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	04/02/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interview with staff, it was determined that the facility failed to notify the office of the state long term care ombudsman of emergency transfers for 10 of 31 residents reviewed (Residents 1, 10, 14, 20, 46, 84, 91, 126, 134, and 165).Findings include:Finding include Review of Resident 1's clinical record revealed Resident 1 was transferred to the hospital on March 11, 2026, due to abnormal vitals. Further review of Resident 1's clinical record revealed Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 1's transfer and admission to the hospital. Review of Resident 10's progress note of December 27, 2025, revealed that resident's power of attorney requested that resident be sent to the hospital for respiratory distress. Further review of the clinical record revealed that the resident was readmitted to the facility on [DATE]. Review of Resident 10's progress note of January 24, 2026, revealed that resident was sent to the emergency department for an unwitnessed fall. Additional note of January 24, 2026, revealed that Resident 10 was admitted for hypotension (low blood pressure) and syncope (fainting). Resident 10 was readmitted to the facility on [DATE], Review of Resident 10's progress note of March 19, 2026, revealed that resident was sent to the emergency department for evaluation and treatment. Further review of the clinical record revealed that resident was admitted for dyspnea (shortness of breath) and readmitted to the facility on [DATE]. Review of Resident 10's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 10's transfer and admission to the hospital. Review of Resident 14's clinical record revealed Resident 14 was transferred to the hospital on October 31, 2025, for worsening discoloration of toes. Further review of Resident 14's clinical record revealed Resident 14 was readmitted to the facility on [DATE]. Review of Resident 14's clinical record and facility documentation failed to reveal evidence that the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	State Ombudsman's office was notified of Resident 14's transfer and admission to the hospital. Review of Resident 20's clinical record revealed Resident 20 was transferred to the hospital on December 30, 2025, for a fall resulting in a right femur fraction. Further review of Resident 20's clinical record revealed Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 20's transfer and admission to the hospital. Interview with the Nursing Home Administrator on April 2, 2026, at 12:50 p.m. confirmed that notification of Resident 1, Resident 14 and Resident 20's transfer and admission to the hospital was not sent to the State Ombudsman's office as required Review of Resident 46's progress note of February 22, 2026, revealed that the resident was sent to the emergency department. Additional progress note of February 22, 2026, revealed that resident was admitted to the hospital for hypoxia (low oxygen levels). Resident 46 was readmitted to the facility on [DATE]. Review of Resident 84's clinical record revealed a nursing progress note dated February 7, 2027 indicating the resident was transferred to the local hospital with a diagnosis of Emphysematous cystitis. Further review of Resident 84's clinical record revealed that Resident 84 was readmitted to the facility on [DATE]. Review of Resident 84's clinical record failed to reveal evidence that the State Ombudsman's office was notified of Resident 84's transfer and admission to the hospital. Review of Resident 91's clinical record revealed Resident 91 was transferred to the hospital on March 8, 2026, with a diagnosis of sepsis. Further review of Resident 91's clinical record revealed Resident 91 was readmitted to the facility on [DATE]. Review of Resident 91's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 91's transfer and admission to the hospital. Interview with the Nursing Home Administrator on April 2, 2026, at 12:50 p.m. confirmed that notification of Resident 91's transfer and admission to the hospital was not sent to the State Ombudsman's office as required. Review of Resident 126's progress note of December 1, 2025, revealed that the resident was admitted to the hospital for constipation and an urinary tract infection. Review of Resident 126's progress note of February 7, 2026, revealed that the resident was sent to the hospital for pain. Resident was readmitted to the facility on [DATE]. Review of Resident 126's progress note of March 14, 2026, revealed that Resident 126 was transferred to the hospital per the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's request. Progress notes of March 15, 2026, indicated that the resident was admitted to the hospital for a pulmonary embolism (blockage in a lung artery). An additional note revealed that the resident was readmitted to the facility on [DATE]. Interview with the Nursing Home Administrator on April 2, 2026, at 10:35 a.m. confirmed that the office of the state long term care ombudsman's office was not being notified of resident 126's transferred to the hospital. Review of Resident 134's clinical record revealed Resident 134 was transferred to the hospital on January 2, 2026, after sustaining a fall at the facility. Further review of Resident 134's clinical record revealed Resident 134 was readmitted to the facility on [DATE]. Review of Resident 134's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 134's transfer and admission to the hospital. Interview with the Nursing Home Administrator on April 2, 2026, at 12:50 p.m. confirmed that notification of Resident 134's transfer and admission to the hospital was not sent to the State Ombudsman's office as required. Review of Resident 165's clinical record revealed a nursing progress note dated January 11, 2026, indicating the resident was transferred to the local hospital for evaluation after the resident was found with intractable vomiting and abdominal pain. Review of Resident 165's clinical record revealed a nursing progress note dated January 13, 2026, indicating that the resident had passed away at the hospital on January 13, 2026. Review of Resident 165's clinical record failed to reveal evidence that the State Ombudsman's office was notified of Resident 165's transfer to the hospital. An interview with the NHA on April 2, 2026, at approximately 11:35AM revealed the Office of the State Long Term Care Ombudsman was not made aware of resident 84's or resident 165's hospital transfer. 483.15 Admission, Transfer, and DischargePreviously cited 2/7/25

