STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395422	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNKNOLL VILLAGE STATE LICENSE NUMBER: **680602**	**208 PENNKNOLL ROAD** **EVERETT, PA 15537**

(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 complaint survey completed on January 15, 2025, it was determined that Pennknoll Village was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

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 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Feeding pump, over bed table and stethoscope cleaned at time of survey 2. All feeding pumps were identified and cleaned. 3. The Director of Nursing/Designee will educate staff on- Cleaning and disinfecting resident care items. 4. Residents with feeding pumps will have audits completed for cleanliness of pumps and equipment 5x per week x2 weeks, then weekly x4 and monthly x1. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Committee for additional oversight. 1. Maintenance notified of wall scratches needing repair- Wall repaired. 2. Review completed of resident rooms to identify any other walls in need of repair.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	3. The Director of Nursing/Designee will educate staff on Maintenance policy and maintenance request forms and document education. 4. Mock surveyors will monitor walls in resident rooms x5 per week x 2 weeks, then weekly x4, then Monthly x1. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Committee for additional oversight.	

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F 0584 SS=D	Continued from page 3 Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in resident rooms for two of 30 residents reviewed (Residents 5, 29). Findings include: The facility's policy, dated March 18, 2024, indicated that resident care equipment, including durable medical equipment, will be kept clean, and resident rooms will be maintained in such a way as to present a homelike appearance. Observations of Resident 5 on January 12, 2025, at 12:10 p.m. and January 14, 2025, at 2:03 p.m. revealed that the resident was lying in her bed with a feeding pump (machine that administers liquid nutrition) running at 50cc/hr. The feeding pump had a moderate amount of a light brown, sticky substance on the front and back, and the resident's overbed table top had two areas measuring approximately one inch by two inches of a yellowish/white removable substance. In addition, a	F 0584		

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F 0584 SS=D	Continued from page 4 red stethoscope dangling from the feeding pump was observed to have a large amount of a bright white, dried substance on it. Interview with Licensed Practical Nurse 1 and the Director of Nursing on January 14, 2025, at 1:06 p.m. and 1:10 p.m., respectively, confirmed that Resident 5's feeding pump, bedside stand, and stethoscope should have been clean, and they were not. Observations in Residents 29's room on January 12, 2025, at 11:30 a.m. revealed that the wall behind the resident's bed had multiple scratches, cuts, and nicks in it. Interview with the Maintenance Director on January 15, 2025, at 11:46 a.m. confirmed that Resident 29's room needed repaired and painted. 28 Pa. Code 207.2(a) Administrator's Responsibility.	F 0584		

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F 0585 SS=E		F 0585		

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F 0585 SS=E	Continued from page 6 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	1. Action to immediately correct the appearance and palatability of food was not possible retroactively. The Dietary Manager/designee will monitor the temperature and palatability of food serve. 2. Grievances in the last 30 days will be reviewed by the Executive Director (ED) to ensure ongoing efforts to resolve grievances. 3. The Executive Director reeducated the Social Services Director and Department Managers on the facility's grievance guidelines and time frames for resolution. 4. The ED/ designee to conduct Quality Improvement (QI) monitoring of regulation deficiency of 585 to ensure ongoing efforts to resolve grievances including dietary complaints. Monitor conducted via weekly grievance reviews times 4 weeks. The Dietary Manager/designee to conduct weekly meetings with the residents who choose to attend, to monitor the overall satisfaction of the food served weekly X 4 weeks, biweekly X 1 months, then monthly as	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0585 SS=E	Continued from page 7 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	needed. Findings reported to the Quality Improvement Performance Improvement committee and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 0585 SS=E	Continued from page 8 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 9 Based on review of facility policy and Food Committee meeting minutes, and resident and staff interviews, it was determined that the facility failed to make ongoing efforts to resolve resident grievances regarding cold food. Findings include: The facility's policy regarding food quality and palatability, dated March 18, 2024, revealed that food will be palatable, attractive, and served at a safe and appetizing temperature. Food Committee meeting minutes for January through August 2024 and October through December 2024 indicated that the residents were receiving cold food. A meeting with a group of residents on January 13, 2025, at 11:15 a.m. revealed that the residents have been served food that was cold and unpalatable. They stated that they have requested food that is	F 0585		

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F 0585 SS=E	Continued from page 10 served at the correct temperature. They stated that this had been occurring for at least one year. Interview with Director of Dietary on January 14, 2025, at 12:14 p.m. confirmed that she was aware that residents complained about cold food, and that it was brought up during the Food Committee meetings. She stated that she did not address the issue because the food that was temped in the kitchen was at the correct temperatures. 28 Pa. Code 201.29(i) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Service.	F 0585		
F 0607 SS=D		F 0607		

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F 0607 SS=D	Continued from page 11 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. Resident 28 currently reside in the facility and is safe for overall well-being. Nurse Aide 3 has been terminated on 11/4/2024. Registered Nurse 2's professional licensure verification with the Pennsylvania State Board of Nursing had been completed on 1/13/2025. 2. On 2/3/2025, Nursing Home Administrator and Director of Nursing began re-education for all staff on abuse policy including procedure for reporting abuse, neglect, and resident rights. On 2/6/2025, In-service education began for all staff by the Social Services Director on abuse policy including procedure for reporting abuse, neglect, and resident rights. 3. Measures / systemic changes made to ensure that the deficient practice will not recur. Quarterly training will be conducted by Social Worker for staff on abuse, neglect, and resident rights. Training for all staff on abuse, neglect, and resident rights to include reporting of abuse and neglect for newly hired employees.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0607 SS=D	Continued from page 12 This REQUIREMENT is not met as evidenced by:	F 0607	4. Social Services Director will complete resident interviews for abuse monitoring with interview able residents weekly X 4 weeks, then monthly X 3 months then quarterly thereafter. Social Services Director will complete resident observation for indicators of abuse for residents considered non-interview able weekly X 4 weeks, then monthly X 3 months then quarterly thereafter. 5. Resident interviews for abuse monitoring will be reviewed by Nursing Home Administrator weekly X 4 weeks, then monthly X 3 months then quarterly thereafter. Facility plans to monitor performance to make sure solutions are sustained. 6. The Nursing Home Administrator will report all findings of resident interviews for abuse monitoring to the Quality Assurance and Performance Committee monthly for a minimum of 3 months.	

