STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance Survey, and an Abbreviated Survey to review six Complaints completed on February 4, 2025, it was determined that The Manor at Penn Village was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0578 SS=D		F 0578		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	The facility clarified the advanced directives for resident 108. An audit of the advanced directives for all current residents was conducted to ensure that a written copy of the advanced directives was on file, and that the written copy matched each resident's orders and care plan. Education on ensuring accurate advanced directives was provided to facility licensed staff and the interdisciplinary team. Audits will be conducted by the Administrator of all new admissions x60 days to ensure that the advanced directives match the orders and the care plan. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=D	Continued from page 3 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear advance directives for one of four residents reviewed (Resident 108). Findings include: A review of the census for Resident 108 revealed the resident was admitted to the facility on January 3, 2025. Current physician orders for Resident 108 revealed an order dated January 3, 2025, that indicated the resident was a "Full Code" (attempt resuscitation and CPR when the person has no pulse and is not breathing). Review of the current care plan for Resident 108 revealed the resident has advanced directives related to full code. An intervention included a physician order for full code. Facility documentation titled, "Advanced Directives	F 0578		

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F 0578 SS=D	Continued from page 4 Discussion Document" for Resident 108 and dated January 3, 2025, indicated Withhold was marked with an "X" for cardiopulmonary resuscitation (CPR) indicating the resident and/or resident representative did not want CPR administered. The document was signed and dated by the Power of Attorney and the registered nurse on January 3, 2025. A review of the Living Will for Resident 108 signed in October 2013, also indicated the resident did not want "heart-lung resuscitation (CPR)." The above discrepancy between the signed wishes of Resident 108/resident's representative, physician's order, and care plan were reviewed in a meeting with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 29, 2025, at 2:00 PM. Further review of the physician orders revealed the order for Resident 108 that noted Full Code was changed to Do Not Resuscitate on January 29,	F 0578		

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F 0578 SS=D	Continued from page 5 2025. A follow-up interview with the NHA and DON on January 30, 2025, at 2:00 PM confirmed that Resident 108 was a DNR and the physician's order was updated. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0578		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 6 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	The facility is unable to retroactively provide physician ordered services for residents 73 and 98 and maintain the restorative nursing programs for residents 85 and 98. Orders for restorative programs will be reviewed to determine if they are still applicable. Orders that are still appropriate will be implemented. The facility will review physician ordered restorative nursing programs to ensure that the restorative nursing services are provided as ordered. Education will be provided to Licensed Nurses on implementing orders for restorative programs. The facility will educate CNAs on the importance of following physician orders for restorative nursing. The DON or designee will audit restorative nursing programs of 3 residents x5 a week for 8 weeks to ensure completion. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0688 SS=E	Continued from page 7 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide physician ordered services to maintain a resident's mobility for two of three residents reviewed (Residents 73 and 98) and maintain a resident's restorative nursing program for two of three residents reviewed (Residents 85 and 98). Findings include: Clinical record review for Resident 85 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 11, 2024, that indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3 that indicated a severe cognitive impairment level. Review of the Tasks list for Resident 85 revealed the following restorative nursing program (a formal, planned, and organized care program designed to restore lost abilities or maintain potentially	F 0688		

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F 0688 SS=E	Continued from page 8 deteriorating functions): Ambulation/locomotion; patient will ambulate 100 to 150 feet with a rolling walker and supervision. A physical therapy discharge summary for Resident 85 dated September 25, 2024, at 9:55 AM revealed the resident was discharged from therapy with a reason noted as maximum potential achieved, referred for a restorative nursing program/functional maintenance program. Review of facility documentation titled, "Therapy Communication to Restorative Nursing Program," dated September 27, 2024, revealed recommendations from therapy that included the resident will ambulate 200 to 300 feet with a rolling walker and supervision. An interview with Employee 4, Director of Rehabilitation, on January 30, 2025, at 1:29 PM confirmed that the above program was recommended by physical therapy for Resident 85 upon discharge from therapy on September 25,	F 0688		

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F 0688 SS=E	Continued from page 9 2024. Employee 4 further stated that the nurse aides complete the restorative programs with the resident. A review of the task documentation for Resident 85's restorative nursing program for October 2024, November 2024, and December 2024, revealed that there was only one date (November 7, 2024) that was documented as having the program completed until the resident went back on active physical therapy on January 10, 2025. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January 30, 2025, at 2:25 PM. There was no further clinical documentation provided by the facility for Resident 85 to indicate the restorative program was completed or why the restorative program was entered differently into the electronic health record than what therapy had recommended.	F 0688		

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F 0688 SS=E	Continued from page 10 Interview with Resident 73 on January 28, 2025, at 12:45 PM revealed that she was no longer receiving skilled therapy services, and staff were supposed to walk with her twice a day. Resident 73 stated that she could not recall the exact day when staff last walked with her, but it was during the previous week. Resident 73 stated that staff said to her, "...why don't (skilled therapy staff) come up and walk you?" Clinical record review for Resident 73 revealed an active physician's order dated January 9, 2025, that instructed staff to complete a restorative nursing program for Resident 73 to ambulate 100 feet with a roller walker with supervision, verbal cues, and a brace (due to risk for hip dislocation). Review of a Documentation Survey Report (electronic documentation completed by nurse aide staff to record care and services provided) dated January 2025, revealed that staff did not complete the restorative ambulation program with Resident 73 twice daily on any day since the physician's order on	F 0688		

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F 0688 SS=E	Continued from page 11 January 9, 2025. The documentation indicated that staff did not complete the program at least once a day on the following days: January 15, 2025 (staff documented not applicable for day shift) January 16, 2025 January 18, 2025 January 21, 2025 January 23, 2025 January 25, 2025 January 26, 2025 January 28, 2025 The surveyor reviewed the above concerns regarding Resident 73's restorative ambulation program during an interview with the Director of Nursing and the Nursing Home Administrator on January 30, 2025, at 1:46 PM. In an interview and observation of Resident 98 on January 28, 2025, at 2:15 PM, the resident stated he had finished his therapy "last week," and that he	F 0688		

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F 0688 SS=E	Continued from page 12 had come to the facility almost paralyzed (partially incapable of movement) but was now walking with the use of a walker and staff assistance. Resident 98 stated since his therapy ended last week no one has walked him on the unit. Resident 98 indicated he had walked once because he went by himself to the nursing station. Review of a physical therapy discharge summary for Resident 98 dated January 23, 2025, revealed the physical therapist discharged the resident on January 23, 2025, with a diagnosis of gait impairment and recommendations for a restorative nursing program, noting the resident's prognosis to maintain his current level of functioning was good with consistent staff follow-through. In an interview with Employee 4, on January 31, 2025, at 10:13 AM, Employee 4 indicated when therapy is finished with a resident and recommending a restorative nursing program a form is completed and provided to nursing staff to order and to implement the program that is indicated on	F 0688		

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F 0688 SS=E	Continued from page 13 the nursing units. A "Therapy Communication to Restorative Nursing Program" form for Resident 98 dated January 23, 2025, indicated the resident's functional status on that date was ambulating 200-250 feet with a rolling walker and contact guard (caregiver places one to two hands on the resident to help with balance) assistance, and transfers with assistance. The recommendation on the form was for the resident to be ambulated up to 250 feet using a rolling walker and staff assistance for mobility and to perform other active range of motion therapeutic exercises to the resident's bilateral lower extremities in three sets of 10. There was no evidence provided to indicate Resident 98's restorative nursing program to include mobility and range of motion was ordered/implemented or completed at all since his discontinuation of therapy on January 23, 2025. An interview with the Nursing Home Administrator	F 0688		

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F 0688 SS=E	Continued from page 14 on January 31, 2025, at 10:35 AM confirmed the above findings regarding Resident 98. 483.25(c)(1)-(3) Increase/prevent Decrease In Rom/mobility Previously cited: 1/26/2024; 3/6/2024 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0688		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 15 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	The care plan for resident 83 was corrected to include the use of bilateral fall mats and to allow resident to eat while in bed. The facility is unable to retroactively provide appropriate interventions for resident 164. The facility will audit the use of fall matts to ensure that those interventions accurately care planned and deployed as needed. The facility will review the previous 2 weeks of falls to ensure that an appropriate intervention has been implemented. Education will be provided for the CNAs to ensure that fall matts are provided for each resident as indicated in the Kardex. Education will also be provided to licensed nurses to ensure all falls have an investigation initiated that includes an immediate intervention. The IDT will be educated to ensure that all initiated facility investigations are completed and reviewed to ensure an appropriate plan in place to prevent recurrence. The DON or designee will complete	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0689 SS=D	Continued from page 16	F 0689	audits x5 a week for 8 weeks of 3 residents to ensure that fall matts are in place in accordance with each resident's care plan. Additional audits of resident fall investigations will occur consisting of 5 a week x 8 weeks to ensure that the facility investigation was completed and an appropriate plan was put in place to prevent recurrence. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