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon clinical record review and interview, it was determined that the facility failed to conduct a baseline care plan meeting for one of 31 residents reviewed (Resident 4).Findings include:Review of Resident 4's clinical record revealed Resident 4 was admitted to the facility on [DATE], with a diagnosis of vascular dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability).Interview with Resident 4's representative on March 30, 2026, at 1:00 p.m. revealed that Resident 4 and Resident 4's representative had not had a care plan meeting to establish a baseline care plan since admission.Review of Resident 4's clinical record revealed a social services progress note dated March 11, 2026, which revealed an attempt had been made to schedule a meeting with Resident 4 but Resident 4 was sleeping. Interview with the Nursing Home Administrator on April 3, 2026, at 10:00 a.m. confirmed that no further contact had been made with Resident 4 or Resident 4's representative to schedule a baseline care plan meeting. 28 Pa. Code 211.16(a) Social ServicesPreviously cited 2/7/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on a resident interview and review of the clinical record, it was determined that the facility failed to ensure that the resident or resident's representative was included in the resident's comprehensive care plan for one of 31 residents reviewed (Resident 3).Findings include:Interview with Resident 3 on March 30, 2026, at 1:00 p.m. revealed that the resident had not been invited to a care plan conference. Review of Resident 3's clinical record revealed that a quarterly MDS (Minimum Data Set - periodic assessment of resident needs) had been completed on February 17, 2026. Further review of the clinical record revealed no evidence that a care plan meeting was held or that the resident was invited to the meeting. Interview with the Nursing Home Administrator on April 2, 2025, at 10:37 a.m. confirmed that there was no evidence that a care plan meeting was held or that the resident was invited. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based upon clinical record review, it was determined that the facility failed to follow physicians' orders in regard to weights and medication administration for two of 31 residents review (Resident 95 and Resident 133).Findings include:Review of Resident 95 face sheet revealed medical diagnoses that includes but not limited to; HEART FAILURE (a chronic condition where the heart is unable to pump enough blood), HYPOMAGNESEMIA (a low concentration of magnesium in the blood), UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION (insufficient intake of both protein and calories), and ADULT FAILURE TO THRIVE (significant decline in physical mental and functional health).Review of Resident 95's physician order revealed an order for weekly weights dated February 23, 2026 noting Weekly weight. Please obtain a weekly weight EVERY Wednesday. Weigh every day shift every Wednesday for Weekly weight. Start date: February 25, 2026Review of Resident 95's weight summary revealed on February 25, 2026, March 11, 2026, March 18, 2026, and March 25, 2026, Resident 95's weight was not obtained.Further review of Resident 95's weight summary revealed that on March 1, 2026, the resident weighed 87 pounds, and on March 4, 2026, weighed 87.2 pounds, indicating a 0.2 pound weight gain over 3 days, representing approximately a 0.23% increase.Review of Resident 95's clinical record failed to reveal evidence that weekly Wednesday weights were consistently obtained as ordered.Interview with the Nursing Home Administrator (NHA) on April 2, 2026, at approximately 10:15AM when the above was presented the NHA confirmed physician orders for weekly Wednesday weights were not being followed.Review of Resident 133's diagnosis list revealed diagnoses including orthostatic hypotension (low blood pressure caused by changes in body position) and coronary artery disease (narrowing of blood vessels which supply the heart with blood and oxygen).Review of Resident 133's March physician orders revealed an order for Midodrine (medication used to treat hypotension) Tablet 2.5 milligrams (mg) to be administered by mouth three times per day and give if SBP (systolic blood pressure) is equal or less than 100 mmHg.Review of Resident 133's March Medication Administration Record (MAR) revealed that Midodrine 2.5 mg was administered on the following days when Resident 133's SBP was greater than 100 mmHg: March 1, 2026 - 109/62, 114/67, 128/64; March 2, 2026 - 110/47; March 3, 2026 - 108/53, 101/54; March 4, 2026 - 124/63; March 6, 2026 - 109/69, 114/64, 110/50; March 7, 2026 - 108/53; March 8, 2026 - 107/54; March 9, 2026 - 132/55; March 14, 2026 - 103/67; March 15, 2026 - 110/60, 127/80, 119/81 and March 25, 2026 - 103/53.Interview with the Nursing Home Administrator on April 2, 2026, at 12:45 p.m. confirmed that the above medication was not administered according to physician's orders. 28 Pa. Code 211.12(c)(d)(1) Nursing ServicesPreviously cited 2/7/2025, 8/19/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility record reviews and interviews, it was determined that the facility failed to ensure monthly Medication Regimen Reviews (MMR) were completed as required for two of seven residents reviewed (Resident 6 and Resident 12).Findings include: Review of the facility's policy titled Medication Regimen Review (MRR) or Drug Regimen Review (DRR) indicated that the MMR includes review of the medical record in order to prevent, identify, report, and resolved medication-related problems, medication errors, or other irregularities. The MMR also involves collaborating with other members of the interdisciplinary team (IDT), including the resident, their family, and/or resident representative. Review of Resident 6's Medication Regimen Reviews between March 29, 2025 and March 8, 2026, revealed pharmacist recommendations documented in the progress notes tab of the resident's clinical chart under Medication Regimen Review on the following dates: March 29, 2025, May 29, 2025, June 28, 2025, July 26, 2025, September 29, 2025, October 25, 2025, November 17, 2025, and December 17, 2025. The facility was unable to provide a record of the pharmacist's recommendations for June 28, 2026, July 26, 2025, September 29, 2025, October 25, 2025, November 17, 2025, or December 17, 2025. Interview with the Nursing Home Administrator on April 2, 2026, at approximately 12:36PM confirmed that the recommendations from those reviews were not available. Review of facility documentation revealed MRR's for Resident 12 were completed for January 2026, February 2026, and March 2026. Further review of facility documents failed to reveal evidence of completed MMR's for any additional months. Interview conducted on April 02,2026, with the Nursing Homes Administrator (NHA) at approximately 12:00 p.m., when the above was presented the NHA confirmed that the MRR's were not available. 28 Pa Code 211.5(f) Clinical Records 28 Pa Code 211.12(d)(3) Nursing Services