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F 0607 SS=D	Continued from page 13 Based on a review of policies, clinical records, personnel files, and investigative reports, as well as interviews with staff, it was determined that the facility failed to ensure that the abuse policy was followed for one of 30 residents reviewed (Resident 28), and failed to complete a professional licensure verification with the Pennsylvania State Board of Nursing prior to hire for one of four employees reviewed (Registered Nurse 1). Findings include: The facility's abuse policy, dated March 18, 2024, indicated that no employee may at any time commit an act of physical, psychological, or emotional abuse; neglect; mistreatment and/or misappropriation of property against any resident, and persons applying for employment with the center will be screened for a history of abuse, neglect, exploitations, or misappropriation of resident property, including but not limited to employment history, criminal background check,	F 0607		

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F 0607 SS=D	Continued from page 14 abuse check with appropriate licensing board and registries prior to hire, and licensure or registration verification prior to hire. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 28, dated November 25, 2024, revealed that the resident was cognitively intact and was dependent on staff for all daily care needs. Investigation documents provided by the facility for Resident 28, dated October 31, 2024, revealed that on October 31, 2024, Nurse Aide 3 was overheard telling Resident 28 to "shut up." The facility determined that Nurse Aide 3 did tell the resident to "shut up" and was subsequently terminated. Interview with the Director of Nursing on January 14, 2025, at 11:04 a.m. revealed that Nurse Aide 3 did not follow the facility's abuse policy when she told Resident 28 to "shut up."	F 0607		

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F 0607 SS=D	Continued from page 15 The personnel file for Registered Nurse 2 revealed that she was hired on September 10, 2024, and as of January 13, 2025 (four months after hire) a professional licensure verification with the Pennsylvania State Board of Nursing had not been completed. Interview with Director of Human Resources on January 15, 2025, at 2:47 p.m. confirmed that there was no documented evidence to indicate that Registered Nurse 2's professional licensure was verified with the State Board of Nursing prior to the nurse's hire date. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0607		
F 0623 SS=D		F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395422	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNKNOLL VILLAGE STATE LICENSE NUMBER: **680602**	**208 PENNKNOLL ROAD** **EVERETT, PA 15537**

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F 0623 SS=D	Continued from page 16 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. The facility cannot retroactively perform notifications for residents Transferred/Discharged. 2. Will review the past 2 weeks of hospital discharges for notification. 3. The Director Of Nursing/Designee will educate Licensed staff on-Transfer/Discharge Notification and Right to Appeal and document education. 4. Audits of notifications and documentation to be completed on residents Transferred/Discharged to the hospital 5x per week x2 weeks, Weekly x4 and Monthly x1. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Committee for additional oversight.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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 0623 SS=D	Continued from page 17 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=D	Continued from page 18 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 19 Based on review of facility policy and clinical record reviews, and staff interviews, it was determined that the facility failed to notify the resident, responsible party, and Ombudsman, in writing, regarding the reason for hospitalization for two of 30 residents reviewed (Residents 68, 70). Findings include: The facility policy for Transfer/Discharge Notification, dated March 18, 2024, revealed that before a resident is transferred or discharged, the facility will notify the resident and resident representative of the transfer or discharge and the reason for the move in writing and will send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 68, dated November 7, 2024, indicated that the resident was cognitively intact and required assistance from staff	F 0623		

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 0623 SS=D	Continued from page 20 for daily care needs. A nursing note for Resident 68, dated October 28, 2024, at 3:42 a.m. revealed that the resident complained of difficulty breathing. Despite interventions she continued to have difficulty breathing and requested to go to the emergency department, and she was transferred to the hospital. There was no documented evidence that a written notice of Resident 68's transfer to the hospital was provided to the resident's responsible party and the Ombudsman regarding the reason for transfer. A quarterly MDS assessment for Resident 70, dated November 14, 2024, indicated that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note for Resident 70, dated April 3, 2024, at 10:40 p.m., revealed that the resident had a fall from her chair and had a bleeding laceration to	F 0623		

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 0623 SS=D	Continued from page 21 the back of her head, and she was transferred to the hospital. There was no documented evidence that a written notice of Resident 70's transfer to the hospital was provided to the resident's responsible party and the Ombudsman regarding the reason for transfer. Interview with the Nursing Home Administrator on January 15, 2025, at 9:41 a.m. confirmed that the facility did not provide a written notice to the residents, the residents' responsible parties, or the Ombudsman when Residents 68 and 70 were transferred to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0623		
F 0625 SS=D		F 0625		

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F 0625 SS=D	Continued from page 22 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. The facility cannot retroactively notify of Bed Hold policy. 2. Will review the last 2 weeks of hospital transfers for bed hold notification. 3. The Director of Nursing/Designee will educate licensed staff on- Bed Hold Policy and procedure and document education. 4. Audits of notifications will be completed on residents transferred out of facility to hospital 5x per week x2 weeks, Weekly x4, and Monthly x1. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Committee for additional oversight.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0625 SS=D	Continued from page 23	F 0625		

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F 0625 SS=D	Continued from page 24 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that appropriate parties were notified about the facility's bed-hold policy upon transfer to the hospital for two of 30 residents reviewed (Residents 68, 70). Findings include: The facility policy for Bed Hold Notice, dated March 18, 2024, revealed that in accordance with state and federal law the facility provides written notice of its bed-hold information to each resident and resident representative. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 68, dated November 7, 2024, indicated that the resident was cognitively intact and required assistance from staff for daily care needs.	F 0625		

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F 0625 SS=D	Continued from page 25 A nursing note for Resident 68, dated October 28, 2024, at 3:42 a.m., revealed that the resident complained of difficulty breathing. Despite interventions she continued to have difficulty breathing and requested to go to the emergency department, and she was transferred to the hospital. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 68. A quarterly MDS assessment for Resident 70, dated November 14, 2024, indicated that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note for Resident 70, dated April 3, 2024, at 10:40 p.m., revealed that the resident had a fall from her chair and had a bleeding laceration to the back of her head, and she was transferred to the hospital.	F 0625		

