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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at Penn State, The	160 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies and procedures, and staff interview, it was determined that the facility failed to implement interventions for fall prevention which resulted in actual harm of pelvic fracture for one of three residents reviewed for falls (Resident 4). Findings include: Review of facility policy titled Falls Risk Assessment System Guidelines, last reviewed without changes January 31, 2026, revealed all residents will be assessed for initial risk for falls using The Fall Risk Assessment. Residents that score a 15 or greater will be considered at risk for falls. A plan of care will be initiated to address the fall risk factors. This assessment will begin on admission and be completed within 24 hours. If a resident triggers a risk for falls, the resident will have further assessment for risk for falls utilizing the Care Area Assessment (CAA) guidelines and the plan of care will be enhanced if indicated, to further minimize the risk of falls. The policy indicated for residents at risk, the care plan will incorporate the following: bed exit alarms, call light within reach, keep room door open, encourage family assistance, provide diversion, offer toileting every two hours, assess for toileting program, environmental room review to reduce hazards, bed in low position, fall mat, signs in room to ring call bell for assistance, and bed bolsters. Clinical record review revealed the facility admitted Resident 4 on March 5, 2026. Resident 4's diagnosis list at the time of admission included Dementia (loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and repeated falls. Review of Resident 4's fall risk assessment dated [DATE], at 1:29 PM revealed staff assessed Resident 4 as having the following risk factors: one to two falls in the past three months, disoriented at all times, ambulatory, incontinent, poor vision, balance problem while walking, decreased muscular coordination and requires the use of an assistive device (cane). The resident's fall risk score was evaluated as a score of 21 (if the total score is 10 or greater, the resident should be considered at high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan). Review of Resident 4's admission MDS (Minimum Data Set - assessment completed at periodic intervals of time to determine resident care needs) dated March 9, 2026, revealed facility staff assessed the resident as having a BIMS (brief interview of mental status assessment) score of four (indicating severe cognitive impairment), independent with sitting to standing, chair to bed transfers, toilet transfers, and walking using a cane/walker. Further review of the same MDS assessment revealed Resident 4 had no recent falls in the last month, or in the last two to six months, contrary to the resident's admitting diagnosis of repeated falls and the fall risk assessment identifying Resident 4 as having one to two falls in the past three months which was completed prior to the MDS assessment. Review of Resident 4's physical therapy documentation revealed a therapy Discharge summary dated [DATE], indicating Resident 4 was on therapy caseload due to her difficulty in walking, and muscle weakness. Further review of a physical therapy progress report from April 2, to April 15, 2026, revealed Resident 4 ambulated 10 feet with partial to moderate assistance, and 50 feet with two turns, and partial to moderate assistance. Nursing documentation dated April 16, 2026, at 12:12 PM revealed nursing staff heard Resident 4 calling out from her room. (continued on next page)

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 - Actual harm Residents Affected - Few	Upon entering room Resident 4 was observed on the floor. Resident 4 was wearing nonslip footwear, her call bell was not alerting, and her assistive device (cane) was approximately five to ten feet away from her. Documentation revealed that Resident 4 was last toileted at approximately 9:15 AM. When Resident 4 was assisted from the floor to a standing position, she complained of pain in her right hip and the back of her head. Resident 4 was placed on her wheelchair and brought to the nursing station. The physician's assistant assessed Resident 4 and recommended sending her to the hospital for further evaluation. Nursing documentation dated April 16, 2026, at 4:28 PM revealed Resident 4's daughter called and informed the nurse of the preliminary results of Resident 4's CAT scan (medical imaging technique that uses X-rays and computer technology to create detailed cross-sectional images of the body) of her right hip showed two displaced fractures of her pelvic rami (bone structures of the pubic bone). Nursing documentation dated April 17, 2026, at 12:26 AM revealed the facility received fax communication indicating Resident 4 was admitted to the hospital. Resident 4 remained in the hospital until April 21, 2026, for treatment of the pelvic fractures. Review of information dated and submitted on April 16, 2026, by the facility to Department of Health revealed Resident 4's was admitted to the facility due to her progressing dementia and walks in her room independently, noting the resident had a cane but would carry it more than using it. It also noted therapy worked with the resident using a walker, but the resident would not always use the walker when in her room. The report further revealed, plan of care being followed. Review of Resident 4's initial and comprehensive care plan failed to reveal the facility implemented a plan of care to address Resident 4's fall risk or identify interventions to aid in the prevention of falls until April 16, 2026, subsequent to Resident 4's fall with resulting fracture. Further review of Resident 4's clinical record revealed there was no evidence to indicate any fall interventions were implemented to reduce the risk of falls or falls with injury for Resident 4 until after the incident on April 16, 2026. Interview with the Director of Nursing on May 14, 2026, at 12:52 PM confirmed the above finding for Resident 4. 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/DevicesPreviously cited 6/6/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing 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. Based on observation and staff interview, it was determined that the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen.Findings include: An observation in the facility's Atrium kitchen and supply room, and the main kitchen on May 12, 2026, at 9:20 AM revealed the following: The Atrium gas burners were observed with black, charred particulate matter that was cooked on to the metal grates. The metal control knobs on the Atrium stove were observed to have a large amount of dust, debris, and grease built up between the knobs. The Atrium oven was observed with black and charred debris throughout the base of the oven and on the oven door. The supply room ice machine was observed to have plastic lids, a small square bucket, a cup, and boxes of gloves behind ice machine on the floor. The supply room refrigerator contained a container of milk was bulging and leaking. And was noted to be frozen. The main kitchen walk-in freezer had an uncovered sheet cake sitting on a shelf. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 13, 2026, at 2:00 PM. 483.60(i)(2) Store, prepare, food safe and sanitaryPreviously cited 6/6/25 28 Pa. Code 201.14 (a) Responsibility of Licensee

