STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396092	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at Penn State, The	260 Lion's Hill Road State College, PA 16803

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that the facility determined a resident's ability to self-administer medications for one of one resident reviewed (Resident 14). Findings include: Observation of Resident 14 on June 4, 2025, at 12:35 PM revealed she was sitting in her chair beside her bed with her bedside table in front of her. On the bedside table she had Flonase nasal spray (a steroid medication used to treat various signs and symptoms that could be caused by allergies) and Afrin nasal spray (a medication used to treat nasal congestion and stuffiness). She indicated that she brought them to the facility from the hospital. She said that both medications have been on her windowsill or overbed table since she came to the facility on [DATE]. She also indicated that she does self-administer the medications. Clinical record review for Resident 14 revealed no physician's order that the resident may self-administer the medication, or that the facility determined the resident was able to safely self-administer the medication. The surveyor confirmed the above noted information related to Resident 14 self-administering medications with the Nursing Home Administrator and Director of Nursing on June 5, 2025, at 10:30 AM. 8 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9 (a)(1)(b) Pharmacy services 28 Pa. Code 211.12(d)(1) 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 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. 44738 Based on observations, clinical record review, and staff interview, it was determined that the facility failed to implement interventions related to fall injury prevention for one of four residents reviewed (Resident 31) and failed to provide adequate supervision resulting in a fall for one of four residents reviewed (Resident 23). Findings include: Clinical record review for Resident 31 revealed a diagnosis list that included a history of falling. Resident 31's quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated April 9, 2025, revealed that staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 5, which indicated severe cognitive impairment. Review of Resident 31's care plan revealed that the resident is at risk for falls due to unsteady gait and poor balance. An intervention dated December 17, 2024, instructed staff to have dycem (a material used to prevent slipping or sliding) on the seat of the resident's wheelchair and the top of the pressure alarm to prevent sliding. Clinical documentation for Resident 31 revealed an Incident Note dated May 18, 2025, at 10:35 PM that indicated the resident had fallen out of the wheelchair and sustained a skin tear to the left elbow. The note indicated, Dycem was not on resident's pressure alarm per care plan, new piece applied. Facility documentation revealed an incident report with a staff statement dated May 19, 2025, that revealed the staff member was sitting at the nursing station and saw Resident 31 scooting to the edge of his wheelchair. The resident leaned to the left and fell out of the wheelchair. An interview with the Nursing Home Administrator on June 6, 2025, at 12:30 PM revealed that the facility could provide no further documentation on the lack of the care planned intervention for Resident 31's wheelchair. Clinical record review for Resident 23 revealed a progress note dated January 3, 2025, at 5:55 PM that indicated Resident 23 had a fall at 5:10 PM. The note indicated she was walking with her walker down the hallway on the first floor accompanied by a nurse aide. The nurse aide heard a gasp and then noted that the resident started to fall sideways and hit the right side of her head on the bottom of the door that leads up to second floor. Resident 23 lost consciousness for a few seconds but became aware and talking with staff. The facility called 911 at 5:15 PM and Resident 23 was taken to the hospital. A progress note dated January 3, 2025, at 10:20 PM revealed that Resident 23 returned from the hospital with a small bump on her right temple. She had no new orders related to the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 23 revealed a fall risk evaluation dated December 21, 2024, that indicated Resident 23 had a fall risk score of 20. The evaluation indicated that any score over 10 is a fall risk. The fall risk evaluation revealed that Resident 23 had 3 or more falls in the past 3 months, intermittent confusion, she is ambulatory, incontinent, she had a decrease in muscular coordination, and required the use of an assistive device. The evaluation section for clinical suggestions revealed no suggestions. Further clinical record review into Resident 23 revealed a physical therapy evaluation dated December 19, 2024, that indicated the reason for the referral was that Resident 23's daughter requested she be assessed due to her having lower extremity weakness, decreased balance, and gait abnormality. Medical factors on the evaluation indicated Resident 23 was a fall risk. The assessment summary indicated that the resident presented with strength impairments, decreased safety awareness, postural alignment/control, decreased functional capacity, and