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F 0625 SS=D	Continued from page 26 There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 70. Interview with the Nursing Home Administrator on January 15, 2025, at 9:41 a.m. confirmed that there was no documented evidence that a bed-hold notice was issued to Residents 68 and 70 or their responsible parties and there should have been. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.	F 0625		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 27 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. The identified right heel care plan resolved at time of survey. 2. Facility pressure ulcer care plans reviewed for goal dates or need of resolution. 3. The Director Of Nursing/Designee will educate licensed staff on- Plan of Care Policy and document education. 4. Audits will be completed of care plans on residents with pressure ulcers for goal dates to review and update plan of care weekly x 8 weeks.. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Committee for additional oversight.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0657 SS=D	Continued from page 28 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for one of 30 residents reviewed (Resident 29). Findings include: The facility's policy regarding care plans, dated March 18, 2024, indicated that an individualized person-centered plan of care will be established by the interdisciplinary team with the resident or resident representative to the extent practicable and will be updated in accordance with state and federal regulatory requirements. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated December 14, 2024, revealed that she was cognitively impaired, was dependent on staff for activities of daily living, and had a diagnoses that included dementia and high	F 0657		

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F 0657 SS=D	Continued from page 29 blood pressure. A consult note for Resident 29 from the wound doctor, dated January 7, 2025, revealed that the consultant company was signing off on the resident and that she has no open wounds at this time. The current care plan for Resident 29, dated July 9, 2024, revealed that the resident has pressure ulcer to right heel. Interview with the Director of Nursing on January 15, 2025 at 12:49 p.m. confirmed that Resident 29's pressure ulcer was healed and that her care plan should have been discontinued. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0679 SS=D		F 0679		

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F 0679 SS=D	Continued from page 30 483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	1. Minimum Data Set (MDS) department will conduct a thorough review of all resident assessments to accurately identify individual interests, abilities, and needs. Activities Director will update all activities care plans to reflect specific activity preferences and goals for each resident. 2. Activities Director will update all activities care plans to reflect specific activity preferences and goals for each resident. 3. Executive Director will educate the Activities Director to develop a diverse and engaging activities calendar that caters to a variety of interests, including physical, cognitive, social, and spiritual needs. Incorporate resident input through suggestion boxes, resident council meetings, and individual discussions. As well as to design activities with varying levels of intensity to accommodate different abilities. 4. Activities Director/Designee to conduct Quality Improvement (QI) monitoring of regulation deficiency	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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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 0679 SS=D	Continued from page 31	F 0679	of 679 to ensure residents engage in activities programs that involve with residents' interests and abilities 5X a week for 4 weeks, then monthly. Findings to be reported to the Quality Improvement Performance Improvement (QAPI) committee meeting and updated as indicated. QI schedule modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395422	A. BLDG: __00_____ B. WING: _____	01/15/2025

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F 0679 SS=D	Continued from page 32 Based on clinical record reviews and resident and staff interviews, it was determined that the facility failed to provide adequate, ongoing activities designed to meet the needs of residents for seven of 30 residents reviewed (Residents 3, 14, 20, 24, 36, 63, 66). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated December 6, 2024, indicated that the resident was cognitively intact and was dependent on staff for daily care needs, and that it was very important for the resident to be provided with books to read, be involved in group activities, participate in favorite activities, and participate in religious activities. A quarterly MDS assessment for Resident 14, dated December 11, 2024, indicated that the resident was cognitively intact and dependent on	F 0679		

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F 0679 SS=D	Continued from page 33 staff for daily care needs, and that it was very important for the resident to listen to music, participate in favorite activities, go outside when the weather is nice, and participate in religious activities. A quarterly MDS assessment for Resident 20, dated December 30, 2024, indicated that the resident was cognitively intact, required partial assistance from staff for daily care needs, and that it was very important for the resident to listen to music, be around animals, participate in favorite activities, go outside when the weather is nice, and participate in religious activities. A quarterly MDS assessment for Resident 24, dated December 1, 2024, indicated that the resident was cognitively intact, required maximum assistance from staff for daily care needs, and that it was very important for the resident to listen to music, participate in favorite activities, and go outside when the weather is nice. A quarterly MDS assessment for Resident 36,	F 0679		

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F 0679 SS=D	Continued from page 34 dated December 21, 2024, indicated that the resident was cognitively intact, was dependent on staff for daily care needs, and that it was very important for the resident to be able to have books to read, listen to music, keep up with the news, do activities with groups of people, and participate in favorite activities. A quarterly MDS assessment for Resident 63, dated December 19, 2024, indicated that the resident was cognitively impaired, was independent with daily care needs, and that it was very important for the resident to participate in favorite activities, do actives in groups of people, and participate in religious activities. An annual MDS assessment for Resident 66, dated November 8, 2024, indicated that the resident was cognitively intact, was dependent on staff for all care needs, and that it was very important for the resident to listen to music, do activities with groups of people, participate in favorite activities, and to go outside when the weather is nice.	F 0679		

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F 0679 SS=D	Continued from page 35 Resident council meeting minutes from January 2025 revealed that the residents were upset because activity hours were cut and they did not have as many activities, and they wanted them back. A review of the activity calendars for October and November 2024 revealed that the residents had three to four activities per day during the week and three activities per day on the weekends. Activity calendars for December, 2024 and January 2025 revealed that the residents had two to three activities during the weeks and two activities on the weekends. Sunday activities were Sunday social and church. Observations of the Sunday Social activity on January 12, 2025, in the activities room consisted of residents sitting around a table, there were no refreshments provided, and residents were quiet and spoke very little. An interview with a group of Residents on January	F 0679		

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F 0679 SS=D	Continued from page 36 13, 2025, at 11:15 a.m. revealed that the residents would like more activities. They stated that two of the activity aides were recently let go, and their activities have been cut in half. They would like more bingo, music, and religious activities. Their bingo is very important to them because they get points during bingo, and they are allowed to purchase items with those points. The residents stated that some residents do not have family who can bring them special items, and by cutting bingo back these residents are no t able to get these items. They stated they only have half as many activities during the week and very little on weekends. Interview with Resident 66 on January 15, 2025, at 1:45 p.m. revealed that she was upset that bingo was decreased and that church during the week was cut. She stated, "What do they want us to do, stare at the walls like we are in a prison? The activities are the only things we have to do here." Interview with the Activity Director on January 13, 2025, at 12:41 p.m. revealed that two activity staff	F 0679		

