

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 01/23/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on review of clinical record reviews, observations, and resident and staff interviews, it was determined that the facility failed to maintain resident dignity for one of 37 residents reviewed (Residents 20). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 20, dated January 7, 2026, revealed that the resident was always understood, always understood others, was cognitively intact, and required assistance from staff for daily care needs. Interview with Resident 20 on January 21, 2026, at 1:42 p.m. and January 22, 2026 at 4:13 p.m., revealed that her grandson brought her a new television for Christmas, but he was called to come and take it back. Resident 20 was not allowed to keep her new television and she wanted it. Interview with the Director of Maintenance on January 22, 2026, at 3:28 a.m. revealed that there was no facility policy or life safety code that determined the size of television that would be allowed in the facility. He confirmed that Resident 20's television was removed. Interview with the Nursing Home Administrator on January 22, 2026, at 2:42 p.m., revealed there was no policy or restriction about televisions brought from outside as personal property. 28 Pa. Code 201.29(j) Resident Rights.</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 - Few</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>Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment for three of 37 residents reviewed (Residents 15, 86, 88.). Findings include: Interview with Resident 15 on January 20, 2026, revealed that the blinds in her room do not go up and they were broken. Interview with the Maintenance Director on January 22, 2026, confirmed that the blinds did not function, due to a broken string. Interview with the Nursing Home Administrator on January 22, 2026, at 3:49 p.m. confirmed that having a blind that does not move up and down was not homelike, and would need replaced. Observations on January 20, 2026 at 12:42 p.m. of Resident 86 in her room seated in a Broda chair (a specialized positioning chair to improve comfort). It was noted that the left arm of the chair had an area approximately twelve inches by five inches where the vinyl covering was torn off, and an area on the right arm of the chair approximately six inches by five inches where the vinyl covering was missing. In addition, the seam on the head rest was torn approximately one inch in width and the entire length of the headrest. Interview with Registered Nurse 1 on January 21, 2026, at 1:06 p.m. confirmed that Resident 86 uses a Broda chair. She revealed that when not in use Resident 86's Broda chair is stored in the shower room. Observations in the shower room on January 21, 2026 at 1:08 p.m. with Registered Nurse 1 confirmed that the vinyl on Resident 86's Broda chair was torn off on both arms and that the seam was tearing apart on the headrest. She further indicated that Resident 86 should not have been sitting in it and that it should be out of circulation. Interview with the Nursing Home Administrator on January 21, 2026, at 1:21 p.m. confirmed that Resident 86 should not have been sitting in a Broda chair with the vinyl torn off and the seams coming apart. Observations of Resident 88 sitting in a Broda chair on January 20, 2026, at 12:07 p.m., January 21, 2026 at 12:30 p.m., January 22, 2026, at 5:10 p.m., and January 23, at 9:12 a.m., revealed a blue pad on the chair that was ripped and torn and the white padding was exposed; the top corners and bilateral sides were also torn. The chair also has large accumulation of a brown sticky dried-on substance, a large amount of grime on the wheels, and a large amount of scattered food debris. Interview with Licensed Practical Nurse 2 on January 23, 2026, at 9:12 a.m. confirmed that Resident 88's Broda chair cushion was ripped and padding was sticking out and that the chair was not clean. Licensed Practical Nurse 2 revealed that a power washer was used to clean the chairs. Interview with the Director of Rehabilitation on January 23, 2026, at 10:05 a.m. confirmed that Resident 88 should not have been sitting in a Broda chair with the padding torn off and the stuffing sticking out. She indicated the chair was brand new when issued to Resident 88. Interview with the House Keeping Director on January 23, 2026, at 10:37 a.m. revealed that there was a monthly schedule for wheelchair cleaning. The wheelchairs should be cleaned once a month. The last time Resident 88's chair was cleaned was December 7, 2025, and he has yet to clean the chairs in January 2026. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of policies and Resident Council/Food Committee meeting minutes, as well as observations and interviews with residents and staff, it was determined that the facility failed to serve food that was palatable and at proper temperatures. Findings include: The facility's policy regarding food and nutritional services, dated January 19, 2026, revealed that the food served will be palatable and at a safe and appetizing temperature. Resident Council/Food Committee meeting minutes, dated January 5, 2026, revealed that residents were asked if meals are served hot. Residents stated that the food is sitting too long in the carts and the food is often cold when it gets to them. Interview with Resident 10 on January 20, 2026, at 11:50 a.m. revealed the food was going downhill, it was over cooked, the meat was hard to chew, and it was cold. Interview with Resident 15 on January 20, 2026, at 12:24 p.m. revealed the food was awful, it was over cooked or undercooked. Observations of the lunch meal on January 20, 2026, at 12:12 p.m. revealed that Resident 36 could not eat her sliced carrots because they were too hard. She said she had mouth pain and the carrots were painful to eat. Interview with Nurse Aide 5 at the time of the observation revealed that she was unable to use a fork to cut the carrots. Interview with Resident 47 on January 20, 2026, at 12:00 p.m. revealed the food was not good, any type of food, all meals, and it was not hot. Observations of the lunch meal service in the main kitchen on January 21, 2026, revealed that the second hall cart containing the test tray left the main kitchen at 11:41 a.m., arrived on the nursing unit at 11:42 a.m., and the last resident was served at 11:55 a.m. The test tray was tasted at 11:56 a.m. and the chicken was 122.0 degrees Fahrenheit (F), the meatballs were 119.2 degrees F. the carrots were 124.9 degrees F, the sliced coleslaw was 55 degrees F. The meal was not palatable or at an appetizing temperature. Interview with the Dietary Director at the time of observation confirmed that the food temperatures should be higher for the hot foods, colder for the coleslaw, and should be served at a more appetizing temperature. 28 Pa. Code 211.6(b) Dietary Services.</p>		