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F 0689 SS=D	Continued from page 17 Based on clinical record review, review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to thoroughly investigate incidents and implement interventions to prevent future falls or accidents for two of six residents reviewed for falls (Residents 83 and 164). Findings include: Clinical record review for Resident 83 revealed a physician's order dated November 1, 2023, for staff to position fall mats beside Resident 83's bed bilaterally. A plan of care developed by the facility identified Resident 83's risk for falls related to gait and balance problems, incontinence, sits himself up on the side of the bed, and is impulsive (will attempt to pick things off floor independently). The plan of care listed interventions that included Resident 83 was not to sit on the side of his bed for meals. He was to be out of bed in his wheelchair for meals or	F 0689		

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F 0689 SS=D	Continued from page 18 sit up 90 degrees in bed with a tray table in front of him. The plan of care did not include an active intervention to use bilateral fall mats beside his bed although there was an active physician's order to implement them. Observation of Resident 83 on January 28, 2025, at 12:05 PM revealed he was in his bed with a fall mat on the left side of his bed. There was no fall mat on the right side of his bed. Staff entered the room to deliver Resident 83's lunch meal tray. Staff lowered Resident 83's bed so his feet would touch the floor and assisted him to sit on the side of his bed to eat his lunch. Staff assisted Resident 83 with opening or cutting food items and left the room while Resident 83 began eating his lunch. Observation of Resident 83 on January 30, 2025, at 9:39 AM revealed he was in bed. There was only one fall mat positioned on the floor on the left side of his bed. There was no fall mat on the right side of	F 0689		

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F 0689 SS=D	Continued from page 19 his bed. Interview with Employee 6 (licensed practical nurse) on January 30, 2025, at 9:41 AM confirmed that Resident 83 only had one fall mat on the left side of his bed. Employee 6 made a telephone call to obtain another fall mat for Resident 83. The surveyor reviewed the above concerns related to Resident 83's positioning for his lunch meal and his fall mats during an interview with Employee 1 (assistant director of nursing) and the Nursing Home Administrator on January 31, 2025, at 10:34 AM. The interview confirmed that Resident 83's plan of care was corrected to have bilateral fall mats after the surveyor's questioning. The interview indicated that the facility discontinued the intervention to prevent Resident 83 from sitting on the side of his bed for meals after the surveyor's questioning. The policy entitled "Accident and Incident Investigation" last reviewed on December 16, 2024, indicates that certain accidents and incidents,	F 0689		

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F 0689 SS=D	Continued from page 20 including injuries of unknown origin, will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event. The investigation will included interviews with the resident, all staff involved (directly or indirectly), and any family, visitors, or volunteers, which may have had contact with the resident and may help with the investigation. Review of Resident 164's clinical record revealed nursing documentation dated December 8, 2024, at 4:48 PM that indicated nursing staff found a dark purple bruise measuring 29 cm (centimeters) by 18 cm on her right abdominal area and a dark purple bruise measuring 18 cm by 6 cm on her left abdominal area. Resident 164 indicated that she did not know how she "got those bruises." Review of the facility's investigation into Resident 164's bruising dated December 8, 2024, indicated that Resident 164 is unaware of her safety needs, and that she was observed bumping self on the side of her chair and bathroom rail. There was no	F 0689		

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F 0689 SS=D	Continued from page 21 documented evidence that the facility collected any other staff statements aside from the staff member who reported it to the nurse. There was no documented evidence to indicate that the facility attempted to implement interventions to decrease future occurrences, since determining that a cause could be the bathroom railing or her wheelchair. Interview with the Administrator and Director of Nursing on January 31, 2025, at 10:30 AM confirmed the above findings for Resident 164. 483.25(d)(1)(2) Accidents Previously cited deficiency 1/26/24, 5/1/24, and 9/12/24 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0689		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 22 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	The facility is unable to retroactively put in place interventions to prevent weight loss for residents 100 and 101. Both residents will received an evaluation by the facility RD and have their care plans reviewed. The facility will complete a 30 day look back of significant weight changes to ensure physician notification was provided and appropriate interventions were implemented. The facility will notify the RD and physician of any identified significant wight changes for additional evaluation and the resident's care plan will be reviewed. The facility RD, Licensed nursing staff and IDT will be educated on the facility weight policy. The DON or designee will complete audits of 5 residents a week x8 weeks to ensure that weights have been obtained and documented as ordered and that unplanned significant weight changes have been communicated to the physician and that care plan updates occurred if applicable.. The results of the audits will be reviewed at the	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0692 SS=D	Continued from page 23	F 0692	facilities QAPI meeting for recommendations.	

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F 0692 SS=D	Continued from page 24 Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition resulting in a significant weight loss for two of six residents reviewed (Residents 100 and 101). Findings include: Clinical record review for Resident 100 revealed the resident was admitted to the facility on November 6, 2024, from the hospital, with a history of multiple stokes (when blood flow to the brain is interrupted leading to brain cell damage). Further review revealed Resident 100 had required the insertion of a PEG tube (percutaneous endoscopic gastrostomy tube, a tube inserted into the stomach to administer food and fluids when a person is unable to eat or drink normally) on September 3, 2024, and had since transitioned to eating again by mouth. Review of Resident 100's hospital records for	F 0692		

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F 0692 SS=D	Continued from page 25 October 18 - November 6, 2024, prior to her admission revealed the resident was noted to be receiving a regular diet in the hospital with nutritional supplementation by mouth and enteral (by tube) feedings only if the resident's evening meal was less than 50 percent, with the ability to increase to all meals less than 50 percent if the resident regressed. Review of Resident 100's diet orders at the facility upon admission on November 6, 2024, revealed the resident's PEG tube was still in place at the time of her admission, and a two-gram sodium diet regular texture was ordered by mouth. A water flush was ordered for the resident's PEG tube of 60 ml two times for patency (keep open), with no enteral feedings ordered. Resident 100's weight on November 6, 2024, was documented as 197.8 pounds. A nutrition evaluation dated November 8, 2024, completed by the registered dietitian noted Resident 100's meal intake was between 50-100 percent most meals, and the resident had a PEG tube	F 0692		

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F 0692 SS=D	Continued from page 26 present with no tube feeding orders at that time. It was noted the resident's weight on November 7, 2024, was 196 pounds, that the resident was receiving a regular diet, and the resident had a PEG tube in place but not in use. The dietitian recommended a two gram sodium restriction diet due to the resident having a history of congestive heart failure (a condition that happens when you heart can't pump blood well enough to give your body a normal supple and blood and fluids collect in your lungs and legs over time) and no enteral feed unless the residents food intake or weight declined. The resident's weekly weight would be monitored. Review of Resident 100's weight documentation revealed the resident was documented as weighing 196.1 on November 9, 2024, and decreasing to 191.4 pounds on November 18, 2024, and 191 pounds on December 2, 2024. Resident 100 lost 6.8 pounds since her admission weight on November 6, 2024, a 3.4 percent loss. A dietary note dated November 18, 2024, at 2:25	F 0692		

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F 0692 SS=D	Continued from page 27 PM reflected Resident 100's weight change since admission to 191.4 pounds, and noted the resident's sodium restricted diet, that the resident was eating 50-100 percent of meals, noting some occasionally low, and the resident had enteral feeding access with no tube feeding regimen at the time. The note indicated some weight change may be due to fluid shifts, although there was no supporting documentation to reflect edema or changes in edema/fluid. No dietary changes were recommended at the time. An additional dietary note for Resident 100 on December 4, 2024, at 9:08 AM referenced the resident's weight on December 2, 2024, of 191 pounds, noting no tube feedings via the PEG tube access with 50-100 completion of most meals with occasional very low intakes for three days, with no nutrition adjustments made. A review of Resident 100's meal intake records for November and December 2024, revealed the resident was consuming 50 - 100 percent of meals	F 0692		

