmed that the facility could not locate any competencies for Employees 7 and 8 related to G-tubes. Cross refer F0726 Competent Nursing Staff 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing service		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice for two of three residents reviewed for pain (Residents 3 and 5). Findings include: Clinical record review for Resident 3 revealed a care plan-initiated on May 22, 2025, noting Resident 3 has chronic pain related to his physical disabilities, immobility, contractures, history of multiple traumatic injuries, and a Stage IV (full thickness tissue loss with exposed muscle, tendon, or bone) sacral wound. Further review of Resident 3's clinical record revealed current physician's orders for the following pain medications: Tylenol 325 milligrams (mg), two tablets every four hours as needed for mild pain Tramadol (opioid medication used to treat moderate to severe pain) HCl 50 mg, one tablet every six hours as needed for moderate pain (4-7) Oxycodone (opioid medication used to treat moderate to severe pain) HCl 5 mg, one tablet every 12 hours as needed for severe pain (8-10) Review of Resident 3's Medication Administration Record (MAR, a form utilized to document the administration of medications) dated November 2025, revealed that he received Tylenol as follows: November 1, 2025, for a pain level of 6 November 2, 2025, for a pain level of 4 November 6, 2025, for a pain level of 4 November 9, 2025, for a pain level of 5 November 11, 2025, for a pain level of 5 November 18, 2025, for a pain level of 5 November 19, 2025, for a pain level of 4 November 20, 2025, for a pain level of 4 November 21, 2025, for a pain level of 5 November 23, 2025, for a pain level of 6 November 28, 2025, for a pain level of 5 November 30, 2025, for a pain level of 6 The facility failed to follow Resident 3's physician ordered pain medication for the level of pain. Interview with Resident 5 on December 3, 2025, at 11:54 AM revealed she has frequent pain from her fall with a fracture at home. Clinical record review revealed the facility admitted Resident 5 on November 6, 2025, and a plan of care was initiated on November 8, 2025, that noted Resident 5 has pain related to arthritis and a right femur fracture. Review of Resident 5's clinical record revealed current physician's orders for the following pain medications: Tylenol 325 mg, two tablets every four hours as needed for mild pain Tramadol HCl 50 mg, one tablet every six hours as needed for moderate pain Oxycodone HCl 5 mg, one tablet every six hours as needed for severe pain Review of Resident 5's MARs dated November and December 2025, revealed that she received Tylenol as follows: November 9, 2025, for a pain level of 4 November 10, 2025, for a pain level of 5 November 19, 2025, for a pain level of 4 November 29, 2025, for a pain level of 10 December 3, 2025, for a pain level of 5 December 4, 2025, for a pain level of 5 Interview with the Nursing Home Administrator and Director of Nursing on December 4, 2025, at 11:35 AM confirmed the above noted findings related to Resident 3 and 5's pain. They were unable to provide any further documentation to ensure that pain medications were administered according to physician orders. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on clinical record review, review of select facility policies and procedures, observation, and resident and staff interview, it was determined that the facility failed to properly store resident medications and treatments on one of three nursing units (First Floor Nursing Unit; Resident 3). Findings include: The policy entitled Medication Storage, last reviewed on December 3, 2025, revealed all drugs and biologicals will be stored in locked compartments under proper temperature controls. Observation of Resident 3's room on December 3, 2025, at 10:12 AM and 1:40 PM revealed a bottle of H-Clor 12 0.125 percent solution (topical antiseptic used for wound care and skin infections) on his windowsill. Resident 3 stated it has been there awhile. He was unaware what the solution was used for. Observation of Resident 3's room on December 4, 2025, at 10:08 AM revealed a bottle of DermaSeptin ointment (skin protectant used to soothe skin irritations and promote healing) on his over bed table. Resident 3 was not in the room at this time. The above findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on December 4, 2025, at 11:30 AM. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to maintain clinical records that were complete, accurate, and readily accessible for one of 32 residents reviewed (Resident 31). Findings include: Clinical record review for Resident 31 revealed a diagnosis list that included weakness and difficulty in walking. Current physician orders for Resident 31 revealed an order dated June 9, 2025, at 2:48 PM for a restorative ambulation program that the resident will ambulate 50 to 100 feet with a rollator (a type of walker), contact guard (a type of assistance used in physical therapy), and a wheelchair to follow. Further review of the current physician orders for Resident 31 revealed an order dated April 28, 2025, at 11:28 AM for a restorative program to include an active range of motion to the bilateral upper extremities on all plains and joints for three sets of 10 repetitions. The task list (located in the electronic health record where staff document specific care related events for a resident) for Resident 31 revealed a task dated March 29, 2025, that included the following: RESTORATIVE: ambulate 20-40 feet with rollator. This task did not match the parameters noted in the current physician orders. A review of the documentation for the restorative program in the task list for the past 30 days revealed that staff were documenting the task as the following: Not applicable on November 6, 7, 10, 11, 12, 14, 19, 21 (at 8:42 PM), 23, 24, 25, 28, 29, 2025; December 1 and 4. Resident refused was documented by staff on November 15 (at 1:43 PM) and staff completed passive range of motion at 9:59 PM. Ambulation and locomotion documented as completed on