STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395199	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbeyville Skilled Nursing and Rehabilitation Cent	100 Abbeyville Road Lancaster, PA 17603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based review of the facility's policy, clinical records facility documentation review, and staff interview, it was determined that the facility failed to thoroughly and timely investigate an allegation of being mishandled with roughness by a resident who verbalized feeling of not being safe in the facility for one of two residents reviewed (Resident CL1). Findings include: Review of the facility's policy titled Abuse Prohibition, review date October 24, 2022, revealed that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, initiate an investigation within 24 hours of an alleged of abuse that focuses on whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries if indicated; causative factor; and interventions to prevent further injury. The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is located. Review of Resident CL1's clinical records revealed Resident CL1 was admitted to the facility on [DATE], to receive therapy post-abdominal surgery. Review of Resident CL1's Admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated April 27, 2024, revealed resident was cognitively intact. The same MDS revealed that the resident required substantial/maximal assistance with toileting. Review of Resident CL1's nursing progress notes dated April 27, 2024, at 6:19 p.m., revealed that at 3:00 p. m., the resident was in the hall in front of the nurses' station very upset unable to verbalize the issue except that she had to wait to go to the bathroom on day shift. The resident called her daughter who came in within 10 minutes. The resident informed the daughter that she does not feel safe in the facility and thus requested to leave. The physician was notified, and the resident was discharged against medical advice. The resident left the facility at 5:02 p.m., and the Director of Nursing (DON) was informed of the issue at 6:51 p.m. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's documentation revealed on April 28, 2024, the Resident's daughter sent an email to the facility's compliance department and reported observed care concerns from a male nurse during the Resident's stay in the facility which included leaving the bathroom door open while being assisted with toileting and not providing appropriate assistance with transfers. The daughter wrote in the email that she reported it to the charge nurse and requested not to let the male nurse assist her mother. The charge nurse informed her that the male nurse had spoken to them and that the incident would be reported to the supervisor. An hour later, she received a call from her mother, crying for help, and reported that the male nurse came back and mishandled the resident with roughness. Interview with the Nursing Home Administrator (NHA) was conducted on June 11, 2024. The NHA reported the email sent to the compliance department was not forwarded to her until May 2, 2024. The NHA reported that the alleged perpetrator was an agency staff and was no longer allowed in the facility. The facility was unable to provide documented evidence that the alleged report of being roughly mishandled was investigated by the facility. The facility failed to ensure Resident CL1's allegation of being roughly mishandled was thoroughly and timely investigated by the facility. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on observations and staff interviews it was determined that the facility failed to ensure a safe and sanitary environment for one of the two units observed ([NAME]) Findings include: Observation in Resident R1's room conducted on June 11, 2024, at 10:45 a.m., revealed a multiple black pellet-looking object approximately 20 plus on the bottom wall vent and approximately 50 on the floor below the resident ' s television. Observation of room [ROOM NUMBER] bathroom conducted on June 12, 2024, at 10:50 a.m., revealed three tiles were broken exposing a hole in the bottom wall of the bathroom. Interview with licensed nurse, Employee E3 was conducted with the above observations on June 11, 2024, at 11:00 a.m. Employee E3 confirmed that the multiple black pellets-looking objects in resident 1's room were mouse droppings. Observation conducted on June 11, 2024, at 1:30 p.m., revealed the mouse droppings observed earlier were still present in the resident's room. Interview conducted with the maintenance director on June 11, 2024, revealed that he/she was not notified of the broken tiles/holes in room [ROOM NUMBER]-bathroom bottom wall. The above information was conveyed to the Nursing Home Administrator on June 11, 2024, at 2:00 p.m. The facility failed to ensure a safe and sanitary environment in the [NAME] Unit. Unit 28 Pa. Code 201.18(b)(1) Management