

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: 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.			
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that non pharmacological interventions were attempted prior to the administration of a psychotropic medication for one of 37 residents reviewed (Resident 29). Findings include: The facility's policy regarding use pf psychotropic medications, November 13, 2025, indicated these medications should only be used to treat a resident's medical symptoms and not used for discipline or staff convenience. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated December 4, 2025, revealed that the resident was severely cognitively impaired, required assistance for care needs, had a diagnosis of dementia and was taking antianxiety medication. Physician orders for Resident 29 dated November 4, 2025, November 24, 2025, December 8, 2025, and December 25, 2025, revealed that the Resident was to be administered 0.5 milligrams (mg) of Lorazepam (antianxiety medication) every six hours for increased anxiety for 14 days. A review of Resident 29's electronic medication administration record (EMAR) dated November 2025, December 2025, and January 2026, revealed the Resident was administered 0.5 mg of Lorazepam on November 4, 2026 at 5:37 pm; November 13, 2025 at 4:35 p.m.; November 17, 2025, at 12:17 p.m., December 6, 2025, at 1:08 p.m.; December 17, 2025, at 8:22 a.m.; December 20, 2025, at 12:20 p.m.; and January 3, 2026, at 7:45 a.m. There is no documented non-pharmacological interventions attempted prior to the administration of Lorazepam. Interview with the Director of Nursing on January 23, 2025, at 3:51 p.m. confirmed that there were no non-pharmacological interventions prior to Lorazepam administration for the dates above for Resident 29, and there should have been. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on review of Food Committee minutes, as well as observations and resident and staff interviews, it was determined that the facility failed to have sufficient dietary staff to perform essential kitchen duties in the main kitchen. Findings include: Food committee minutes, dated April 2, 2026, revealed that residents were not being offered alternatives for meals, food was received ice cold, undercooked, or overcooked, and they were not being served what was on their meal ticket. Interview with Resident 2 on April 16, 2026, at 11:45 a.m. revealed that the kitchen had no staff. Observations in the main kitchen on April 16, 2026, at 12:15 p.m. revealed that the Director of Nursing and Licensed Practical Nurse 2 were running dishes through the dishwasher, and Nurse Aide 3 was assisting with tray line. Interview with the Director of Nursing at that time revealed that she was volunteering her time and helping out the kitchen. Interview with Licensed Practical Nurse 2 revealed that she assisted with gathering information for the completion of the MDS assessments and was asked to help in the kitchen. Interview with Nurse Aide 3 at that time revealed that she is the unit clerk and transportation and was pulled to help in the kitchen. She indicated that the last time she was pulled to the kitchen, she was there for three days. Interview with the Corporate Account Manager on April 16, 2026, at 12:40 p.m. confirmed that the kitchen was having staffing issues. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code 211.6(c) Dietary services.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on review of planned, written menus, as well as observations and staff interviews, it was determined that the facility failed to follow their pre-approved planned menu, and failed to inform residents of menu changes. Findings included: Review of the posted menus for the lunch meal on Wednesday, January 21, 2026, revealed that residents were to receive fried chicken, macaroni and cheese, sliced carrots, cornbread with margarine, and marble cake with white frosting and a beverage. The alternate meal was to be a hot dog with chili and cheese on a bun, potato wedges, creamy coleslaw and a beverage. Observations of a test tray for the lunch meal service on January 21, 2026, at 11:35 a.m. revealed baked chicken, not fried, and no cornbread was provided as per the menu. In addition, the alternate meal was meatballs and gravy with mashed potatoes, and not a hot dog with chili and cheese on a bun and potato wedges as posted. Interview with the Dietary Director and District Manager on January 21, 2026, at 12:25 p.m., revealed that the chicken was fried as per their recipe and the corn bread was not available and was changed to a dinner roll. The Dietary Director and District Manager confirmed that mashed potatoes were served instead of potato wedges and meatballs with gravy were served instead of a hot dog with chili and cheese on a bun. Additionally, they confirmed that what was on the menu is not what was served and that the change was not posted anywhere for residents to observe, nor were the residents informed verbally, and they should have been. 28 Pa. Code 211.6(a) Dietary Service		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 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.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, observations and staff interviews, it was determined that the facility failed to ensure that food stored in the kitchen was labeled, dated and secured. Findings include: The facility policy regarding food storage, dated January 19, 2026, revealed that any food that has been opened must be labeled, dated and secured in such a way that the food item is air tight. Proper labeling and dating ensures that all foods are stored, rotated and utilized in a manner that will minimize waste and ensure that items that are passed their due date are discarded. Observations in the kitchen's cooler on January 20, 2026, at 9:25 a.m. revealed that the following items were opened and not dated with an open date; one half bag (two pounds) of cabbage with carrots, three pounds of bacon, 25 cinnamon rolls, two and half pounds of Mozzarella cheese, a jar with a mixture of approximately eight pickles and tomatoes, one pound of broccoli salad, approximately three pounds of beefaroni and 30 cookies