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F 0679 SS=D	Continued from page 37 were recently let go, and that her hours were cut back. She stated that she was aware the residents were requesting more activities like bingo, music, and church, but it is difficult to schedule them with the cut in her hours and the loss of activites staff. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0679		
F 0684 SS=E		F 0684		

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 0684 SS=E	Continued from page 38 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. The facility cannot retroactively correct Medication Administration Record (MAR). Physician updated on blood sugar readings and interventions of identified resident. 2. Charts of residents receiving routine blood sugar checks reviewed for notification parameters. 3. The Director Of Nursing/Designee will educate licensed staff on Physician orders and Administering Medications Policy and document education. 4. Audits of medication administration records to confirm signatures on 5 residents 5x per week x2 weeks, weekly x4. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Improvement Committee for additional oversight. Audits of 5 residents receiving blood sugar checks for	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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 0684 SS=E	Continued from page 39	F 0684	documentation of notifications per physician orders 5x per week x2 weeks, Weekly x4. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Improvement Committee for additional oversight.	

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F 0684 SS=E	Continued from page 40 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 30 residents reviewed (Residents 40, 53). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40, dated November 13, 2024, revealed that the resident was cognitively intact, was independent with daily care needs, had diagnoses that included high blood pressure, diabetes, and Parkinson's. Current physician's orders for Resident 40 included orders for the resident to receive 10 milligrams of Cetirizine at bedtime every Monday and Thursday for allergies, 100 micrograms of Synthroid daily for hypothyroidism (when the thyroid gland does not make enough thyroid hormones), 17 grams of	F 0684		

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F 0684 SS=E	Continued from page 41 Miralax daily for constipation, 30 milligrams of Diltiazem twice a day for high blood pressure, and 500 milligram of Tylenol twice a day for left knee pain. A review of Resident 40's Medication Administration Records (MAR's) for December 2024 revealed no documented evidence that the medications were administered as ordered on December 3, 9, 10, 12, 16, 18, 21, and 24, 2024. Interview with Resident 40 on January 14, 2025, at 11:41 a.m. revealed that he has not been receiving his medications per the physician orders. An interview with the Director of Nursing on January 14, 2025, confirmed that Resident 40's MAR revealed no documented evidence to indicate that the medications were administered on the dates listed above. An admission MDS for Resident 53, dated	F 0684		

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F 0684 SS=E	Continued from page 42 December 3, 2024, revealed that the resident was cognitively impaired, required assistance with daily care needs, had diagnoses that included diabetes (a disease that interferes with blood sugar control), high blood pressure, and a stroke. Physician's orders for Resident 53, dated November 27, 2024, included orders for accuchecks every morning and at bedtime and to notify the physician if the blood sugar was less than 60 mg/dL or greater than 400 mg/dl. A review of the MAR for Resident 53, dated December 2024, revealed that on December 1, 2024, at 9:00 p.m. the resident's blood sugar was 32 mg/dl and on December 2, 2024, at 6:00 a.m. the resident's blood sugar was 41 mg/dl. There was no documented evidence that the physician was notified of these low blood sugars as ordered. Interview with the Director of Nursing on January 15, 2025, at 10:15 a.m. confirmed that the physician was not notified of Residents 53's low blood sugars	F 0684		

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F 0684 SS=E	Continued from page 43 mentioned above, and he should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0684		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 44 483.25(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	1. Incident report/Investigation completed at time of incident. Immediate intervention, education and Relias training given to direct staff involved. 2. Care plan and Kardexs audited on residents for transfer statuses. 3. The Director Of Nursing/Designee will educate nursing staff on- Lifting and moving residents, Transfer/Mobility evaluation Low Lift, and Low Lift program and document education. Annual education to continue per facility protocol on transferring residents. 4. Audits/Staff interviews will be completed on 3 random staff members to ensure staff knowledge of where to obtain resident transfer status information 3x weekly x 2 weeks, then weekly x 4. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Improvement Committee for	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0689 SS=D	Continued from page 45	F 0689	additional oversight.	

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F 0689 SS=D	Continued from page 46 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's transfer status was followed for one of 30 residents reviewed (Resident 68). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 68, dated November 7, 2024, revealed that the resident was cognitively intact, required two-person assistance for transfers, and had diagnoses of acute respiratory failure and muscle weakness. A nursing note for Resident 68, dated December 20, 2024, at 10:45 a.m. revealed that the resident was being transferred from the bed to a wheelchair by one nurse aide when the resident became weak and was slowly lowered to a sitting position on the floor. Resident was wearing black sneakers and	F 0689		

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F 0689 SS=D	Continued from page 47 was assessed, no injuries were found and there were no complaints of pain. Interview with the Nursing Home Administrator on January 15, 2025, at 9:41 a.m. confirmed that Resident 68 was transferred by one staff member and she should have been transferred by two staff members. 28 Pa. Code 211.10(a) Resident Care Policies. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0689		
F 0725 SS=D		F 0725		

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F 0725 SS=D	Continued from page 48 483.35(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	1. Facility unable to fix retroactively. Dining room times to be displayed along with daily meals outside of dining room. 2. Audits to be completed for each hall to obtain which residents would like to attend the dining room for meals. Dining services to be updated on current resident preference of meal location. 3. All staff will be educated on resident rights and dining room times. 4. Audit of dining room attendance will be completed 5x per week x2 weeks then weekly x 4. ED/Scheduler will review schedules 5x weekly to ensure adequate staffing to get residents to the dining room. Findings will be monitored by the Executive Director and reported to QAPI Committee for additional oversight. 5. Audit of activity attendance to be completed 5x per week x2 weeks then	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNKNOLL VILLAGE STATE LICENSE NUMBER: **680602**	**208 PENNKNOLL ROAD EVERETT, PA 15537**

(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 0725 SS=D	Continued from page 49	F 0725	weekly x 4. Findings will be monitored by the Executive Director and reported to Quality Assurance Performance Improvement Committee for additional oversight.	