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F 0692 SS=D	Continued from page 28 most often in November with some occasional lower intakes or an occasional refusal of a meal. Review of December meal intakes revealed an increase in refusal of meals, and an increase in meals with less than 50 percent consumed. Resident 100 was not documented as having a weight assessment again until December 31, 2024, which reflected a weight of 176.4 pounds, a 21.4-pound (significant 10.8 percent) weight loss since admission to the facility. There were no dietary notes, nutrition assessments, or further weekly weights for Resident 100 from December 2 to December 31, 2024, who presented a high nutritional risk upon admission and in her first month at the facility as the resident had only had the PEG tube inserted two months prior to her admission, transitioned to eating by mouth again, and presented weight loss in the first few weeks in the facility. A dietary note dated January 1, 2025, at 7:41 PM noted the weight of 176.8 pounds for Resident 100, and the resident's diet was changed to regular with	F 0692		

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F 0692 SS=D	Continued from page 29 no salt packed and a health shake was added by mouth with all meals, and weekly weight monitoring for four weeks was initiated. It was again noted the resident had PEG enteral feed access with no tube feeding regimen. Resident 100 was weighed on January 6, 2025, at 174.2pound, a further loss of 2.6 pounds since the December 31, 2024, weight. Resident 100 did not have a documented weight again until January 24, 2025, of 167.9 pounds, another 6.3-pound decrease, and 29.9 pounds (15 percent severe weight loss) since admission on November 6, 2024. A dietary note dated January 17, 2025, referenced the January 6, 2025, weight with no additional nutrition adjustments or interventions, and did not address the resident had missed a weekly weight after January 6, to the date of the note. A dietary note then dated January 24, 2025, also only referenced the weight on January 6, 2025, with an additional medication pass nutritional supplement	F 0692		

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F 0692 SS=D	Continued from page 30 being added, but did not address missing weekly weights. The resident was not documented as being weighed again until January 24, 2025, as noted above reflecting further loss. A physician assistant's encounter note dated January 8, 2025, indicated the resident was seen as nursing staff was asking for medication time changes as the resident was difficult to awaken in the mornings, and staff were questioning the continued need for the PEG tube as it had not been used since her admission to the facility. Physician's assistant encounter documentation dated January 15, 2025, noted staff expressed concern that the resident seemed depressed and has not been eating well, noting she lost weight since being admitted to the facility. The note indicated the tube is not being used as the resident can tolerate a regular diet. There was no evidence of any discussion if the PEG tube would need utilized for the resident, the extent of Resident 100's weight loss, or that the resident had not been weighed since	F 0692		

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F 0692 SS=D	Continued from page 31 January 6, 2025. Nursing documentation dated January 15, 2025, at 10:52 AM noted an appointment was made with gastroenterology regarding PEG tube removal for Resident 100 on January 23, 2025. Resident 100 was sent to gastroenterology on January 23, 2025, for PEG tube removal despite no further weight assessment since January 6, 2025, as the resident had last reflected a weight loss, or discussion as to if the PEG tube may need to be utilized again for the resident. A review of Resident 100's consultation report from the Nutrition and Weight Management facility (gastroenterology) dated January 23, 2025, noted the resident "is on nutrition support currently, tube feeds, but reportedly does not take them and has been maintaining herself on a "PO" (by mouth) diet alone." It was noted the removal of the tube was not warranted as the resident can have the tube stay in for nine months to a year prior to removal, and	F 0692		

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F 0692 SS=D	Continued from page 32 the resident is losing weight and will very likely need the PEG tube. It also noted the resident's weight needed to be monitored more closely to determine malnutrition status, and close dietitian follow up was needed to help oversee the tube care and use. Resident 100 presented to the facility as high nutritional risk and in the resident's initial weekly weights for four weeks after admission, the resident experienced decreasing weight. No further weekly weights were continued after that time when the weights ended on December 2, 2024. The resident's intakes continued to show decline in December 2024, with the next weight on December 31, 2024, reflecting a significant 21-pound weight loss since the resident's admission to the facility in the beginning of November 2024. When weekly weights were initiated again on January 1, 2025, by the dietitian, a weight was documented for January 6, 2025, with further loss, and not again until January 24, 2025, with additional weight loss. The resident's last available weight was January 27, 2025, of 166.7 a 9.7-pound loss since December	F 0692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0692 SS=D	Continued from page 33 31, 2024, significant 5.4 percent for one month, and 31.1-pound loss (15.7 percent) since the November 6, 2024, admission. No feedings through the PEG tube were ordered/attempted at any time during the resident's stay as of January 31, 2025, as a supplemental intake as the resident's weight and intakes declined, or any evidence they were discussed to be implemented/attempted when the resident's intakes were poor/refused and the weight kept decreasing. The only reference regarding the PEG tube was for removal as noted above. There was no evidence adequate monitoring was implemented (weights) to monitor a high-risk resident, or that additional measures were implemented/attempted timely to prevent the significant weight loss for the resident. The above information for Resident 100 was reviewed with the Nursing Home Administrator on January 31, 2025, at 10:38 AM. Review of Resident 101's clinical record revealed	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

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F 0692 SS=D	Continued from page 34 that the facility weighed him on January 2, 2025, as 186.1 pounds. The facility weighed Resident 101 on January 5, 2025, as weighing 175.2 pounds, a significant 5.86 percent weight loss in just three days. A dietary note dated January 8, 2025, indicated that the registered dietician implemented weekly weights for Resident 101. Weight documented on January 9, 2025, indicated that the facility weighed Resident 101 at 164 pounds, another 6.39 percent weight loss in four days. Weight documented on January 13, 2025, indicated that the facility weighed Resident 101 at 155 pounds, another 5.49 percent loss in four days. There was no documented evidence in Resident 101's clinical record to indicate that Resident 101's physician was notified of continued weight loss on January 9, 2025, or on January 13, 2025, and no documented evidence that the facility implemented additional interventions to deter further weight loss until this surveyor questioning.	F 0692		

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F 0692 SS=D	Continued from page 35 Interview with the Administrator and Director of Nursing on January 31, 2025, at 10:15 AM, confirmed the above findings for Resident 101. 483.25 g(1) Maintain acceptable parameters of nutritional status Previously cited 4/9/24 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 36 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	The facility corrected the O2 settings for resident 96. The order for resident 49s supplemental oxygen was discontinued. An audit of current residents with oxygen was conducted to ensure that oxygen settings matched each resident's orders. An education was provided to facility CNAs and licensed nursing staff to ensure accurate O2 settings in accordance with each resident's care plan. The DON or designee will complete observations of 5 residents a week x 8 weeks to ensure that resident O2 settings are in place in accordance with each resident's care plan. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0695 SS=D	Continued from page 37 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide respiratory care consistent with professional standards of practice for two of four residents reviewed for respiratory concerns (Residents 49 and 96). Findings include: Clinical record review for Resident 96 revealed a diagnosis list that included the following: respiratory failure with hypoxia (low levels of oxygen in the body), chronic obstructive pulmonary disease (COPD, a lung disease that causes restricted airflow and breathing problems), and dependence on supplemental oxygen. Review of current physician orders for Resident 96 revealed an order dated January 15, 2025, that instructed staff to administer supplemental oxygen at four liters per minute (LPM) by nasal cannula (medical tubing that delivers supplemental oxygen directly to the nose) with humidification.	F 0695		

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F 0695 SS=D	Continued from page 38 Resident 96's care plan revealed the resident has COPD and an intervention noted is to administer "humidified oxygen via nasal prongs as ordered." Observation of Resident 96 on January 29, 2025, at 10:38 AM and January 30, 2025, at 8:53 AM and 9:27 AM revealed that Resident 96 was in bed. The resident was being given supplemental oxygen via nasal cannula. Each observation revealed the oxygen was being administered at 1.5 LPM and not 4 LPM as ordered by the physician. Interview with Employee 7, licensed practical nurse, on January 30, 2025, at 9:27 AM revealed that Resident 96 is supposed to administered supplemental oxygen via nasal cannula at 4 LPM. Employee 7 proceeded to change the oxygen to the correct flow rate of 4 LPM as noted in the order. The above information for Resident 96 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January	F 0695		