wrapped and undated. Observations in the kitchen's walk freezer on January 20, 2026, at 9:42 a.m. revealed that the following items were opened and not dated with an open date; a two pound box of stuffing and 12 muffins, in addition, 25 beef fritters and 15 sugar cookies were not labeled, dated or secured. Observations in the dry storage room on January 20, 2026, at 9:56 a.m. revealed that the following items were opened and not dated with an open date; a one pound plastic container of cheerios, a half pound bag of rice Krispie's, a two pound bag of brownie mix, two pounds of spaghetti and a half pound bag of dry milk. In addition, there was a half pound each of corn flakes and raisin bran and four and a half bags of coconut shavings that were expired, and one pound of Hershey [NAME] that was outdated and unsecured. Interview with the Dietary Manager on January 20, 2024, at 10:10 a.m. confirmed that all food items in the kitchen should be labeled, dated and secured, and they were not. 28 Pa. Code 211.6(f) Dietary services.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents were provided with dental care as scheduled for one of 13 residents reviewed (Resident 1). Findings include: The facility's policy for Activities of Daily Living (ADLs), dated [DATE] indicated that residents would be provided oral hygiene as per their request or as per facility schedule protocols. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated [DATE], indicated that the resident was cognitively intact and was dependent on staff for daily care needs including oral care. A review of Resident 1's task record, dated February 2026, indicated that the resident was tasked to have oral hygiene care after each meal. Observation of Resident 1 on [DATE] at 1:15 p.m. revealed that he ate his lunch meal while sitting in the hallway and then remained in the hallway until 1:53 p.m. at which time Nurse Aide 1 took the resident into his room to provide care. Observations of care with Nurse Aide 1 and Resident 1 revealed that she put the resident into bed, provided incontinence care then positioned him for a nap. Interview with Nurse Aide 1 on [DATE], at 2:04 p.m. confirmed that she readied Resident 1 for a nap after his lunch meal, provided incontinence care to him and that she did not provide oral care for him as he is care planned to receive. She stated that she did not have time to do it. Interview with the Director of Nursing on [DATE], at 2:45 p.m. revealed that staff did not have time to provide oral care after the resident finished his meal as he is care planned to receive. 28 Pa. Code 211.12(d)(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 review of facility policies and clinical records, observations and staff interviews, it was determined that the facility failed to ensure that a resident's environment remained free of accident hazards by failing to ensure care-planned interventions were in place for two of 37 residents reviewed (Resident 17, 57) who were at risk for falls. Findings include: The facility's policy regarding fall prevention and management, dated January 19, 2026, indicated that the facility will identify those residents at risk for falls upon admission, readmission, and quarterly and provide appropriate interventions to modify and/or compensate for risk factors, and that environmental interventions would be used to decrease the risk of the resident falling. The care plan will be updated to reflect resident-specific safety needs and interventions. The facility had no policy regarding the use of foot plates while transporting residents in the facility. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated November 10, 2025, revealed that the resident was severely cognitively impaired, required assistance from staff for personal care needs, used a wheelchair, and had diagnoses that included stroke and hemiplegia (lose of feeling and control of half of the body). A care plan for Resident 20 dated January 31, 2025, revealed that the resident had impaired balance and activity intolerance due to a brain bleed. Resident was to have bilateral leg rests to the wheelchair for propelling. Observations of Resident 17 on January 22, 2026, at 2:40 p.m. revealed that the resident was transported in his chair by Registered Nurse 3 from the 200 Hall to the nurses station. Resident 17's feet were dangling and he was using one foot to support the other. Interview with Registered Nurse 3 at the time of the observation and January 22, 2026, at 3:19 p.m. respectively, revealed that the resident was able to self propel and that she was encouraging him to go to the activity. Registered Nurse 3 confirmed that Resident 17 should have his foot rests on when staff are propelling the resident's wheelchair. An interview with the Director of Nursing on January 22, 2026, at 11:09 a.m. confirmed that Resident 17 was unsafe with foot plates on while self propelling and that staff were keeping him safe. A quarterly Minimum Data Set (MDS) assessment for Resident 57, dated December 22, 2025, revealed that the resident was severely cognitively impaired, had a history of multiple falls, with the most recent fall resulting in a compression fracture of the thoracic and lumbar spine, had a current fall risk care plan that indicated that the resident was at risk for falls related to dementia, psychotic disturbances and anxiety, and that dycem (a mat that provides gripping and anti-slip stabilization) was to be placed between the mattress and the bed frame to reduce slippage. Observations of Resident 57's bed on January 22, 2026, at 3:20 p.m. revealed that there was no dycem between the mattress and the bedframe as care planned. Interview with he Director of Nursing on January 22, 2026, at 3:30 p.m. confirmed that Resident 57 did not have dycem between the mattress and bedframe as care planned, and she should have. Interview with the Nursing Home Administrator on January 22, 2026, at 3:53 p.m. confirmed that Resident 17 should have had foot rests in place while being transported in the facility, and that Resident 57 should have had dycem in place as ordered and care planned. 