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 0725 SS=D	Continued from page 50 Based on observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that there was sufficient nursing staff available to transport residents to activities and to provide licensed nursing staff in the facility's main dining area for the lunch and dinner meals. Findings include: A grievance from Resident 68, dated November 15, 2024, revealed that the resident was unable to go to activities due to nursing aides not being able to take her there. Staff were educated on the importance of ensuring residents were out of bed and transferred to their activities per each resident's preference. Review of the facility's dietary delivery times, undated, revealed that breakfast meals were to be delivered to the units from 7:00 a.m. to 8:15 a.m., lunch meals were to be delivered to the units from 12:40 a.m. to 1:00 p.m., the main dining room was to be served at 1:10 p.m., and dinner meals were to	F 0725		

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F 0725 SS=D	Continued from page 51 be delivered to the units from 5:00 p.m. to 6:15 p.m. Observations in the main dining room for lunch on January 12, 2025, at 1:02 p.m. revealed that only one resident was present (Resident 83). Interview with Resident 83 at that time revealed that he prefers to eat in the dining room and would prefer to eat dinner in the dining room too. Interview with a group of residents on January 13, 2025, at 11:15 a.m. revealed that they preferred to eat their meals in the dining room and were not aware that the dining room was open and available to eat in. They stopped going because they had to wait for long periods of time in the dining room for a nurse to get there. They were too hungry, and said they were served faster if they just ate in their rooms, so they stopped going. Interview with Licensed Practical Nurse 4 on January 13, 2025, at 12:19 p.m. confirmed that staff do not use the dining room because it is easier for them to serve the residents in their rooms rather than	F 0725		

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F 0725 SS=D	Continued from page 52 getting them all to the dining room. Interview with Dietary Manager on January 14, 2025, at 12:20 p.m. confirmed that only one resident comes to the dining room for lunch and stated the residents used to come all the time for lunch and for their monthly special breakfast. The residents really enjoyed it, but there has to be a licensed nurse in the dining room and the residents do not like waiting a long time until one is able to come. Interview with Nurse Aide 5 and Nurse Aide 6 on January 14, 2025, at 1:38 p.m. confirmed that only one resident was in the dining room for lunch, and that was because he takes himself. The other residents are served in their rooms due to staffing. They also stated that they were not able to get the residents to activities because the activity aides used to help transport the residents, but they were let go. Nurse Aides 5 and 6 said they were kept too busy with their daily care tasks.	F 0725		

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F 0725 SS=D	Continued from page 53 Interviews with Nurse Aide 7, Nurse Aide 8, and Nurse Aide 9 on January 14, 2025, at 1:49 p.m. revealed that they did not have enough staff to get their daily care tasks done. They were still showering residents at 12:00 p.m. and were not able to take all the residents to the dining hall that wanted to go. They would have to take the residents down early and they would have to wait for one to two hours. Residents are served in their rooms. Nurse Aides 7, 8, and 9 believed it was due to staffing. Nurse aides used to have help from the activity aides but they lost two of their people. Interview with Director of Nursing on January 14, 2025, at 2:46 p.m. confirmed that the dining room is open for residents for lunch and dinner. She was not sure why the residents were not using it, and Resident 68 should have been transported to the activity by the nurse aides. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0725		

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F 0725 SS=D	Continued from page 54	F 0725		
F 0730 SS=D		F 0730		

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 0730 SS=D	Continued from page 55 483.35(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	1. No residents were identified with this alleged deficient practice. 2. The Human Resource Coordinator (HRC) reviewed the employee files for Certified Nurse Aides (CNA) who have been employed for at least one year to ensure performance evaluations were completed annually. Follow up completed based on findings. 3. The Executive Director (ED) reeducated the HRC and the Director of Nursing (DON) on the facility's employee job performance evaluation policy. The HRC will notify the DON of upcoming performance evaluations so that the appropriate supervisor can ensure that they are completed in a timely manner. 4. The HRC/Designee to conduct Quality Improvement (QI) monitoring of regulation deficiency of 730 to ensure nurse aide performance evaluations were completed annually based on hire date. QI monitoring conducted via nurse aide personnel file review weekly for 8 weeks. Findings to be reported to the	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0730 SS=D	Continued from page 56	F 0730	Quality Improvement Performance Improvement (QAPI) committee meeting and updated as indicated. QI schedule modified based on findings.	

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 0730 SS=D	Continued from page 57 Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually based on hire dates for one of three nurse aides reviewed (Nurse Aide 10). Findings include: A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation for Nurse Aide 10 was due September 24, 2024. As of January 15, 2025, there was no documented evidence that the annual performance evaluation was completed as required for Nurse Aide 10. Interview with the Director of Human Resources on January 15, 2025, at 2:03 p.m. confirmed that there was no documented evidence that the annual performance evaluation for Nurse Aide 10 was completed as required.	F 0730		

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F 0730 SS=D	Continued from page 58 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(a)(c) Staff Development.	F 0730		
F 0804 SS=F		F 0804		

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 0804 SS=F	Continued from page 59 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	1. Action to immediately correct the appearance and palatability of food was not possible retroactively. 2. All residents have the potential to be affected by this issue. The Dietary Manager will observe random tray passes by completing test trays. 3. The Dietary Manager will re-educate the dietary staff on the proper food temperatures and palatability. The Dietary Manager or designee will educate dietary staff regarding the proper temperature and palatability of food procedure. 4. Nursing staff will also receive education/re-education regarding passing meal trays in a timely manner to preserve temperatures. 5. Dietary Manager will conduct test tray audits 5x weekly for 4 weeks and then monthly. Quality Assurance Performance Improvement will monitor findings.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0804 SS=F	Continued from page 60 Based on observations, as well as resident and staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures. Findings include: Review of food committee meeting minutes for 2024 revealed that the food is burnt, has been cold, and tasted bad. Interview with Resident 66 on January 12, 2025, at 10:47 a.m. indicated that the food tastes burnt and does not taste good, and it is cold at times. Interview with Resident 74 on January 12, 2025, at 1:22 p.m. indicated that the food is terrible and has no taste, there is too much pork, and it is cold. Observations of the kitchen's lunch meal tray line on January 14, 2025, revealed that it began at 12:10 p.m. and included macaroni and cheese, chicken, mashed potatoes, fruit cocktail, and coffee. The last	F 0804		