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F 0695 SS=D	Continued from page 39 30, 2025, at 2:15 PM. Clinical record review for Resident 49 revealed an active physician's order dated October 13, 2024, for staff to administer supplemental oxygen for a pulse ox (pulse oximeter, an assessment done by a small device applied to the tip of a finger to assess the amount of oxygen in the blood) below 92 percent. The order did not include at what liter flow staff were to administer the supplemental oxygen. Observation of Resident 49 on January 29, 2025, at 10:21 AM revealed no supplemental oxygen in use. Review of Resident 49's MAR and TAR (Medication Administration Record and Treatment Administration Record, electronic documentation completed by licensed staff to record care provided) dated January 2025, revealed no oxygen saturation assessments obtained by staff. Review of Resident 49's plans of care developed by the facility to address diagnoses and problems that	F 0695		

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F 0695 SS=D	Continued from page 40 require special focus by the facility and the implementation of individualized interventions revealed no intervention to use supplemental oxygen. A focus area initiated on September 18, 2024, indicated that Resident 49 had altered respiratory status and difficulty breathing related to secretions and pneumonia (infection of the lungs). Staff resolved (discontinued) the intervention for oxygen as ordered for a pulse ox below 92 percent on December 3, 2024, however, the physician's order requiring this assessment continued as an active order after that date. Interview with Employee 2 (licensed practical nurse) on January 29, 2025, at 10:26 AM confirmed that licensed staff were not obtaining routine pulse ox assessments for Resident 49 although her physician orders required the application of supplemental oxygen for an assessment less than 92 percent. The surveyor reviewed the above concerns regarding Resident 49's physician ordered oxygenation assessments and supplemental oxygen	F 0695		

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F 0695 SS=D	Continued from page 41 during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 (assistant director of nursing) on January 29, 2025, at 1:45 PM. The facility discontinued Resident 49's physician order for supplemental oxygen on January 29, 2025, at 2:45 PM (following the surveyor's questioning). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0695		
F 0725 SS=D		F 0725		

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F 0725 SS=D	Continued from page 42 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	The facility is unable to retroactively ensure sufficient staffing to meet the immediate needs of residents 66 and 25, but was able to provide appropriate assistance later that same morning. A 2-week look back will be conducted of the facilities' staffing to identify trends and an appropriate intervention to ensure sufficient staffing in the facility. Education will be provided to the facility scheduler and RN supervisors on ensuring sufficient staffing. Measures will be put in place to adequately provide staff. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will educate ppd staffing levels to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The DON or designee will complete audits x5 a week x 8 weeks to ensure that the facility maintains sufficient staffing. Weekly staffing reviews will	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0725 SS=D	Continued from page 43	F 0725	occur between the DON and Administrator. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	

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F 0725 SS=D	Continued from page 44 Based on observation, review of nursing staffing schedules, and resident and staff interview, it was determined that the facility failed to have sufficient nursing staff to meet residents' schedules for activities of daily living for two of three residents reviewed for concerns regarding resident choices (Residents 66 and 25). Findings include: Observation of Resident 66 on January 29, 2025, at 9:13 AM revealed he was in his bed. Resident 66 stated that he must wait for staff to transfer him out of bed to his wheelchair. Resident 66 stated that the time he gets out of bed is dependent upon how many nurse aides are working. Resident 66 stated that he is usually out of bed at 6:30 AM, which is his choice and preference. Resident 66 stated that he considered it to be exceptionally late for him to still be in bed at 9:13 AM. Interview with Resident 25 on January 29, 2025, at 9:33 AM revealed that staff assisted her out of bed	F 0725		

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F 0725 SS=D	Continued from page 45 at 8:00 AM that morning. Resident 25 stated that she prefers to be out of bed early, by 6:30 AM, because she does not like to eat her breakfast in her bed due to her likelihood of dropping food items in her bed. Resident 25 stated that she had to eat her breakfast in bed this morning because staff did not assist her to transfer to her chair. Interview with Employee 11 (nurse aide) on January 30, 2025, at 10:16 AM confirmed that Residents 66 and 25 were not out of bed at their preferred time on January 29, 2025, because there were only three nurse aides assigned to the unit at the time. Employee 11 stated that there were four nurse aides on the unit on January 30, 2025, and everyone was out of bed per their preferred schedule. The surveyor reviewed the above concerns related to sufficient staffing to meet residents' needs during an interview with the Nursing Home Administrator and the Director of Nursing on January 30, 2025, at 1:46 PM.	F 0725		

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F 0725 SS=D	Continued from page 46 28 Pa. Code 201.18(b)(3)(e)(1)(6) Management 28 Pa. Code 211.12(d)(4)(5)(f.1)(3) Nursing services	F 0725		
F 0730 SS=E	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	The performance reviews for employees 8 and 9 were completed. All employees eligible for an annual performance review received one/ Education was provided to the facility DON to ensure the completion of annual performance reviews. The Administrator or designee will conduct weekly audits x 12 weeks will be completed to ensure that eligible employees receive a performance review. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0730 SS=E	Continued from page 47 Based on employee personnel record review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for two of three nurse aides reviewed (Employees 8 and 9). Findings include: The facility noted the following hire dates for two employees reviewed for performance evaluations: Employee 8's hire date: May 29, 2013. Employee 9's hire date: October 27, 1998 A request to review the annual performance evaluations revealed no documented evidence that the facility is completing the evaluations at least once every 12 months. Interview with Employee 10, human resources, on January 31, 2025, at 11:15 AM confirmed that performance evaluations were not completed on the two employees.	F 0730		

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F 0730 SS=E	Continued from page 48 483.35(d)(7) Nurse Aide Perform Review-12 Hr/yr In-Service Previously cited 1/26/2024 28 Pa. Code 201.19 (2) Personnel policies and procedures	F 0730		
F 0756 SS=E	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 0756	The pharmacy recommendations for residents 77, 20, and 63 were addressed by their attending physicians. A 30 day look back was completed to ensure that all pharmacy recommendations were addressed. The DON and ADON were educated on ensuring that pharmacy recommendations are addressed timely. The Administrator or designee will audit pharmacy recommendations monthly x2 to ensure they are addressed by a physician. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0756 SS=E	Continued from page 49 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: __00_____ B. WING: _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204 SELINSGROVE, PA 17870**

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F 0756 SS=E	Continued from page 50 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed pharmacy recommendations for three of five residents reviewed (Residents 77, 20, and 63). Findings include: The policy entitled "Monthly Drug Regimen Review," last reviewed on December 16, 2024, indicates that during a drug regimen review, the consultant pharmacist is to identify drug regimen irregularities. Reports are to be addressed by the attending physician within one to 21 days, unless urgent. If follow up to the consultant pharmacist recommendations are not completed within the specified time frame, this should be reported to the Medical Director. Review of Resident 77's clinical record revealed a pharmacy form entitled "Consultation Report" dated June 21, 2024, indicating that the consultant	F 0756		

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F 0756 SS=E	Continued from page 51 pharmacist identified that Resident 77 was taking Ativan (for anxiety) 0.5 mg (milligrams) as needed longer than 14 days without a stop date. There was no documented evidence that Resident 77's physician reviewed or responded to the recommendation from the pharmacist. The facility did not obtain a physician's order to stop Resident 77's Ativan until November 4, 2024, five months after the recommendation. A pharmacy form entitled "Consultation Report" dated July 31, 2024, indicated that the consultant pharmacist identified that Resident 77 was taking an "activating" antidepressant (which can act as a stimulant) at bedtime, and recommended that the dose be switched to a morning administration time. There was no documented evidence that Resident 77's physician reviewed or responded to the recommendation by the pharmacist. A pharmacy form entitled "Consultation Report" dated November 27, 2024, indicated that the consultant pharmacist again identified that Resident	F 0756		

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F 0756 SS=E	Continued from page 52 77 was taking an "activating" antidepressant at bedtime, and recommended that the dose be switched to a morning administration time. There was no documented evidence that Resident 77's physician reviewed or responded to the recommendation by the pharmacist. The facility obtained a physician's order on January 30, 2025, to switch Resident 77's antidepressant to a morning administration, six months after it was first recommended and after questioning by this surveyor. Interview with the Administrator and Director of Nursing on January 31, 2025, at 10:30 AM confirmed the above findings for Resident 77. Clinical record review for Resident 20 reveled a pharmacist monthly consultation recommendation report dated April 20, 2024, to evaluate the resident's medications of Aripiprazole (used for schizoaffective (mental health) disorder,), Clozapine (used for schizophrenia), Bupropion (an antidepressant), Lorazepam (used for anxiety),	F 0756		