decreased balance. The evaluation indicated that Resident 23 required skilled physical therapy services to minimize falls, improve dynamic balance, increase lower extremity range of motion and strength, and promote safety awareness. The summary also indicated that Resident 23 refused physical therapy after the evaluation. Further review of therapy documentation revealed that Resident 23 was started on physical therapy on December 23, 2024. Review of physical therapy documentation for December 23, 2024, revealed that she required supervision or touching assistance with ambulation to walk 10 feet, and her baseline for transfers and ambulation were supervision to contact guard assistance with a rollator walker (a walker with wheels) 120 feet. A physical therapy progress note dated December 30, 2024, revealed that resident ambulated 350 feet with a rollator and stand by assistance. She had a slow cadence (a slow pace of steps taken per minute) with frequent stopping due to distractions. She had a forward posture with verbal cues throughout to stand tall and pick up her feet. A physical therapy progress note dated December 31, 2024, revealed that resident ambulated 700 feet with a rollator walker and stand by assistance. She had a shuffle and required verbal cues throughout to stand tall and stay close to her rollator walker. Review of Resident 23's task documentation for December 18, 2024, to December 31, 2024, revealed that her ambulation in the hallway ranged from independent to extensive assist of one person with her rollator walker. Review of Resident 23's care plan entitled Activities of Daily living self-care deficit initiated on July 11, 2023, revealed that she had no interventions indicating what type of ambulation assistance she needed. Review of Resident 23's care plan entitled At risk for falls related to gait/balance disturbances, last revised on May 20, 2025, revealed no interventions that indicated the resident's ambulation assistance needs, and there were no resolved care plan interventions that indicated what level of assistance she required with her ambulation. Review of the facility's investigation into Resident 23's January 3, 2025, fall revealed that the nurse aide was walking ahead of Resident 23, heard a gasp, turned around, and saw her fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that Resident 23 was provided with adequate supervision and appropriate fall interventions after it was noted that she had a fall risk assessment score of 20 on December 21, 2024, had declined in her balance and strength, and required verbal cues to safely ambulate as noted by physical therapy progress notes referenced above. Interview of Director of Nursing and Nursing Home Administrator on June 6, 2025, at 11:30 AM confirmed the above noted findings related to Resident 23. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 36798 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 two residents reviewed (Residents 4 and 18). Findings include: Clinical record review for Resident 4 revealed current physician orders for Oxycodone HCl 5 milligrams (mg) Clinical record review for Resident 4 revealed current physician orders for Acetaminophen (a medication used to control mild pain) extra strength 500 mg by mouth every four hours as needed for pain, (no pain level identified), Oxycodone HCl (a narcotic pain medication used to control moderate to severe pain) oral tablets 5 mg every six hours as needed for moderate to severe pain, and Oxycodone HCl oral tablets 5 mg give 2.5 mg every four hours as needed for pain (no pain level identified). Review of Resident 4's most recent quarterly MDS (Minimum Data Set, an assessment completed by the facility, at intervals to determine the care needs of the resident) dated May 20, 2025, revealed that she had occasional pain with the worst pain being a 5 on a scale of 1-10, and that she received scheduled, and as needed pain medication during the assessment period. Review of Resident 4's medication administration record for May 2025, revealed that she did not receive her as needed Acetaminophen Extra Strength 500 mg during the month. Review of Resident 4's medication administration records (MAR) for May 2025, revealed that she received Oxycodone 2.5 mg as follows: May 6, 2025, 5:47 AM for a pain level of 6 May 11, 2025, at 9:15 PM for a pain level of 5 May 18, 2025, at 9:32 AM for a pain level of 7 Review of Resident 4's medication administration records (MAR) for May 2025, revealed that she received Oxycodone 5 mg as follows: May 2, 2025, at 10:00 AM for a pain level of 7 May 2, 2025, at 5:00 PM for a pain level of 7 May 14, 2025, at 4:28 PM for a pain level of 7 May 23, 2025, at 1:34 PM for a pain level of 8 May 24, 2025, at 12:47 PM for a pain level of 8 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 25, 2025, at 1:09 PM for a pain level of 3 May 28, 2025, at 10:27 AM for a pain level of 7 May 29, 2025, at 5:27 AM for a pain level of 6 May 30, 2025, at 6:41 AM for a pain level of 6 May 31, 2025, at 12:40 PM for a pain level of 6 Interview with the Director of Nursing on June 5, 2025, at 10:35 AM revealed that the facility does not have a policy defining mild, moderate, or severe pain. She also confirmed that Resident 4's current physician orders do not provide specific guidance to the