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F 0804 SS=F	Continued from page 61 tray was placed on the cart at 12:15 p.m. The cart left the kitchen and arrived on the unit at 12:16 p.m. and the last tray was removed from the cart and served at 12:27 p.m. The test tray was removed from the cart at 12:28 p.m. The macaroni and cheese was 141 degrees Fahrenheit (F), the chicken was 136.5 degrees F and dry to taste, the mashed potatoes were 136.5 degrees F and not palatable, the fruit cocktail was 61 degrees F and warm to taste, and the coffee was 138.3 degrees F. Interview with Director of Dietary on January 14, 2025, at 12:40 p.m. confirmed that the fruit cocktail was a little warmer than she liked. She stated that she had pulled it out of the refrigerator and did not put it back to keep it cold. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services.	F 0804		

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F 0807 SS=D		F 0807		

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F 0807 SS=D	Continued from page 63 483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by:	F 0807	1. Residents' drink and food preferences will be honored depending on the resident's diet order and menu's availabilities. 2. Current residents will be reviewed for completion of food preference data collection. Residents and residents' families may bring in desired food and drinks. 3. Facility do not honor tubular food as relation to a choking hazard in other facility. Facility will provide same substance of tubular food, but not in tubular forms. Company did not developed a policy in regards to the facility not serving tubular meats. 4. Dietary and Nursing staff will receive training by the Nursing Home Administrator or designee on food preferences and will be reviewed upon admission, annually and as needed. 5. The Certified Dietary Manager or designee will conduct quality review of three resident meals weekly X 4 weeks, then monthly as needed to ascertain that food preferences are being honored.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/12/2025**

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F 0807 SS=D	Continued from page 64	F 0807	6. Dietary Manager or designee to present findings of rounds/audits along with root cause analysis of any identified issues with findings to be reviewed to the Quality Assurance Performance Improvement Committee Meeting monthly for further analysis and corrective actions.	

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F 0807 SS=D	Continued from page 65 Based on observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents' drink and food preferences were honored. Findings include: Interview with a group of residents on January 13, 2025, at 11:15 a.m. revealed that they would enjoy soda, but you can only get soda now if you are sick. They have requested dippy eggs, hot dogs, sausage, kielbasa, and also asked for ice cream as a snack but were told no. One resident stated, "We have no joy in our lives, we may as well be in prison." Interview with the Dietary Manager and Nursing Home Administrator on January 14, 2025, at 1:07 p.m. revealed that she is not able to purchase any of the requested drink or snack items for residents and that everything she receives was determined by corporate. She revealed that the beverages on the menu are juices and not soda, and that with the increased cost of food there is no money left to buy	F 0807		

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F 0807 SS=D	Continued from page 66 the requested snacks such as soda and ice cream. Residents have to purchase the items themselves. She indicated that sometimes she uses her own money to buy things. The Nursing Home Administrator revealed that they do not have hot dogs because it is a choking hazard and someone choked. The Dietary Manager indicated that there is no facility policy regarding tube meat such as hot dogs being a choking hazard. 28 Pa. Code 201.29(j) Resident Rights.	F 0807		
F 0812 SS=E		F 0812		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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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 0812 SS=E	Continued from page 67 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. No specific residents were cited in deficiency of 812 on the Annual Survey. Dietary Employee 11 was educated about wearing appropriate hair and beard net. Opened containers of food products that were undated were discarded. 2. Dietary Manager to complete kitchen rounds to verify that dietary employees always have hair and beard net in the dietary kitchen's areas and confined in a hair net or cap and have facial hair properly restrained. Food is labeled, dated, stored properly and variances to be corrected. 3. Dietary Manger or designee to review labeling/dating and staff attire policy which details dietary staff to verify food is labeled, dated, and stored properly and that employees have hair off the shoulders and confined in a hair net or cap and have facial hair properly restrained. Nursing Home Administrator or designee will complete weekly kitchen tours with dietary manager to ensure compliance.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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 0812 SS=E	Continued from page 68	F 0812	4. Dietary Manager or designee to complete quality monitoring of food to assure food is labeled, dated, and stored properly and proper confinement of hair 5 X per week times 4 weeks then monthly. 5. The Dietary Manger or designee to present findings of quality monitoring at the Quality Assurance Performance Improvement Meeting monthly times one year. Quality monitoring schedule modified based on findings.	

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 0812 SS=E	Continued from page 69 Based on review facility policy, as well as observations and staff interviews, it was determined that the facility failed to store and serve food in accordance with professional standards for food service safety by failing to store and serve food under sanitary conditions. Findings include: The facility's current policy for outside food indicated that when food items are intended for later consumption the responsible facility staff member will label foods with the resident's name and current date. Frozen foods may be retained for 30 days. Observations in the main kitchen during an initial tour on January 12, 2025, at 9:17 a.m. revealed that Dietary Employee 11 was removing a cake from the cooler and his hair and beard were exposed and not covered with a hair net or beard guard. Interview with Dietary Employee 11 at that time confirmed that he should have been wearing a hair net and beard guard but he was just getting a cake out.	F 0812		

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F 0812 SS=E	Continued from page 70 Observations in the solarium refrigerator on January 12, 2025, at 9:35 a.m. revealed that the following items that had resident names but were open and undated or outdated: five pints of ice cream; one cup of ranch dressing; one cup of applesauce; two cups of butterscotch pudding; an eight-ounce glass of chocolate milk with a milk ring around the glass; one piece of pumpkin pie on a paper plate; a half full 16-ounce cup of applesauce; a Tupperware container with two deviled eggs that were turning to liquid and had a bad smell; one old stalk of celery; a plastic bag dated December 29, 2024, with spaghetti; one snack-sized Ziploc bag of moldy meat and cheese dated December 2, 2024; one hard sandwich roll in a Ziploc bag; one plate of grilled chicken breast and mashed potatoes; one four- ounce container of cottage cheese, dated November, 2024; three four-ounce containers of cottage cheese, dated December, 2024; one 1.3-ounce package of pepper snack sticks; and two 10-ounce containers of diet cranberry juice that were three-quarters full. There was a brown,	F 0812		

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 0812 SS=E	Continued from page 71 removable substance on the refrigerator door. Interview with the Director of Nursing on January 12, 2025, at 10:22 a.m. confirmed that the food listed above should have been thrown out and that food should be labeled with the resident's name and date upon arrival per the facility's policy. Interview with the Nursing Home Administrator on January 12, 2025, at 1:58 p.m. confirmed that Dietary Employee 11 should have been wearing a hair net and beard guard while in the kitchen. 28 Pa. Code 211.6(f) Dietary Services.	F 0812		
F 0867 SS=E		F 0867		

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F 0867 SS=E	Continued from page 72 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	1. Previous leaderships have failed to comply with the regulation deficiency of 867. Current Nursing Home Administrator will monitor the scope of practice 867. 2. The Executive Director or designee will ensure that grievances were resolved care plans were revised/updated, quality of care that physician's orders were followed, nurse aide's performance reviews were conducted, and food and drink preferences were honored. 3. The Director of Nursing (DON)/designee reeducated the licensed staff on the facility's care plan policy. The DON/designee reeducated the licensed nursing staff of the quality of care that physician's orders were followed. The DON/designee will ensure that the nurse aide performance's reviews were conducted. Executive Director (ED) reeducated the Human Resources Coordinator (HRC) and the Director of Nursing on the facility's employee job performance evaluation policy. The Human Resources Coordinator will notify	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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F 0867 SS=E	Continued from page 73 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867	the Director of Nursing of upcoming performance evaluations so that the appropriate supervisor can ensure that they are completed in a timely manner. 4. The Executive Director reeducated the department managers on the facility's Quality Improvement Performance Improvement (QAPI) policy and on the elements of QAPI. 5. The Director of Nursing/designee to conduct Quality Improvement monitoring of regulation F657 in correcting deficient practices related to revising/updating care plans. Audits will be completed of care plans on residents with pressure ulcers for goal dates to review and update care plan weekly X 8 weeks. The DON/designee to conduct Quality Improvement of regulation F684 in correcting deficient practices related to quality of care, following physician's orders. Audits of 5 residents receiving blood sugar checks for documentation of notifications per physician orders 5X per week X 2 weeks, weekly X 4. The HRC/Designee to conduct	

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F 0867 SS=E	Continued from page 74 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867	Quality Improvement (QI) monitoring of regulation deficiency of 730 to ensure nurse aide performance evaluations were completed annually based on hire date. QI monitoring conducted via nurse aide personnel file review weekly for 8 weeks. 6. Findings to be reported to the QAPI committee meeting and updated as indicated. Quality Improvement schedule modified based on findings.	

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F 0867 SS=E	Continued from page 75 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=E	Continued from page 76 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of correction for a State Survey and Certification (Department of Health) survey ending February 23, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 15, 2025, identified repeated deficiencies related to a failure to ensure that grievances were resolved, care plans were revised/updated, quality of care-physician's orders	F 0867		

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F 0867 SS=E	Continued from page 77 were followed, nurse aide performance reviews were conducted, and food and drink preferences were honored. The facility's plan of correction for a deficiency regarding a failure to resolve grievances, cited during the survey ending February 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F585, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to resolving grievances. The facility's plan of correction for a deficiency regarding a failure to revise or update care plans, cited during the survey ending February 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's	F 0867		

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F 0867 SS=E	Continued from page 78 QAPI committee was ineffective in correcting deficient practices related to revising/updating care plans. The facility's plan of correction for a deficiency regarding quality of care, following physician's orders, cited during the survey ending February 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to quality of care, following physician's orders. The facility's plan of correction for a deficiency regarding a failure to conduct nurse aide performance reviews, cited during the survey ending February 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The	F 0867		

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F 0867 SS=E	Continued from page 79 results of the current survey, cited under F730, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to conducting nurse aide performance reviews. The facility's plan of correction for a deficiency regarding a failure to honoring food and drink preferences, cited during the survey ending February 23, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F807, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to honoring residents food and drink preferences. Refer to F585, F657, F684, F730, F804. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		

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P 5520	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	1. The facility cannot retroactively correct nursing staffing hours and ratios. 2. The facility is focusing on the retention of existing nursing staff and recruiting new staff through the efforts of the staffing committee and human resource department. 3. The Executive Director (ED) re-educated the scheduler and nursing supervisors on the staffing ratios and hours per patient day (HPPD). Staffing meetings to review the calculations for nursing staff ratios and HPPD for accuracy. 4. The ED or Designees to conduct Quality Improvement (QI) monitoring of daily schedules to ensure the ratio of care/minimum PPD will be met. QI monitoring conducted via OnShift Daily Schedules reviewed 5X per week X 4 weeks, then weekly X 4 weeks. Findings reported to the Quality Improvement Performance Improvement (QAPI) committee and updated as indicated. QI monitoring schedule modified based on findings.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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

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P 5520	Continued from page 1 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for two of 21 days, failed to ensure a minimum of one NA per 11 residents on the evening shift for two days, and failed to ensure a minimum of one NA per 15 residents on the overnight shift for four of 21 days (24-hour periods) reviewed. Findings Include: Review of facility census data indicated that on December 26, 2024, the facility census was 84, which required 5.60 NA's during the night shift. Review of the nursing time schedules revealed 4.55 NA's provided care on the night shift on December 26, 2024. Review of facility census data indicated that on January 1, 2025, the facility census was 84, which	P 5520		

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P 5520	Continued from page 2 required 7.64 NA's during the evening shift. Review of the nursing time schedules revealed 7.46 NA's provided care on the evening shift on January 1, 2025. Review of facility census data indicated that on January 5, 2025, the facility census was 87, which required 8.70 NA's during the day shift. Review of the nursing time schedules revealed 7.85 NA's provided care on the day shift on January 5, 2025. Review of facility census data indicated that on January 5, 2025, the facility census was 87, which required 5.80 NA's during the night shift. Review of the nursing time schedules revealed 5.44 NA's provided care on the night shift on January 5, 2025. Review of facility census data indicated that on January 9, 2025, the facility census was 88, which required 8.80 NA's during the day shift. Review of the nursing time schedules revealed 8.00 NA's provided care on the day shift on January 9, 2025.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395422	A. BLDG: 00 B. WING:	01/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PENNKNOLL VILLAGE STATE LICENSE NUMBER: **680602**	**208 PENNKNOLL ROAD** **EVERETT, PA 15537**

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P 5520	Continued from page 3 Review of facility census data indicated that on January 9, 2025, the facility census was 88, which required 8.00 NA's during the evening shift. Review of the nursing time schedules revealed 7.75 NA's provided care on the evening shift on January 9, 2025. Review of facility census data indicated that on January 9, 2025, the facility census was 88, which required 5.87 NA's during the night shift. Review of the nursing time schedules revealed 5.54 NA's provided care on the night shift on January 9, 2025. Review of facility census data indicated that on January 10, 2025, the facility census was 89, which required 5.93 NA's during the night shift. Review of the nursing time schedules revealed 4.73 NAs provided care on the night shift on January 10, 2025. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 4 Interview with the Nursing Home Administrator on January 15, 2025, at 4:00 p.m. confirmed that the facility did not meet the required NA-to-resident staffing ratios for the days listed above.	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 5 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	1. The facility cannot retroactively correct nursing staffing hours and ratios. 2. The facility is focusing on the retention of existing nursing staff and recruiting new staff through the efforts of the staffing committee and human resource department. 3. The Executive Director (ED) re-educated the scheduler and nursing supervisors on the staffing ratios and hours per patient day (HPPD). Staffing meetings to review the calculations for nursing staff ratios and HPPD for accuracy. 4. The ED or Designees to conduct Quality Improvement (QI) monitoring of daily schedules to ensure the ratio of care/minimum PPD will be met. QI monitoring conducted via OnShift Daily Schedules reviewed weekly x 4 weeks, then once a month as needed. Findings reported to the Quality Improvement Performance Improvement (QAPI) committee and updated as indicated. QI monitoring schedule modified based on findings.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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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PENNKNOLL VILLAGE STATE LICENSE NUMBER: 680602	208 PENNKNOLL ROAD EVERETT, PA 15537

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P 5530	Continued from page 6 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for three of 21 days, failed to ensure a minimum of one licensed practical nurse (LPN) per 30 residents during the evening shift for one of 21 days, and failed to ensure a minimum of one LPN per 40 residents on the night shift for two of 21 days reviewed. Findings include: Review of facility census data indicated that on December 31, 2024, the facility census was 85, which required 2.83 LPN's during the evening shift. Review of the nursing time schedules revealed 2.40 LPN's worked on the evening shift on December 31, 2024. Review of facility census data indicated that on	P 5530		

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P 5530	Continued from page 7 January 1, 2025, the facility census was 84, which required 3.36 LPN's during the day shift. Review of the nursing time schedules revealed 3.30 LPN's worked on the day shift on January 1, 2025. Review of facility census data indicated that on January 1, 2025, the facility census was 84, which required 2.10 LPN's during the night shift. Review of the nursing time schedules revealed 1.18 LPN's worked on the night shift on January 1, 2025. Review of facility census data indicated that on January 3, 2025, the facility census was 86, which required 3.44 LPN's during the day shift. Review of the nursing time schedules revealed 2.86 LPN's worked on the day shift on January 3, 2025. Review of facility census data indicated that on January 5, 2025, the facility census was 87, which required 3.48 LPN's during the day shift. Review of the nursing time schedules revealed 3.27 LPN's worked on the day shift on January 5, 2025.	P 5530		

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P 5530	Continued from page 8 Review of facility census data indicated that on January 5, 2025, the facility census was 87, which required 5.80 LPN's during the night shift. Review of the nursing time schedules revealed 5.44 LPN's worked on the night shift on January 5, 2025. No additional excess higher-level staff were available to compensate this deficiency. Interview with the Nursing Home Administrator on January 15, 2025, at 4:00 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	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 9 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	1. The facility cannot retroactively correct nursing staffing hours and ratios. 2. The facility is focusing on the retention of existing nursing staff and recruiting new staff through the efforts of the staffing committee and human resource department. 3. The Executive Director (ED) re-educated the scheduler and nursing supervisors on the staffing ratios and hours per patient day (HPPD). Staffing meetings to review the calculations for nursing staff ratios and HPPD for accuracy. 4. The ED or Designees to conduct Quality Improvement (QI) monitoring of daily schedules to ensure the ratio of care/minimum PPD will be met. QI monitoring conducted via OnShift Daily Schedules reviewed weekly x 4 weeks, then once a month as needed. Findings reported to the Quality Improvement Performance Improvement (QAPI) committee and updated as indicated. QI monitoring schedule modified based on findings.	Completion Date: **02/26/2025** Status: **APPROVED** Date: **02/11/2025**

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P 5640	Continued from page 10 Based on review of nursing schedules and staff interviews, it was determined that the facility failed to provide 3.20 hours of direct resident care for each resident for five of 21 days (24-hour periods) reviewed. Findings include: Nursing time schedules provided by the facility for the days of December 25, 2024, through January 14, 2025, revealed that the facility provided only 3.09 hours of direct care for each resident on December 25, 2024; 3.02 hours of direct care for each resident on January 1, 2025; 2.98 hours of direct care for each resident on January 3, 2025; 2.91 hours of direct care for each resident on January 5, 2025; and 2.88 hours of direct care for each resident on January 9, 2025. Interview with the Nursing Home Administrator on January 15, 2025, at 4:00 p.m. confirmed that the facility did not meet the required daily hours of	P 5640		

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P 5640	Continued from page 11 direct resident care on the days listed above.	P 5640		

Certified End Page

PENNKNOLL VILLAGE

STATE LICENSE NUMBER: 680602

SURVEY EXIT DATE: 01/15/2025

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
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