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F 0756 SS=E	Continued from page 53 Melatonin (used to help sleep), and Sertraline (an antidepressant), for an annual dose reduction. Facility staff were not able to produce any evidence Resident 20's physician reviewed/responded to the pharmacy recommendation. Additional pharmacy consultation reports for Resident 20 dated May 2, 2024, recommending a trial dose reduction of the resident's Aripiprazole and Bupropion, and another dated October 15, 2024, recommending medications be evaluated as possible causes or contributors to a fall, were identified with no evidence provided of any physician review/response to the recommendations within 30 days or of the recommendation. The above information was confirmed with the Nursing Home Administrator on January 31, 2025, at 12:33 PM. Clinical record review for Resident 63 revealed a pharmacy consultant note dated October 31, 2024, at 5:29 PM that revealed irregularities with the	F 0756		

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F 0756 SS=E	Continued from page 54 medication regimen review and, "See report for any noted irregularities." Documentation titled "Consultation Report" for Resident 63 revealed a pharmacy recommendation dated October 31, 2024, that indicated the resident received methenamine (a medication used to treat or prevent urinary tract infections) for urinary tract infection prophylaxis (preventatively). The recommendation from the pharmacist included to reevaluate use and, if appropriate, discontinue the medication while monitoring for signs and symptoms of recurrent urinary tract infections. The physician's response section of the form revealed no response from the physician. Clinical record review for Resident 63 revealed a pharmacy consultant note dated June 21, 2024, at 9:21 PM that revealed irregularities with the medication regimen review and, "See report for any noted irregularities." Documentation titled, "Consultation Report," for	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0756 SS=E	Continued from page 55 Resident 63 revealed a pharmacy recommendation dated June 21, 2024, that indicated the resident received methenamine (a medication used to treat or prevent urinary tract infections) for urinary tract infection prophylaxis. The recommendation from the pharmacist included to reevaluate use and, if appropriate, discontinue the medication while monitoring for signs and symptoms of recurrent urinary tract infections. The physician's response section of the form revealed no response from the physician. Clinical record review for Resident 63 revealed a pharmacy consultant note dated April 16, 2024, at 2:12 PM that revealed irregularities with the medication regimen review and, "See report for any noted irregularities." Documentation titled, "Consultation Report," for Resident 63 revealed a pharmacy recommendation dated April 16, 2024, that indicated the resident received three or more central nervous system active medications, which can cause and increased	F 0756		

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F 0756 SS=E	Continued from page 56 risk for falls and fractures. The listed medications included the following: Venlafaxine Hydrochloride (a medication used to treat depression and/or anxiety), Quetiapine Fumarate (an antipsychotic medication), and Gabapentin (a medication used to treat certain things such as seizures and nerve pain). The recommendation from the pharmacist included to reevaluate the combination and consider a trial dose reduction of one of these medications. The physician's response section of the form revealed no response from the physician. An interview with Employee 1, assistant director of nursing, on January 31, 2025, at 10:30 AM confirmed the pharmacist recommendations for Resident 63 and no documented evidence that the physician reviewed or responded to the recommendations. The Administrator was also present during the interview. 483.45(c) Drug Regimen Review Previously cited 1/26/24	F 0756		

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F 0756 SS=E	Continued from page 57 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0756		
F 0758 SS=E		F 0758		

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F 0758 SS=E	Continued from page 58 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	The orders for residents 69 and 77 were discontinued. The order for resident 85 was corrected on 1/6/25. An audit of prn psychotropics medications for current residents was completed to ensure that each order included a 14 day stop. An audit of current residents with orders for psychotropic medications was completed to ensure the delivered medication matches the physician's order. Education will be provided to all licensed nurses to ensure orders received for prn-psychotropic medications include a 14 day stop, and to identify and report any discrepancies with delivered medications and physician orders for administration. The DON or designee will complete audits of new psychotropic medication orders to ensure that prn medications include a 14 day stop and that delivered medications match physician orders x8 weeks. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0758 SS=E	Continued from page 59 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=E	Continued from page 60 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for three of six residents reviewed (Residents 69, 77, and 85). Findings include: Review of Resident 69's clinical record revealed a physician's order dated January 5, 2025, that indicated nursing staff may administer Ativan (for anxiety) 0.5 mg (milligrams) every six hours as needed for agitation or anxiety. There was no documented evidence that Resident 69's physician documented a rational for the continued use of the Ativan beyond a 14-day period. The facility obtained a physician's order on January 30, 2025, to discontinue the use of the Ativan after the surveyors questioning. Review of Resident 77's clinical record revealed a physician's order dated May 21, 2024, that indicated nursing staff may administer Ativan 0.5 mg	F 0758		

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F 0758 SS=E	Continued from page 61 every six hours as needed for agitation or anxiety. There was no documented evidence that Resident 77's physician documented a rationale for the continued use of the Ativan beyond a 14-day period. The facility obtained a physician's order to discontinue the Ativan on November 4, 2024, almost six months after it being initiated. Interview with the Administrator and Director of Nursing on January 31, 2025, at 10:30 AM confirmed the above findings for Residents 69 and 77. Clinical record review for Resident 85 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 11, 2024, that indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3 that indicated a severe cognitive impairment level. Review of the Medication Administration Record (MAR) for Resident 85 revealed an order for	F 0758		

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F 0758 SS=E	Continued from page 62 Lorazepam (Ativan, a medication used to treat anxiety) dated December 16, 2024, and discontinued January 4, 2025, that noted: Lorazepam 0.5 mg; give 0.25 mg by mouth three times a day. Facility documentation dated December 31, 2024, revealed an "FYI (for your information)" written to the physician that noted, "Please review narc (narcotic) sheet. Med errors noted. Ordered Lorazepam 0.5 mg, give 0.25 mg three times a day and 0.5 mg as needed every eight hours. Please note and advise." The physician acknowledged that they were aware and signed and dated the document on January 4, 2025. No further orders were noted on the documentation. Nursing documentation for Resident 85 dated January 3, 2025, at 6:35 PM noted the staff member observed an FYI to the physician regarding the family's concern for lethargy and an Ativan medication error from December 28-31, 2024. "Resident was receiving double doses of Ativan."	F 0758		

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F 0758 SS=E	Continued from page 63 The staff member also made the family aware of, " ...med errors." Nursing documentation for Resident 85 dated January 3, 2025, at 11:14 PM noted a "late entry for 12/31/2024." The staff member reported the registered nurse (RN) who was being relieved informed of, "Ativan med errors she noted during the 1600 (4:00 PM) med pass." Nursing documentation for Resident 85 dated January 3, 2025, at 11:47 PM noted an assessment that indicated "resident excessively sleeping." Nursing documentation for Resident 85 dated January 6, 2025, at 2:03 PM revealed that on one card the regular and as needed orders were merged. The combined orders were discontinued. The medication card that was delivered from the pharmacy on December 11, 2024, were 0.5 mg tablets and the directions noted to give 0.5 (half) tablet for a total dose of 0.25 mg per dose. The tablets that were sent were not scored and could not	F 0758		

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F 0758 SS=E	Continued from page 64 be cut in half. New cards are to be sent with the new clarified order. Nursing documentation for Resident 85 dated January 6, 2025, at 2:32 PM noted that on the evening of January 3, 2025, it was reported to nursing that something "didn't look right with the medication card / sheet" for the resident. This was documented as discussed with the RN supervisor who investigated and reported it was more of a transcription issue due to the way the card came from pharmacy and was "very confusing." The documentation further noted that the order, as it was initially written in the electronic health record, combined both the routine and the as needed order onto one order and so it was filled in that manner from the pharmacy, which led to confusion. A review of the facility document (the documentation that comes with the pharmacy medication packs to track administration and accountability of the controlled medication) titled, "Controlled Medication Utilization Record,"	F 0758		

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F 0758 SS=E	Continued from page 65 revealed the following medication instructions for Resident 85: "Give 0.5 (half) tab (0.25 mg total) by mouth every 8 hours routine and one tab by mouth every eight hours as needed for anxiety. The following administrations for the Lorazepam were marked on the Controlled Medication Utilization Record: December 28, 2024: 1:00 PM, 5:00 PM; dose given at each timestamp indicated one December 29, 2024: 10:00 AM, 1:00 PM, 5:00 PM; dose given at each timestamp documented as one December 30, 2024: 10:00 AM, 1:00 PM, and a second 1:00 PM was documented; doses given at each timestamp documented as one December 31, 2024: 10:00 AM, 1:00 PM; dose given at each timestamp documented as one December 31, 2024: 5:00 PM; dose given documented as one with 1/2 (half) marked as wasted.	F 0758		

