STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395422	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pennknoll Village	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on clinical record reviews, staff interviews, and investigation reports, it was determined that the facility failed to ensure that residents were free from neglect which resulted in harm as evidenced by a fall with fracture for one of five residents reviewed (Resident 3). Findings include: The facility's policy regarding abuse, neglect, exploitation, and misappropriation, dated January 16, 2025, revealed that each resident was afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Nurse aide documentation revealed that Resident 3 was an extensive assist of two for bed mobility and toileting at the time of the fall. The care plan for Resident 3, dated June 2, 2023, for a self-care performance deficit related to limited mobility included interventions for two assist with bed mobility. An occupational therapy note for Resident 3, dated for the certification period of May 2 to May 31, 2025, indicated that Resident 3 was dependent and in need of two assist for toileting hygiene. A nursing note for Resident 3, dated May 6, 2025, at 6:49 a.m., revealed that Registered Nurse 1 was called to the room where the resident was found on the floor between the beds. She was face down moaning in pain and was rolled onto her back with the support of three staff. A registered nurse assessment at that time revealed that there was bleeding and bruising to the nose and right side of the face, as well as skin tears to the right elbow and right shin. The resident was sent to the emergency room for evaluation. An emergency room X-ray report for Resident 3, dated May 6, 2025, at 10:59 a.m., revealed a nondisplaced fracture of the third digit of the right hand. An incident report for Resident 3, dated May 6, 2025, at 5:52 a.m. revealed that Nurse Aide 2 was in the resident's room providing incontinent care when the resident shifted her weight causing her to slip through the aide's arms and roll onto the floor between the beds. Nurse Aide 2 performed care by herself and did use a two person assist. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A witness statement, dated May 6, 2025 at 5:52 a.m., revealed that the Nurse Aide 2 was removing Resident 3 from the bedpan when the resident shifted her weight and slid through her hands and off the bed. She indicated that the RN and other aide were in another room attending to a resident at that time. She went on to say that she was trying to get Resident 3 settled in time for the other aide to leave at 6:30 a.m., because at that time she would be by herself. In addition, she indicated that the resident was wanting to get off the bedpan as soon as possible. A fall investigation form, dated May 6, 2025, submitted at 3:24 p.m., indicated that one staff person was providing care at the time of the fall. Interview with the Director of Therapy on May 29, 2025, at 3:15 p.m. indicated that at the time of Resident 3's fall, she was a maximum assist of two for bed mobility. She went on to say that during the facility's morning meeting on the day of the fall, the Director of Nursing indicated that Resident 3 was to be an assist of two while removing the bedpan and not one. Interview with Resident 3 on May 29, 2025, at 3:25 p.m. indicated that on the day of the fall, the aide tilted her and she went off the bed. Additionally, she indicated that the there is usually two staff in the room assisting with her care. Interview with the Director of Nursing on May 29, 2025, at 6:14 p.m. confirmed that there should have been two nursing assistants providing care to Resident 3 while removing her from the bedpan. Nurse Aide 2 did not follow the resident's plan of care for a two person assist resutling in a fall from bed and a fracture. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(5) Nursing Services.

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(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 - 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 reviews, staff interviews, and investigation reports, it was determined that the facility failed to ensure that a safe environment was provided for one of five residents reviewed (Resident 3) resulting in a fall with fracture. Findings include: The facility's policy regarding fall prevention, dated January 16, 2025, revealed that the facility was to provide an environment that is free from accident hazards over which the facility has control, and provide supervision to prevent avoidable accidents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 16, 2025, indicated that the resident was cognitively intact, could understand and was understood. Nurse aide documentation revealed that Resident 3 was an extensive assist of two for bed mobility and toileting at the time of the fall. The care plan for Resident 3, dated June 2, 2023, for a self-care performance deficit related to limited mobility included interventions for two assist with bed mobility. An occupational therapy note for Resident 3, dated for the certification period of May 2 to May 31, 2025, indicated that Resident 3 was dependent and in need of two assist for toileting hygiene. A nursing note for Resident 3, dated May 6, 2025, at 6:49 a.m., revealed that Registerd Nurse 1 called to the room where the resident was found on the floor between the beds. She was face down moaning in pain and was rolled onto her back with the support of three staff. A registered nurse assessment at that time revealed that there was bleeding and bruising to the nose and right side of the face, as well as skin tears to the right elbow and right shin. The resident was sent to the emergency room for evaluation. An emergency room X-ray report for Resident 3, dated May 6, 2025, at 10:59 a.m., revealed a nondisplaced fracture of the third digit of the right hand. An incident report for Resident 3, dated May 6, 2025, at 5:52 a.m. revealed that Nurse Aide 2 was in the resident's room providing incontinent care when the resident shifted her weight causing her to slip through the aide's arms and roll onto the floor between the beds. A witness statement, dated May 6, 2025 at 5:52 a.m., revealed that Nurse Aide 2 was removing Resident 3 from the bedpan when the resident shifted her weight and slid through her hands and off the bed. She indicated that the RN and other aide were attending to another resident at that time. A fall investigation form, dated May 6, 2025, submitted at 3:24 p.m., indicated that one staff person was providing care at the time of the fall. Interview with the Director of Therapy on May 29, 2025, at 3:15 p.m. indicated that at the time of Resident 3's fall, she was a maximum assist of two for bed mobility. She went on to say that during the facility's morning meeting on the day of the fall, the Director of Nursing indicated that Resident 3 was to be an assist of two while removing the bedpan and not one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident 3 on May 29, 2025, at 3:25 p.m. indicated that on the day of the fall, the aide tilted her and she went off the bed. Additionally, she indicated that the there is usually two staff in the room assisting with her care. Interview with the Director of Nursing on May 29, 2025, at 6:14 p.m. confirmed that there should have been two nursing assistants providing care to Resident 3 while removing her from the bedpan. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(5) Nursing Services.