28 Pa. Code 211.12(d)(5) 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 a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to store medications properly for one of 37 residents reviewed (Resident 47). Findings include: The facility's policy regarding medication storage, dated January 19, 2026, revealed that all drugs and biologicals would be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Current physician's orders for Resident 47, included orders for the resident to receive 100 milligrams (mg) of Allopurinol (used to treat gout) once a day, 10 mg of Fluoxetine (anti-depressant) one time day, 300 mg of Gabapentin (used to treat neuropathy/pain) three times day, and 1 gram of Methenamine Hippurate (antibiotic) one time a day. Observations on January 22, 2026, at 9:01 a.m. revealed that Registered Nurse 4 prepared medications for Resident 47, which included medication cards containing Allopurinol, Fluoxetine, Gabapentin, and Methenamine Hippurate. He flipped over the cards of medications on top of the medication cart, locked the medication cart and proceeded to enter Resident 47's room to administer her medications. The medications were left on top of the medication cart in the hallway unattended and out of Registered Nurse 4's sight. Interview with Registered Nurse 4 on January 22, 2026, at 9:03 a.m. confirmed that he should not have left the medications on top of the cart unattended. 28 Pa. Code 211.12(d)(1) Nursing Services.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on a review of facility policy, clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that residents were provided with assistive devices for eating as ordered by the physician for one of 13 residents reviewed (Resident 1). Findings include: A review of the facility's policy regarding Use of Assistive Devices, dated January 19, 2026 revealed that the use of assistive devices for eating will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. A comprehensive Minimum Data Set (MDS) assessment for Resident 1, dated January 17, 2026, revealed that the resident was cognitively intact, is dependent on staff for daily care tasks, including assistance with eating. Physician's orders for Resident 1, dated March 18, 2026, included an order to provide a rimmed plate for meals (a plate that has high sides), maroon spoons (special order to help the resident take small bites), and two handled cup with a spouted lid (special order to help with resident to not spill drinks). The resident's task record, dated April 2026, indicated that staff were to set the resident up with maroon spoons, a two handled cup with a spouted lid, and a rimmed plate for all meals. Observations of Resident 1 during the lunch meal on April 16, 2026, at 12:31 p.m. revealed that he did not have a rimmed plate, maroon spoons, or a two handled cup with a spouted lid. Interview with Nurse Aide 4 on April 16, 2026, at 12:31 p.m. confirmed that Resident 1 was to have a rimmed plate, maroon spoons, and handled cup with spout with his meal and that he did not. Interview with the Director of Nursing on April 16, 2026, at 2:45 p.m. confirmed that Resident 1 should have had his adaptive devices for eating as ordered by the physician. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.		

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)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) surveys ending January 15 and May 29, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 23, 2026, identified repeated deficiencies related to homelike environment, ensuring that the resident's environment was free from accident hazards, failure to serve palatable food at appropriate temperatures, and to store and prepare food under sanitary conditions. The facility's plan of correction for a deficiency regarding a homelike environment cited during the survey ending January 15, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F584, revealed that the facility's QAPI committee failed to successfully implement their plan regarding a homelike environment. The facility's plans of correction for deficiencies regarding ensuring that the resident environment was free of accident hazards, cited during the surveys ending on January 15 and May 29, 2025, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding ensuring that the environment was free of accident hazards. The facility's plan of correction for a deficiency for not serving palatable food at appropriate temperatures, cited during the survey ending January 15, 2025, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding palatable food and food temperatures. The facility's plan of correction for a deficiency regarding food storage and labeling, cited during the surveys ending January 15, 2025, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding food storage and labeling. Refer to F584, F689, F804, F812.28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		

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	Provide and implement an infection prevention and control program. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the proper hand-washing procedures were followed, and that proper infection control practices were followed for two of 37 residents reviewed (Residents 47, 80). Findings include: The facility's policy regarding hand hygiene, November 13, 2025, indicated that when staff washed their hands, they were to dry them with a single use towel and then turn the faucet off with a clean towel. Observations on January 22, 2026, at 8:55 a.m. revealed that Registered Nurse 4 administered medications to Resident 80. He then washed his hands and turned the faucet off with his clean hand and dried his hands with a paper towel. Observations on January 22, 2026, at 9:01 a.m. revealed Registered Nurse 4 administered medications to Resident 47. He then washed his hands and turned the faucet off with his clean hand and dried his hands with a paper towel. Interview with Registered Nurse 4 on January 22, 2026, at 9:03 a.m. confirmed that he should not have turned the faucet off with his clean hand. Interview with the Director of Nursing on January 22, 2026, at 11:30 a.m. confirmed that after Registered Nurse 4 washed his hands, he should have used a paper towel to turn the faucet off, according to their policy. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		