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MANOR AT PENN VILLAGE, THE	**51 ROUTE 204 SELINSGROVE, PA 17870**
STATE LICENSE NUMBER: **040302**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=E	Continued from page 66 There was only one instance during the time of December 28, 2024, to December 31, 2024, (which was December 31, 2024, at 5:00 PM), where half a tablet of Ativan was wasted as indicated in the directions on the "Controlled Medication Utilization Record" to administer a half tab for the routine dose (0.25 mg). An interview with the Director of Nursing (DON) on January 29, 2025, at 1:45 PM revealed that Resident 85 was getting a "double dose of Ativan." There was no further clinical documentation provided by the facility to indicate that Resident 85 was not being administered a double dose of Lorazepam during the medication administration dates from December 28-31, 2024, or any investigative report related to a medication error as indicated by the staff in the nursing documentation and documentation to the physician. 483.45(c) Drug Regimen Review Previously cited 1/26/24	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: __00_____ B. WING: _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204 SELINSGROVE, PA 17870**

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F 0758 SS=E	Continued from page 67 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0758		
F 0759 SS=E	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	The facility is unable to retroactively correct the medication errors for residents 40 and 66. A house audit of current resident's medication was completed to ensure proper orders for administration were in place for crushed medications and insulin. Licensed nurses were educated on appropriate crushing of medications and proper use of insulin syringes. The DON or designee will complete med pass observations of 3 licensed staff a week x8 weeks to ensure appropriate administration. If variances are identified the nurse will receive re-education. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0759 SS=E	Continued from page 68 Based on observation and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (C Nursing Unit and F Nursing Unit; Residents 40 and 66). Findings include: The facility's medication error rate was 10 percent based on 30 medication opportunities with three medication errors. Observation of Resident 40's medication administration pass on January 30, 2025, at 9:00 AM revealed that Employee 7, licensed practical nurse (LPN), prepared the medications prior to administration. Employee 7 proceeded to place the resident's medications in a disposable medication pouch and crush them with a tablet crusher and then mix them in pudding. Clinical record review for Resident 40 revealed a physician/'s order dated May 20, 2024, that noted crushable medications may be crushed, mixed, and	F 0759		

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F 0759 SS=E	Continued from page 69 administered together unless contraindicated. Physician orders for Resident 40 dated April 25, 2022, revealed Isosorbide Mononitrate (a medication used to help widen the blood vessels and prevent chest pain) ER (extended release) 30 milligrams (mg), give one tablet by mouth one time a day. The pill package (the package from pharmacy which contained the medications) for the Isosorbide Mononitrate noted, "Do not chew or crush before swallowing." A physician's order for Resident 40 dated January 14, 2025, for Pantoprazole Sodium Oral Tablet Delayed Release (DR) (a medication used to treat certain stomach problems), give 20 mg by mouth one time a day. Employee 7 administered 40 mg of the medication instead of 20 mg as noted in the order. The pill package for the Pantoprazole noted, "Do not chew or crush." The medication was also crushed by Employee 7 prior to administration. An interview with Employee 7 on January 30, 2025,	F 0759		

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F 0759 SS=E	Continued from page 70 at 12:29 PM confirmed the medications were crushed for Resident 40 and Employee 7 administered 40 mg of Pantoprazole. The pill package for the 20 mg of Pantoprazole was found in the bottom drawer of the medication cart. The above information was reviewed in a meeting with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 30, 2025, at 2:00 PM. Facility documentation titled, "Common Oral Dosage Forms That Should Not Be Crushed," provided by the facility on January 31, 2025, revealed that both the Isosorbide ER and Pantoprazole DR were on the list. Clinical record review for Resident 66 revealed an active physician's order for staff to administer 10 units from a Humalog Kwikpen (a disposable single-patient-use prefilled pen containing 300 units of Humalog, an injectable hormone used to lower blood sugar. You can give more than one dose from	F 0759		

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F 0759 SS=E	Continued from page 71 the pen) before meals. Instructions regarding the use of a Humalog Kwikpen (https://pi.lilly.com/us/humalog-kwikpen-um.pdf) stipulate that the user is to prime the pen before each injection. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step six of the instructions note to turn the insulin pen dose knob to two units. Step seven instructs to hold the pen with the needle pointing up and tap the cartridge holder gently to collect air bubbles at the top. Step eight is to continue holding the pen with the needle pointing up, push the dose knob in until it stops, and a zero is seen in the dose window; there should be insulin visible at the tip of the needle. Then the user can select the desired dose. Observation of a medication administration pass on January 28, 2025, at 11:37 AM revealed Employee	F 0759		

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F 0759 SS=E	Continued from page 72 2 (LPN)prepared medications for administration. Employee 2 obtained a Humalog Kwikpen and a disposable needle from the medication cart. Employee 2 applied the needle to the tip of the Humalog Kwikpen and dialed 10 units for administration to Resident 66. Employee 2 entered Resident 66's room and administered the insulin medication into Resident 66's right upper arm. Employee 2 did not prime the needle before administration of Resident 66's insulin medication. Interview with Employee 2 on January 28, 2025, at 11:53 AM confirmed that she did not prime the needle before administering Resident 66's insulin. The surveyor reviewed the above concerns regarding Resident 66's insulin administration during an interview with the NHA, DON, and Employee 1 (assistant director of nursing) on January 30, 2025, at 2:16 PM. 28 Pa. Code 211.9(a)(1) Pharmacy services	F 0759		

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F 0759 SS=E	Continued from page 73 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0759		
F 0791 SS=E	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must	F 0791	A dental referral was made for resident 20. A house audit of current residents was completed to ensure that eligible residents received dental referrals. Education will be provided to the IDT on ensuring dental referrals are made for eligible residents. The DON or designee will audit new residents for 60 days to ensure that dental referrals are made for eligible residents. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/21/2025**

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F 0791 SS=E	Continued from page 74 provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=E	Continued from page 75 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide necessary dental services for one of one resident reviewed for dental concerns (Resident 20). Findings include: In an interview and observation of Resident 20 on January 28, 2025, at 12:46 PM the resident was observed to have visible black/decayed appearance of her lower teeth with multiple teeth missing. Resident 20 stated she did not recall seeing a dentist since she had been at the facility. Clinical record review for Resident 20 revealed the resident was admitted to the facility on April 7, 2018. Review of an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 20, 2024, revealed the resident was assessed as having natural teeth with no likely cavities or broken natural teeth.	F 0791		

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F 0791 SS=E	Continued from page 76 A review of Resident 20's active plan of care revealed the resident has a care plan initiated on February 5, 2019, indicated the resident has oral/dental health problems related to poor nutrition and poor dentition. The plan of care indicated interventions of the same date to coordinate arrangements for dental care, transportation as needed/ordered. A review of a facility "Request for Service" form dated March 3, 2023, for Resident 20 revealed the resident selected "yes" as wishing to be seen for dental care. Facility staff did not provide any evidence to indicate Resident 20 had seen a dentist, or evidence the resident refused a dentist since a confirmed dental visit on August 26, 2019. The Nursing Home Administrator confirmed in an interview on January 31, 2025, at 10:38 AM there was no evidence Resident 20 had services	F 0791		

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F 0791 SS=E	Continued from page 77 coordinated to see a dentist since 2019. Facility staff provided an email notification with the facility's dental provided dated January 30, 2025, indicating Resident 20 was added to the list to be seen with the next dentist visit to the facility, after it was brought to the facility staff's attention. 483.55(b)(1)(3)(5) Routine/emergency Dental Services Previously cited deficiency 1/26/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0842 SS=D		F 0842		