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on clinical record review and staff interview it was determined that the facility failed to ensure that active physician orders incorporated resident wishes related to end-of-life care for one of four residents reviewed for advanced directives concerns (Resident 3). Findings include: Clinical record review revealed the facility admitted Resident 3 on March 30, 2026. Review of Resident 3's active physician order dated March 20, 2026, revealed staff are to implement full treatment in the event of a medical emergency (Full Code, chest compressions and breathing assistance). A POLST (Physician Orders for Life Sustaining Treatment, portable medical order form that records treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency) form signed by Resident 3 on March 23, 2026, revealed Resident 3 wanted staff to implement DNR (Do Not Resuscitate, do not provide chest compressions or assist with breathing) directives in the event of a medical emergency. The above findings for Resident 3 were reviewed during a meeting with Nursing Home Administrator and the Director of Nursing, on May 13, 2026, at 2:00 PM. Interview with the Director of Nursing on May 14, 2026, at 10:44 AM confirmed the above findings for Resident 3 and indicted that the facility received a new physician order dated May 13, 2026 (after surveyor's questioning) noting DNR, with limited interventions. The facility failed to ensure that active physician orders incorporated Resident 3's wishes related to end-of-life care. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a cardiac pacemaker for two of 11 residents reviewed (Residents 28 and 33).Findings Include: Clinical record review for Resident 28 revealed a diagnosis list that included the presence of a cardiac pacemaker (an electronic device to help regulate the beating of the heart), sick sinus syndrome (a malfunctioning of the heart that impacts the heart's natural pacemaker node), and atrial fibrillation (an irregular heart rhythm). Medical provider documentation for Resident 28 dated April 8, 2026, at 10:29 AM also revealed a diagnosis list that included the presence of a cardiac pacemaker. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) for Resident 28 dated March 18, 2026, revealed an active diagnosis of the presence of a cardiac pacemaker. Review of Resident 28's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker, any pertinent assessments related to the pacemaker and/or clinical care, or any associated precautions. Documentation related to Resident 28's pacemaker was requested in a meeting with the Nursing Home Administrator and Director of Nursing on May 13, 2026, at 11:10 AM. An observation of Resident 28's room on May 14, 2026, at 8:54 AM revealed there was a transmittal device on the resident's dresser located next to the bed. A concurrent interview with Employee 3, licensed practical nurse, revealed that the device was utilized to transmit data from the resident's pacemaker that is remotely monitored. A follow-up review of Resident 28's care plan provided by the facility after discussion about the resident's pacemaker revealed that the resident is at risk for bleeding from falls related to anticoagulant (a medication used to help prolong or prevent the clotting of blood) use. An intervention dated May 13, 2026, noted monthly pacemaker check. The care plan did not address the transmittal device care. The additional information for Resident 28 was reviewed with the Nursing Home Administrator and Director of Nursing on May 14, 2026, at 11:30 AM. Clinical record review for Resident 33 revealed a diagnosis list that included the presence of a cardiac pacemaker, sick sinus syndrome, and atrial fibrillation. Medical provider documentation for Resident 33 dated April 22, 2026, at 10:13 AM revealed a pacemaker with recent replacement. The diagnoses list included the presence of a cardiac pacemaker. Xray documentation for Resident 33 dated April 12, 2026, revealed results that included, Left sided pacemaker noted. Review of Resident 33's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker, any pertinent assessments related to the pacemaker and/or clinical care, or any associated precautions. The information for Resident 33's pacemaker was reviewed in a meeting with the Nursing Home Administrator on May 13, 2026, at 11:10 AM and May 14, 2026, at 11:30 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of employee personnel and education records and staff interview, it was determined that the facility failed to ensure that each nurse aide received 12 hours of in-service training annually for one of three nurse aides reviewed (Employee 1). Findings include: Review of Employee 1's (nurse aide) personnel record revealed that the facility hired her on April 17, 2023. Review of training records provided by the facility for Employee 1 dated April 2025, to April 2026, revealed that Employee 1 completed six hours and 25 minutes of in-service education. Interview with the Nursing Home Administrator on May 14, 2026, at 12:04 PM confirmed the above findings for Employee 1. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview it was determined that the facility failed to provide a written notice of transfer that included all the necessary contents to residents' responsible parties at the time of transfer for two of two residents reviewed for hospitalizations (Residents 2, and 4); and failed to provide timely written notice of the facility bed-hold policy to residents' responsible parties at the time of transfer that included all the necessary contents for one of two residents reviewed for hospitalizations (Resident 2).Findings include: Clinical record review revealed that resident 2 was admitted to the hospital on [DATE]. Review of the facility form related to bed hold information and notification of transfers did not include the following information: Notification of the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing. A statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. Interview on May 13, 2026, at 1:00 PM, with Employee 2, Social Services, revealed that there was no evidence of written notification given to the resident representative. Clinical record review revealed that Resident 4 was transferred to the hospital on April 16, 2026. Review of the transfer notice given to Resident 4 and emailed to Resident 4's family revealed it did not contain all the necessary components, including a statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. Interview with Employee 2 (social services) on May 13, 2026, at 1:36 PM confirmed the above findings for Resident 4. The above information regarding the transfer and bed hold notifications for Residents 2 and 4 were reviewed with the Nursing Home Administrator and the Director of Nursing on May 14, 2026, at 11:15 AM. 28 Pa. Code 201.14(a) Responsibility of license28 Pa. Code 201.29(a) Resident rights