November 21, 2025, at 8:48 AM. Ambulation and locomotion documented as completed on November 22, 2025, at 11:36 AM. Resident refused was documented by staff on November 27 and 30, 2025. An interview with Employee 4, Director of Rehab, on December 5, 2025, at 9:19 AM revealed that Resident 31 is currently on physical and occupational therapy and the resident should be discharged from the restorative program before being placed on therapy. Employee 4 revealed that the resident has been on both physical therapy since October 18, 2025, and occupational therapy since October 16, 2025. Nursing staff oversee restorative therapies. The above information for Resident 31 was reviewed with the Nursing Home Administrator and Director of Nursing on December 4, 2025, at 11:30 AM and December 5, 2025, at 2:15 PM. 483.70(h) Medical Records Previously cited deficiency 2/4/2025 28 Pa. Code 211.5(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding Transmission Based Precautions for three of 32 residents reviewed (Residents 19, 31, and 42) and failed to provide a safe and sanitary environment to help prevent development and transmission of disease and infection for one of 32 residents reviewed (Resident 10). Findings include: Observation of the room shared by Resident 31 and Resident 42 on December 3, 2025, at 2:20 PM revealed a sign on the door that directed visitors to Stop due to Contact Precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment). The sign instructed that everyone must clean their hands, put on gloves, put on a gown before room entry, and use dedicated or disposable equipment. Further observation of the room revealed a sign on the right doorframe that indicated Enhanced Barrier Precautions (EBP, utilized for residents with chronic wounds or indwelling medical devices [i.e., indwelling urinary catheters] during high-contact resident care activities regardless of their multidrug-resistant organism status; high-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care). An interview with Employee 3, licensed practical nurse, on December 3, 2025, at 2:23 PM revealed that Resident 31 was on contact precautions due to ESBL (Extended-Spectrum Beta-Lactamase; a type of bacteria that is resistant to certain antibiotics). Clinical record review for Resident 31 revealed an order dated November 20, 2025, for enhanced barrier precautions related to a suprapubic catheter (medical tubing used to drain urine from the bladder through the abdomen) and a wound. There was no order noted for contact precautions. Resident 31's care plan initiated on November 26, 2025, revealed the resident has an infection of the suprapubic catheter site and an intervention dated November 26, 2025, included to maintain universal precautions when providing resident care. The care plan did not specify to utilize contact precautions. Resident 31's Kardex (documentation by nursing to note important information and care planning and facilitate resident care) did not indicate to staff that the resident was on contact precautions. A wound culture for Resident 31 obtained on November 25, 2025, revealed multiple bacterial including ESBL in the sample. The above information for Resident 31 was reviewed with the Director of Nursing on December 3, 2025, at 2:50 PM. An interview with Employee 1, registered nurse, on December 3, 2025, at 3:00 PM confirmed that Resident 31 was on contact precautions and the order was not placed in the medical record and did not carry over to the resident's care plan and Kardex. Follow-up review of Resident 31's electronic health record revealed an order dated December 3, 2025, at 10:00 PM for contact isolation related to bacteria in the suprapubic wound drainage. Observation of Resident 19's room on December 5, 2025, at 8:23 AM revealed a sign outside the door to the resident's room that directed visitors to Stop due to Contact Precautions. The sign instructed that everyone must clean their hands, put on gloves, put on a gown before room entry, and use dedicated or disposable equipment. Observation during medication pass for Resident 19 on December 5, 2025, at 8:23 AM revealed Employee 3, licensed practical nurse, entered the room without donning (putting on) an isolation gown as instructed by the signage. An interview with Employee 3 on December 5, 2025, at 9:02 AM revealed that Resident 19 is on enhanced barrier precautions due to a wound. Employee 3 revealed that staff would check the physician orders to see if the resident is on enhanced barrier precautions or contact isolation. Upon checking the resident's chart, Employee 3 revealed there was no order for contact precautions or enhanced barrier precautions. A review of Resident 19's current physician orders revealed no order for contact precautions or enhanced barrier precautions. Resident 19's care plan revealed that the resident has a history of open wounds on the bilateral lower extremities. An intervention dated November 19, 2025, revealed the resident was on enhanced barrier precautions related to the wounds. There was no documentation in Resident 19's clinical record that indicated the resident was on contact precautions as the sign indicated. An interview with Employee (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1, infection control, on December 5, 2025, at 9:33 AM stated the discrepancy was corrected. Follow-up review of Resident 19's electronic health record revealed an order dated December 5, 2025, for enhanced barrier precautions related to leg wounds. The above information for Residents 19 and 31 was reviewed with the Nursing Home Administrator and Director of Nursing on December 5, 2025, at 2:15 PM. An observation of Resident 10's bathroom on December 3, 2025, at 2:51 PM revealed a cardboard box with several open and unopened packs of briefs and incontinence pads stored directly on the floor under the sink. The above information regarding the storage of Resident 10's incontinence products was reviewed with the Nursing Home Administrator and Director of Nursing on December 4, 2025, at 11:45 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		