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F 0842 SS=D	Continued from page 78 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	The order for resident 108 was discontinued and replaced with an appropriate order. A house audit of current resident's medications will be completed to ensure that all medication is available. Nursing staff will be re-educated on the importance of accurate documentation. The DON or designee will complete weekly audits of 5 residents x8 weeks to ensure that resident medications are available and the medical record has accurate documentation of the medication administration. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0842 SS=D	Continued from page 79 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 80 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 81 Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate clinical documentation for one of 23 residents reviewed (Resident 108). Findings include: Physician orders for Resident 108 revealed an order for a Prenatal Oral Tablet (6.75-0.2 milligrams), prenatal vitamin with ferrous fumarate-folic acid (a multivitamin that contains different concentrations of vitamins and minerals), give one table by mouth in the afternoon. Review of the Medication Administration Record (MAR) for Resident 108 for January 2025, revealed the Prenatal Oral Tablet was documented by staff as being administered on January 4-9, 13, 17, 19, 21-29, 2025. Clinical documentation for Resident 108 revealed the following MAR notes regarding the Prenatal Oral Tablet:	F 0842		

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F 0842 SS=D	Continued from page 82 January 11, 2025, at 11:13 AM: "This medication is not available to give; we do not carry this as house stock. FYI (for your information) to doctor was written to switch this medication to multi-vitamin with minerals instead. RN (registered nurse) aware." January 12, 2025, at 1:31 PM: "Medication not available to give- not available as house stock. Doctor notified to switch medication to a multivitamin with minerals. RN aware." January 14, 2025, at 12:46 PM: "Not available from pharmacy. Will call to see when it will be delivered. MD (physician) aware." January 15, 2025, at 1:16 PM: "Medication is not available to give, FYI was written to doctor for a substitution, and RN was made aware." January 16, 2025, at 1:15PM: "Medication not available to give. Not available as house stock. RN and MD were made aware to switch to	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

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F 0842 SS=D	Continued from page 83 multivitamins with minerals." January 20, 2025, at 12:21 PM: "Medication is not available to give. Medication is not available in-house stock. MD has been made aware to switch medication to a multivitamin. RN was notified also." Multiple facility staff documented the medication as administered for Resident 108 on the above days while other staff noted the medication was unavailable for administration. The above information for Resident 108 was reviewed with the Nursing Home Administrator and Director of Nursing on January 29, 2025, at 1:45 PM. Further review of the MAR for Resident 108 revealed the Prenatal Oral Tablet was discontinued on January 29, 2025, at 2:52 PM (after the surveyor spoke to the facility) and an order was placed on the same date for Multivitamin-Minerals Oral Tablet (Multiple Vitamins with Minerals) give	F 0842		

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MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204 SELINSGROVE, PA 17870**

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F 0842 SS=D	Continued from page 84 one tablet by mouth one time a day. A follow-up interview on January 31, 2025, at 2:25 PM with Employee 13, licensed practical nurse, revealed that the above information for Resident 108 was due to a "documentation issue" and the order was not previously changed in the electronic health record. 28 Pa. Code 211.5(i) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0842		
F 0883 SS=D		F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 85 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	The facility offered Pneumococcal vaccinations to residents 85, 21, and 53. The facility will offer the Pneumococcal vaccinations to all eligible current residents and document acceptance and refusals. The facilities infection preventionist will receive education on the facilities "Pneumococcal vaccine" policy. The DON or designee will audit newly admitted residents to ensure a pneumococcal vaccine is offered to eligible residents with 30 days of admission. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

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F 0883 SS=D	Continued from page 86 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 87 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide recommended pneumococcal immunizations for three of five residents reviewed for immunizations (Resident 21, 53, and 85). Findings include: The policy entitled "Pneumococcal Vaccine," last reviewed December 16, 2024, indicates that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine, and when indicated, will be offered the vaccine within 30 days of admission. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with the current CDC (Center for Disease Control and Prevention) recommendations at the time of the vaccinations. Review of Resident 21's clinical record revealed that the facility admitted her on June 20, 2021. Documentation in Resident 21's clinical record	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 88 revealed that she received a pneumococcal vaccine (Prevnar 13) prior to her admission in 2016. According to the CDC guidance entitled "Pneumococcal Vaccination Timing" dated April 1, 2022, Resident 21's pneumococcal vaccinations would not be complete until she received a PPSV23 or Pneumovax one year after she received her Prevnar 13. There was no documented evidence to indicate that the facility offered Resident 21 an updated pneumococcal vaccination. Review of Resident 53's clinical record revealed that the facility admitted him on October 18, 2022. There was no documented evidence in Resident 53's clinical record to indicate that the facility determined his eligibility to receive a pneumococcal vaccine or offered the vaccine within 30 days of admission. Review of Resident 85's clinical record revealed that the facility admitted her on August 18, 2024. Documentation in Resident 85's clinical record revealed that she received a pneumococcal vaccine	F 0883		

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F 0883 SS=D	Continued from page 89 (PPSV23 or Pneumovax) prior to her admission to the facility on July 1, 2008. According to the CDC guidance entitled "Pneumococcal Vaccination Timing" dated April 1, 2022, Resident 85's pneumococcal vaccinations would not be complete until she received a PCV15 or PCV20 one year after she received her PPSV23. There was no documented evidence to indicate that the facility offered Resident 85 an updated pneumococcal vaccination. Interview with Employee 1, infection control preventionist, on January 31, 2025, at 10:33 AM confirmed the above findings for Resident 21, 53, and 85. 483.80(d) Influenza and Pneumococcal Immunizations Previously cited 1/26/24 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management	F 0883		

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F 0883 SS=D	Continued from page 90 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		
F 0887 SS=E	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;	F 0887	The facility offered Covid vaccinations to residents 4, 16, 21, 53, 85, and to staff member 12. The facility will screen employees and current residents for Covid vaccine eligibility and offer the vaccine or educate on the risks and benefits. The facilities infection preventionist will receive education on the facilities "Covid 19 Vaccine" policy. The DON or designee will audit new hires and newly admitted residents to ensure a covid vaccine is offered to eligible persons and provide them or their responsible party with education regarding its risks and benefits. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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F 0887 SS=E	Continued from page 91 (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887		

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F 0887 SS=E	Continued from page 92	F 0887		

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F 0887 SS=E	Continued from page 93 Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were educated, offered, and received the COVID-19 vaccine if they consented for five of five residents reviewed for immunizations (Residents 4, 16, 21, 53, and 85) and failed to screen, educate, and offer the COVID-19 vaccine for one of one employee reviewed (Employee 12). Findings include: The policy entitled, "COVID-19 Vaccine, Resident," last reviewed on December 16, 2024, indicates that residents or their representatives will be educated about and offered the COVID-19 vaccine. The vaccines will be offered to residents per CDC (Centers for Disease Control and Prevention) and/or FDA (Food and Drug Administration) guidelines unless such an immunization is medically contraindicated, the individual has already been immunized during this time or the individual refuses to receive the vaccine.	F 0887		

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F 0887 SS=E	Continued from page 94 The policy entitled "COVID-19 Vaccine, Staff," last reviewed on December 16, 2024, indicates that employees will be offered the COVID-19 vaccine in accordance with state and local health departments and the CDC. The facility will screen new employees to determine their eligibility, offer the COVID-19 vaccine, and provide education including the risks and benefits of the vaccine. The CDC (Centers for Disease Control) recommendations for COVID-19 vaccines (https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf) indicate that for people 65 years of age and older should have one additional dose administered at least eight weeks following the last recommended dose of 2023-24 COVID-19 Vaccine. Review of Resident 4's clinical record revealed that her last COVID-19 vaccine was provided on November 10, 2022. There was no documented	F 0887		

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F 0887 SS=E	Continued from page 95 evidence that the facility offered Resident 4 or her responsible party an updated COVID-19 vaccine or provided education regarding its risks and benefits. Review of Resident 16's clinical record revealed that her last COVID-19 vaccine was prior to her admission to the facility in 2022. There was no documented evidence that the facility offered Resident 16 or her responsible party an updated COVID-19 vaccine or provided education regarding its risks and benefits. Review of Resident 21's clinical record revealed that her last COVID-19 vaccine was provided on February 16, 2023. There was no documented evidence that the facility offered Resident 21 or her responsible party an updated COVID-19 vaccine or provided education regarding its risks and benefits. Review of Resident 53's clinical record revealed that his last COVID-19 vaccine was provided on	F 0887		

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F 0887 SS=E	Continued from page 96 February 16, 2023. There was no documented evidence that the facility offered Resident 53 or his responsible party an updated COVID-19 vaccine or provided education regarding its risks and benefits. Review of Resident 85's clinical record revealed that the facility admitted her on August 18, 2024. There was no documented evidence that the facility obtained a COVID-19 vaccination history, offered Resident 85 the COVID-19 vaccine, or provided education regarding its risks and benefits. Review of Employee 12's, registered nurse, personnel record revealed that she was hired on September 17, 2024. There was no documented evidence to indicate that the facility screened Employee 12 for eligibility of the vaccine, offered the vaccine, or educated her about the risks and benefits of the vaccine. Interview with Employee 1, infection control preventionist, on January 31, 2025, at 10:33 AM	F 0887		

