

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Pennknoll Village		STREET ADDRESS, CITY, STATE, ZIP CODE 208 Pennknoll Road Everett, PA 15537	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47819</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcers were assessed and documented on for two of four residents reviewed (Residents 1, 3).</p> <p>Findings include:</p> <p>The facility's policy regarding pressure ulcer monitoring, dated February 13, 2024, indicated that the facility would document the presence of skin impairments/new skin impairment related to pressure when first observed, and weekly thereafter until the site is resolved.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 24, 2024, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included left femur fracture (large leg bone). A skin integrity care plan for Resident 1, dated July 17, 2024, indicated that the care and treatment included weekly wound assessments with documentation to include the width, length, depth, type of tissue, exudate, and any other notable changes or observations for each area of skin breakdown.</p> <p>A nursing note for Resident 1, dated July 22, 2024, indicated that new pressure areas were identified on the left and right heel and coccyx. Physician's orders for Resident 1, dated July 22, 2024, included an order for skin prep to bilateral heels and to coccyx daily.</p> <p>A nursing note for Resident 1, dated July 31, 2024, indicated that the area to the coccyx was worsening and measured 5.0 centimeters (cm) x 2.0 cm with no measurable depth due to slough (a form or necrosis that appears as soft yellow or white tissue in a wound). Physician's orders for Resident 1, dated July 31, 2024, included an order for Dakins wet to dry dressing and secure with tape twice a day for pressure ulcer.</p> <p>A review of the clinical record for Resident 1 revealed no documented evidence that weekly wound assessments or wound documentation was completed from July 22, 2024, through September 9, 2024.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An admission MDS assessment for Resident 3, dated July 23, 2024, revealed that the resident was moderately cognitively impaired, required assistance with daily care needs, and had diagnoses that included a traumatic brain injury with paraplegia and cellulitis (infection of the skin). A skin integrity care plan for Resident 3, revised on July 24, 2024, indicated that the care and treatment included weekly wound assessments with documentation to include the width, length, depth, type of tissue, exudate, and any other notable changes or observations for each area of skin breakdown.</p> <p>A nursing note for Resident 3, dated June 29, 2024, indicated that an open area was identified on the right buttock.</p> <p>Physician's orders for Resident 3, dated June 29, 2024, included an order to cleanse the right buttock wound with soap and water, pat dry, irrigate with one quarter Dakin's Solution (an antiseptic), cover with dry gauze, and secure with tape.</p> <p>A review of Resident 3's clinical record revealed that from July 6, 2024, through September 9, 2024, there were only two weeks (July 18, 2024, and August 22, 2024) with wound documentation.</p> <p>An interview with Licensed Practical Nurse 1 on September 9, 2024, at 2:50 p.m. confirmed that weekly wound assessments were not done in the facility. The residents were followed by an outside wound clinic, who determines the wound treatments.</p> <p>An interview with the Nursing Home Administrator on September 9, 2024, at 4:15 p.m. confirmed that Resident 1 and Resident 3 were care planned for weekly wound assessments that should have been completed by the facility.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		