administering nurse indicating what as needed pain medication should be administered in accordance with Resident 4's pain ratings. Interview with the Nursing Home Administrator and Director of Nursing on June 5, 2025, at 2:22 PM, confirmed the above noted findings related to Resident 4's pain. Clinical record review for Resident 18 revealed the resident was ordered Acetaminophen (a medication used to treat mild pain) Oral Tablet 325 mg two tablets every four hours as needed for pain on April 16, 2025. Resident 18 also had an active order for Tramadol HCL (a narcotic used to treat moderate to moderately severe pain) 50 mg every four hours as needed for pain ordered on April 16, 2025. A review of Resident 18's May and June 2025 medication administration records revealed the resident was administered the as needed Acetaminophen as follows: May 18, 2025, for a pain level of 6 May 20, 2025, for a pain level of 4 May 25, 2025, for a pain level of zero, and again for a pain level of 6 May 26, 2025, for a pain level of 5, again for a pain level of 6, and administered again for a pain level of 6 May 28, 2025, for a pain level of 6 Resident 18 had not been administered any as needed Acetaminophen to date in June 2025. A review of Resident 18's May and June 2025 medication administration records revealed Resident 18 was administered the Tramadol as follows: May 3, 2025, for a pain level of 8 May 14, 2025, for a pain level of 9 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 20, 2025, for a pain level of 5 May 21, 2025, for a pain level of 6 May 22, 2025, for a pain level of 6 May 25, 2025, for a pain level of 9 May 26, 2025, for a pain level of 6 June 4, 2025, for a pain level of 5 There was no evidence of any pain scale parameters for Resident 18's as needed pain medication of Acetaminophen and Tramadol to indicate which medication staff is to utilize for the resident's pain. The Nursing Home Administrator and Director of Nursing confirmed in an interview on June 5, 2025, at 2:30 PM that there was no pain parameters indicated as to what pain level staff should administered which medication. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in a safe and sanitary manner in the facility's main kitchen, Atrium kitchen, and pantry. Findings include: Observation of the Atrium kitchen on June 3, 2025, at 9:30 AM revealed the following: Multiple sheet pans were observed stored and in use in the cooking area contained significant black buildup on the pans. A large plastic wrap holder on the production table was observed with dried liquid splatter, food crumbs, and dust on the exterior and interior of the holder. The flooring under the dish machine, cooler, and food cooking equipment contained dirt/debris buildup on the flooring and wall edges. A three-tier black cart located across from the dish machine with clean glasses and trays stored on it had dried spills, dried food, and debris on the shelves of the cart. An observation of the main kitchen on June 3, 2025, at 9:50 AM, which is utilized to store food and prepare some food items for the Atrium kitchen revealed the following: A significant buildup of dirt/debris was observed on the walk-in freezer floor. A speed-rack (a tall rolling cart that hold trays of food) was observed in the walk-in cooler with trays of food stored on it. The rack was soiled with a buildup of dried food, dried spills, dust, and debris on the cart frame and tray holders. The wall behind the handwashing sink outside the dry storage area was covered in brown splatter four feet up the wall. A tilt kettle and braising kettle (cooking equipment) were observed in the cooking area by the steamer, covered in thick dust build up, which extended to the side of the steamer. Employee 1, director of dining services, indicated the kettles were out of service and the facility was waiting for new equipment. The knobs and front of additional cooking equipment in the main kitchen area (flat top, grill, and stove) were also observed with significant dust and blackened/debris build up. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the of the pantry storage area located on the first floor of the Atrium on June 3, 2025, at10:30 AM revealed a large amount of water/liquid pooled on the flooring in front of the ice machine, the remainder of the flooring contained debris and was sticky. Dirt/debris was observed under the equipment and along all wall edges. A small metal table holding a juice dispenser unit was observed with dried, orange-colored spills on the top of the table. The lower shelf of the table was dusty and sticky. A cardboard box sitting on the shelf labeled main light fix atrium was partially stuck to the shelf. A previously opened gallon can of paint was sitting on top of the box. Two upright freezers in the pantry contained the following items that had no date to indicate when they were placed there or when the needed to be used by: Four packs of cupcakes A bag of potato tots Two bags of onion rings Two pans of cream chipped beef Three pans of beef stew Six pans of meat lasagna The above information was reviewed with the Nursing Home Administrator and Director of Nursing on June 4, 2025, at 2:15 PM. 483.60(i)(2) Store, prepare, food safe and sanitary Previously cited 7/19/24 28 Pa. Code 201.14 (a) Responsibility of Licensee