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F 0887 SS=E	Continued from page 97 confirmed the above findings for Residents 4, 16, 21, 53, 85, and for Employee 12. 483.80(d)(3) COVID-19 Immunization Previously cited 1/26/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0887		

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P 1700	Prevention, control and surveillance of tuber (b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. This REGULATION is not met as evidenced by:	P 1700	The facility cannot retroactively obtain a TB result for employee 3. A TB result has since been obtained. A review of current employees hired within the last 6 months was completed to ensure that each had obtained the appropriate TB results prior to beginning employment. The HR Coordinator and representatives from the facilities contracted partners will be educated on ensuring TB surveillance and pre-employment screening. The Administrator or designee will complete audits of all new hires to ensure that each receives the appropriate TB screening prior to employment. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: 040302	51 ROUTE 204 SELINSGROVE, PA 17870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1700	Continued from page 1 Based on review of select personnel records and staff interview, it was determined that the facility failed to implement pre-employment screening procedures for tuberculosis (TB) for one of five newly hired employees reviewed (Employee 3). Findings include: The Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/tb-healthcare-settings/hcp/screening) last updated December 15, 2023, stipulates that all U.S. health care personnel should be screened for TB upon hire (i.e., preplacement) by either a TB blood test or a two-step TB skin test. Information from the baseline individual TB risk assessment should be used to interpret the results of a TB blood test or TB skin test given upon hire (i.e., preplacement). Health care personnel with a positive TB test result should receive a symptom evaluation and a chest x-ray to rule out TB disease. If a previous documented negative TB results in less than 12 months before new employment is provided	P 1700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

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P 1700	Continued from page 2 only a single test is required. Review of Employee 3's, Occupational Therapist, personnel file revealed the facility hired the employee on October 28, 2024. Further review revealed Employee 3 provided evidence of a negative QuantiFERON Gold blood test dated December 20, 2023. There was no evidence any further testing (one-step, blood test, or chest x-ray) was completed prior to Employee 3's employment at the facility. The Nursing Home Administrator confirmed the above findings in an interview on January 31, 2025, at 1:06 PM.	P 1700		
P 5520		P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: 00 B. WING:	02/04/2025

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P 5520	Continued from page 3 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot retroactively correct past Nursing aide ratios. The facility will continue to take measures to adequately provide nurse-aid staff to ensure the needs of the residents are met. Measures will be put in place to adequately provide staff with the required nurse aide to resident ratios. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will educate minimum staffing ratios to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The Director of Nursing/designee will audit the daily schedules 5x week x 6 weeks to ensure that the minimum number of nurse aide staff to resident ratios have been scheduled. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: __00_____ B. WING: _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204 SELINSGROVE, PA 17870**

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P 5520	Continued from page 4 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents during the day shift for three of the 21 days reviewed; a minimum of one NA per 11 residents during the evening shift for two of the 21 days reviewed; and one NA per 15 residents during the overnight shift for nine of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility for the dates of December 29, 2024, through January 4, 2025; January 12 through 18, 2025; and January 24 through 30, 2025, revealed the following NAs scheduled for the resident census: Day shift (requires one NA per 10 residents): December 29, 2024, 10 NAs for a census of 115, requires 11.50 NAs January 4, 2025, 10.57 NAs for a census of 114, requires 11.40 NAs	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: __00_____ B. WING: _____	02/04/2025

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MANOR AT PENN VILLAGE, THE	**51 ROUTE 204 SELINSGROVE, PA 17870**
STATE LICENSE NUMBER: **040302**	

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P 5520	Continued from page 5 January 29, 2025, 8.93 NAs for a census of 110, requires 11.0 NAs Evening shift (requires one NA per 11 residents): December 29, 2024, 8.80 NAs for a census of 115, requires 10.45 NAs January 3, 2025, 8.40 NAs for a census of 110, requires 10 NAs Night shift (requires one NA per 15 residents): December 29, 2024, 7.20 NAs for a census of 115, requires 7.67 NAs December 30, 2024, 6.67 NAs for a census of 113, requires 7.53 NAs January 1, 2025, 5.20 NAs for a census of 111, requires 7.40 NAs January 2, 2025, 6.93 NAs for a census of 111, requires 7.40 NAs January 3, 2025, 6.40 NAs for a census of 110, requires 7.33 NAs January 12, 2025, 6.40 NAs for a census of 116,	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204** **SELINSGROVE, PA 17870**

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P 5520	Continued from page 6 requires 7.73 NAs January 13, 2025, 7.20 NAs for a census of 116, requires 7.73 NAs January 16, 2025, 6.40 NAs for a census of 113, requires 7.53 NAs January 17, 2025, 6.80 NAs for a census of 112, requires 7.47 NAs The surveyor reviewed the above concerns during an interview with the Nursing Home Administrator and the Director of Nursing on January 30, 2025, at 1:45 PM.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility cannot retroactively correct past LPN ratios. The facility will continue to take measures to adequately provide LPN staff to ensure the needs of the residents are met. Measures will be put in place to adequately provide staff with the required LPN to resident ratios. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will educate minimum staffing ratios to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The Director of Nursing/designee will audit the daily schedules 5x week x 6 weeks to ensure that the minimum number of LPN staff to resident ratios have been scheduled. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395172	A. BLDG: __00_____ B. WING: _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: 040302	51 ROUTE 204 SELINSGROVE, PA 17870

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P 5530	Continued from page 8 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one LPN per 40 residents during the overnight shift for one of the 21 days reviewed: Findings include: A review of nursing care hours provided by the facility for the dates of December 29, 2024, through January 4, 2025; January 12 through 18, 2025; and January 24 through 30, 2025, revealed the following LPNs scheduled for the resident census: Overnight shift (requires one LPN per 40 residents): January 28, 2025, 2.63 LPNs for a census of 109, requires 2.73 LPNs Interview with Employee 5, scheduler, on January 31, 2025, at 11:10 AM confirmed that there was an LPN shortage on the overnight shift of January 27 into 28, 2025, as noted above.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MANOR AT PENN VILLAGE, THE STATE LICENSE NUMBER: **040302**	**51 ROUTE 204 SELINSGROVE, PA 17870**

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P 5530	Continued from page 9 The surveyor reviewed the above concerns during an interview with the Nursing Home Administrator on January 31, 2025, at 11:30 AM.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 10 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility cannot retroactively correct past PPD staffing levels. The facility will continue to take measures to adequately provide nursing staff to ensure the needs of the residents are met. Measures will be put in place to adequately provide staff. These measures include, continuing our retention committee, increased advertising efforts, utilization of agency staff, and sign on bonuses. The Director of Nursing/designee will educate ppd staffing levels to RN Supervisors, HR, and the nursing scheduler who are responsible to maintain adequate staffing ratios. The Director of Nursing/designee will audit the daily schedules 5x week x 6 weeks to ensure that the minimum PPD staffing levels have been scheduled. The results of the audits will be reviewed at the facilities QAPI meeting for recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/18/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 11 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure that the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient per day (PPD), effective July 1, 2024, for 10 of 21 days reviewed. Findings include: A review of nursing care hours provided by the facility for the dates of December 29, 2024, through January 4, 2025; January 12 through 18, 2025; and January 24 through 30, 2025, revealed that the facility failed to meet the minimum hours PPD for the following days: December 29, 2024, hours PPD 2.91 January 1, 2025, hours PPD 3.01 January 2, 2025, hours PPD 3.15 January 3, 2025, hours PPD 3.09 January 4, 2025, hours PPD 3.01 January 12, 2025, hours PPD 3.16 January 16, 2025, hours PPD 3.15	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 12 January 18, 2025, hours PPD 3.18 January 27, 2025, hours PPD 3.11 January 29, 2025, hours PPD 2.96 The surveyor reviewed the above concerns during an interview with the Nursing Home Administrator and the Director of Nursing on January 30, 2025, at 1:45 PM.	P 5640		

Certified End Page

MANOR AT PENN VILLAGE, THE

STATE LICENSE NUMBER: 040302

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY