

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Abington Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Edella Road South Abington Towns, PA 18411	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on review of clinical records and select resident incident/accident reports and staff interview, it was determined that the facility failed to provide adequate staff supervision to timely identify a resident's unauthorized absence from the facility to assure the safety of one resident (Resident 1) and failed to consistently implement planned safety measures, including necessary staff supervision, to prevent a fall for one resident out of four sampled (Resident 2)</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease (decline in brain function which causes memory loss and causes brain tissue to breakdown) and mild dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) with behavior disturbance</p> <p>A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated December 15, 2023, revealed that the resident was severely cognitively impaired with a BIMS of 3 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00 - 07 equates to severe cognitive impairment) and required extensive assistance of two staff for activities of daily living.</p> <p>A fall risk assessment dated [DATE], indicated that the resident was at high risk for falls. Care planned interventions on this date were the use of bed alarm while in bed, call bell in reach, encourage to transfer and change positions slowly, fall mats to both sides of bed, provide assistance to transfer and ambulate as needed. Staff were to check the resident's bed alarm and chair alarm every shift and as needed.</p> <p>Documentation in Resident 2's clinical record dated February 26, 2024, at 3:00 PM revealed a nurse aide, Employee 7 heard a loud yell and a bang and responded to the resident dining/day room. Employee 7 found Resident 2 on the floor, on the resident's left side, bleeding from his right hand and blood on the floor. Upon nursing assessment, the resident was identified to have an an open area to his right hand on his fourth finger with tendons exposed measuring 1 cm x 1.5 cm x 0.1 cm. The resident was sent to the hospital, received three sutures to close the wound and returned to the facility.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395701
		If continuation sheet Page 1 of 10

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's investigation into the resident's fall, revealed a statement from Employee 8, the nurse aide responsible for Resident 2's care on February 26, 2024, indicating that she, along with another staff member, assisted the resident into his wheelchair because he was climbing out of bed. She stated she forgot to put the chair alarm on his wheelchair. She placed him in the dining room. Employee 8 stated she last saw the resident at 1:00 PM sitting in the dining room at 1:00 PM. At 2:50 PM staff found the resident on the floor of the dining room/day room. The resident along with another resident were in the dining room unsupervised. No facility staff were present in the dining room/day room at that time.</p> <p>Interview with the assistant director of nursing on April 3, 2024, at 3:00 PM confirmed the facility failed to implement planned safety interventions and provide adequate staff supervision to prevent Resident 2's fall with minor injury.</p> <p>Clinical record review revealed Resident 1 was admitted to the facility on [DATE] with diagnoses of insulin dependent diabetes mellitus (commonly referred to as diabetes, is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period, unspecified visual disturbance, cataract removal, and cerebral ischemia (in which there is insufficient blood flow to the brain to meet metabolic demand. This leads to poor oxygen supply or cerebral hypoxia and this leads to death of brain tissue. It is a subtype of stroke).</p> <p>A review of this resident's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 13, 2024, revealed that the resident was cognitively intact with a BIMS score of 14 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). The resident was independent with ambulation and activities of daily living.</p> <p>Interview with multiple facility staff members who wish to remain anonymous for fear of retaliation, on April 3, 2024, at approximately 8:30 AM revealed that staff were unable to locate Resident 1 in the facility for many hours on Easter Sunday March 31, 2024.</p> <p>A telephone interview with Employee 6 an RN on April 3, 2024 at approximately 2:00 PM revealed that she received a telephone call from the nurse practitioner in the facility (CRNP) on March 31, 2024, at 5:45 PM inquiring if she had seen Resident 1 and another call at 6:15 PM from the ADON inquiring about Resident 1's whereabouts. Employee 6 replied by suggesting that they check the casino because the resident had been known to frequent the local casino.</p> <p>A late note entered by the ADON (assistant director of nursing) in Resident 1's clinical record on April 1, 2024, at 6:45 PM indicated that Resident 1 was discharged from the facility.</p> <p>An order written by the CRNP dated April 1, 2024, indicated that the resident was discharged from facility on March 31, 2024, with home health services.</p> <p>A review of the resident's medication administration record (MAR) for March 31, 2024 revealed he received his 6:00 AM medications but staff did not administer his scheduled medications at 9 AM, 5 PM, and 9 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the NHA and ADON during an interview on April 3, 2024 at approximately 11:00 AM the ADON stated she received a call from the facility staff on March 31, 2024 approximately 5:30 PM indicating that Resident 1 was not in the building and he did not sign out as a leave of absence (LOA). She stated she contacted the NHA. The facility's Social Worker stated she knew he was at the casino however, but did not know how he got there or when he left the building. The NHA stated she called the casino and they confirmed he was there. The Social Worker and the RNAC (registered nurse assessment coordinator) traveled to the casino and met the ADON there, around 6:30 PM on March 31, 2024. The resident was located and he stated he did not want to return to the facility because he had three nights of a hotel stay which was paid for by the casino. The ADON and the Social Worker had the resident sign a paper, created in handwriting which stated I {the resident name} am signing myself out of {name of facility} against medical advice (AMA) on March 31, 2024. I am signing out against medical advice despite being educated on the risks and consequences. This handwritten form was signed by the ADON and Social Worker. They stated the resident left the facility at approximately 10:30 AM and was appropriately discharged .</p> <p>A telephone interview on April 3, 2024 at 11:30 AM with Employee 1 a Registered Nurse who was assigned to this resident on March 31, 2024, revealed she did not arrive at the facility that day (March 31, 2024) until 9:00 AM . She stated she relieved Employee 2 who had possession of the medication cart at the time. Employee 1 stated she didn't see Resident 1. She stated she wasn't concerned about the resident's medication administration scheduled for 9 AM, because Resident 1 usually came to her for his medication. She stated she disposed of his medication that wasn't given and when her shift was over at 3:00 PM she left the resident's unit to work from 3:00 PM to 11:00 PM on another unit. She stated she did not see the resident from the time she arrived on duty at 9:00 AM and did not report his absence to anyone because she was responsible for 28 residents and he was someone that always showed up. Employee 1 confirmed, however, that she did not know where the resident was during her shift.</p> <p>A telephone interview with Employee 4, a nurse aide, on April 3, 2024, at 11:35 AM Employee 4 confirmed Resident 1 was on her assignment that day. She stated that she saw Resident 1 at the very beginning of her shift at approximately 9:30 AM and did not see him after that time. When asked about the resident's lunch meal and if she attempted to locate the resident to have lunch on the date, she stated It was too too busy! A lot going on! No time to do books!</p> <p>Employee 3, a licensed practical nurse (LPN) as per written statement indicated that she went to Resident 1's room at 4:30 PM to get his Accucheck and she noticed that his lunch tray was on his bedside table untouched. She stated she asked some of the nurse aides if they knew where the resident was and they said no. She looked into the LOA book to see if he signed out for the day and there was nothing signed out. She then went to the supervisor. The RN supervisor, Employee 5, and told her she could not find Resident 1.</p> <p>During an interview with the RN Supervisor Employee 5 on April 3, 2024 at 2:45 PM she stated Employee 3 notified her that Resident 1 was not available for his Accucheck and his lunch tray was in his room untouched on March 31, 2024, at approximately 4:30 PM. Employee 5 indicated she contacted the ADON and began to search the grounds for him. She stated they checked the whole building and could not locate him. She learned later on that evening that he was located at the casino.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on April 3, 2024 at approximately 3:00 PM, the Nursing Home Administrator and the ADON confirmed that on March 31, 2024, during the 7:00 AM to 3:00 PM shift nursing staff failed to adequately supervise Resident 1 and were unaware of his whereabouts during that shift to assure that the resident was safe.</p> <p>Refer F725</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on observations, a review of clinical records, and staff interviews it was determined the facility failed to provide sufficient nursing staff to consistently provide timely care and supervision necessary to maintain the physical and mental well-being of two the four residents sampled (Resident 1)</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease (decline in brain function which causes memory loss and causes brain tissue to breakdown) and mild dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) with behavior disturbance</p> <p>A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated December 15, 2023, revealed that the resident was severely cognitively impaired with a BIMS of 3 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00 - 07 equates to severe cognitive impairment) and required extensive assistance of two staff for activities of daily living.</p> <p>A fall risk assessment dated [DATE], indicated that the resident was at high risk for falls. Care planned interventions on this date were the use of bed alarm while in bed, call bell in reach, encourage to transfer and change positions slowly, fall mats to both sides of bed, provide assistance to transfer and ambulate as needed. Staff were to check the resident's bed alarm and chair alarm every shift and as needed.</p> <p>Documentation in Resident 2's clinical record dated February 26, 2024, at 3:00 PM revealed a nurse aide, Employee 7 heard a loud yell and a bang and responded to the resident dining/day room. Employee 7 found Resident 2 on the floor, on the resident's left side, bleeding from his right hand and blood on the floor. Upon nursing assessment, the resident was identified to have an an open area to his right hand on his fourth finger with tendons exposed measuring 1 cm x 1.5 cm x 0.1 cm. The resident was sent to the hospital, received three sutures to close the wound and returned to the facility.</p> <p>A review of the facility's investigation into the resident's fall, revealed a statement from Employee 8, the nurse aide responsible for Resident 2's care on February 26, 2024, indicating that she, along with another staff member, assisted the resident into his wheelchair because he was climbing out of bed. She stated she forgot to put the chair alarm on his wheelchair . She placed him in the dining room. Employee 8 stated she last saw the resident at 1:00 PM sitting in the dining room at 1:00 PM. At 2:50 PM staff found the resident on the floor of the dining room/day room. The resident along with another resident were in the dining room unsupervised. No facility staff were present in the dining room/day room at that time.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the assistant director of nursing on April 3, 2024, at 3:00 PM confirmed the facility failed to implement planned safety interventions and provide adequate staff supervision to prevent Resident 2's fall with minor injury.</p> <p>Clinical record review revealed Resident 1 was admitted to the facility on [DATE] with diagnoses of insulin dependent diabetes mellitus (commonly referred to as diabetes, is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period, unspecified visual disturbance, cataract removal, and cerebral ischemia (in which there is insufficient blood flow to the brain to meet metabolic demand. This leads to poor oxygen supply or cerebral hypoxia and this leads to death of brain tissue. It is a subtype of stroke).</p> <p>A review of this resident's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 13, 2024, revealed that the resident was cognitively intact with a BIMS score of 14 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). The resident was independent with ambulation and activities of daily living.</p> <p>Interview with multiple facility staff members who wish to remain anonymous for fear of retaliation, on April 3, 2024, at approximately 8:30 AM revealed that staff were unable to locate Resident 1 in the facility for many hours on Easter Sunday March 31, 2024.</p> <p>A telephone interview with Employee 6 an RN on April 3, 2024 at approximately 2:00 PM revealed that she received a telephone call from the nurse practitioner in the facility (CRNP) on March 31, 2024, at 5:45 PM inquiring if she had seen Resident 1 and another call at 6:15 PM from the ADON inquiring about Resident 1's whereabouts. Employee 6 replied by suggesting that they check the casino because the resident had been known to frequent the local casino.</p> <p>A late note entered by the ADON (assistant director of nursing) in Resident 1's clinical record on April 1, 2024, at 6:45 PM indicated that Resident 1 was discharged from the facility.</p> <p>An order written by the CRNP dated April 1, 2024, indicated that the resident was discharged from facility on March 31, 2024, with home health services.</p> <p>A review of the resident's medication administration record (MAR) for March 31, 2024 revealed he received his 6:00 AM medications but staff did not administer his scheduled medications at 9 AM, 5 PM, and 9 PM.</p> <p>According to the resident's March 2024 MAR the resident did not receive the following medications as scheduled at 9 AM, 5 PM and 9 PM on March 31, 2024:</p> <p>Amlodipine 2.5 mg by mouth for hypertension at 9 AM</p> <p>Ascorbic Acid 600 mg by mouth as a supplement at 9 AM</p> <p>Cyanocobalamin 600 mg by mouth for anemia at 9 AM</p> <p>Eucerin Cream to upper arms for itching at 9 AM</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ferrous Sulfate 326 mg one tablet by mouth for anemia at 9 AM</p> <p>Aspirin 81 mg one tablet by mouth at 5 PM (documented as given but determined it was not because the resident was not present in the facility)</p> <p>Magnesium Oxide 40 mg by mouth at 9 AM and 5 PM</p> <p>Metformin HCL 500mg by mouth at 7:30 AM and 5 PM (staff documented that the 5 PM dose was given but was not because the resident was not in the facility at that time)</p> <p>Atorvastatin Calcium 40 mg one tablet for elevated cholesterol at 9 PM</p> <p>Fiasp Flex Touch Insulin 100 units/ML 5 units before meals and at bedtime</p> <p>Basaglar Kwik-Pen 100 units/ML insulin 20 units at 9 PM</p> <p>Blood sugars ordered 11 AM 5PM and 9 PM</p> <p>According to the NHA and ADON during an interview on April 3, 2024 at approximately 11:00 AM the ADON stated she received a call from the facility staff on March 31, 2024 approximately 5:30 PM indicating that Resident 1 was not in the building and he did not sign out as a leave of absence (LOA). She stated she contacted the NHA. The facility's Social Worker stated she knew he was at the casino however, but did not know how he got there or when he left the building. The NHA stated she called the casino and they confirmed he was there. The Social Worker and the RNAC (registered nurse assessment coordinator) traveled to the casino and met the ADON there, around 6:30 PM on March 31, 2024. The resident was located and he stated he did not want to return to the facility because he had three nights of a hotel stay which was paid for by the casino. The ADON and the Social Worker had the resident sign a paper, created in handwriting which stated I {the resident name} am signing myself out of {name of facility} against medical advice (AMA) on March 31, 2024. I am signing out against medical advice despite being educated on the risks and consequences. This handwritten form was signed by the ADON and Social Worker. They stated the resident left the facility at approximately 10:30 AM and was appropriately discharged .</p> <p>A telephone interview on April 3, 2024 at 11:30 AM with Employee 1 a Registered Nurse who was assigned to this resident on March 31, 2024, revealed she did not arrive at the facility that day (March 31, 2024) until 9:00 AM . She stated she relieved Employee 2 who had possession of the medication cart at the time. Employee 1 stated she didn't see Resident 1. She stated she wasn't concerned about the resident's medication administration scheduled for 9 AM, because Resident 1 usually came to her for his medication. She stated she disposed of his medication that wasn't given and when her shift was over at 3:00 PM she left the resident's unit to work from 3:00 PM to 11:00 PM on another unit. She stated she did not see the resident from the time she arrived on duty at 9:00 AM and did not report his absence to anyone because she was responsible for 28 residents and he was someone that always showed up. Employee 1 confirmed, however, that she did not know where the resident was during her shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview with Employee 4, a nurse aide, on April 3, 2024, at 11:35 AM Employee 4 confirmed Resident 1 was on her assignment that day. She stated that she saw Resident 1 at the very beginning of her shift at approximately 9:30 AM and did not see him after that time. When asked about the resident's lunch meal and if she attempted to locate the resident to have lunch on the date, she stated It was too too busy! A lot going on! No time to do books!</p> <p>Employee 3, a licensed practical nurse (LPN) as per written statement indicated that she went to Resident 1's room at 4:30 PM to get his Accucheck and she noticed that his lunch tray was on his bedside table untouched. She stated she asked some of the nurse aides if they knew where the resident was and they said no. She looked into the LOA book to see if he signed out for the day and there was nothing signed out. She then went to the supervisor. The RN supervisor, Employee 5, and told her she could not find Resident 1.</p> <p>During an interview with the RN Supervisor. Employee 5, on April 3, 2024 at 2:45 PM she stated Employee 3 notified her that Resident 1 was not available for his Accucheck and his lunch tray was in his room untouched on March 31, 2024, at approximately 4:30 PM. Employee 5 indicated she contacted the ADON and began to search the grounds for him. She stated they checked the whole building and could not locate him. She learned later on that evening that he was located at the casino.</p> <p>A review of nurse staffing for the 3 west resident unit on which Resident 1 resided, on March 31, 2024, during the 7:00 AM to 3:00 PM shift revealed that staffing was 1 RN, 1 LPN who arrived at 9:00 AM and 2 nurse aides. The resident census was 29 residents on the 3 W resident unit. However, the available staff failed to adequately supervise Resident 1's whereabouts to provide the resident's medications, blood sugar monitoring, nursing care, and meals.</p> <p>During an interview on April 3, 2024 at approximately 3:00 PM, the Nursing Home Administrator and the ADON confirmed that the facility was unable to demonstrate the provision of sufficient nursing staff to supervise and provide care as planned and ordered to Resident 1 on March 31, 2024, during the 7:00 AM to 3:00 PM shift.</p> <p>Refer F689</p> <p>28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services</p> <p>28 Pa. Code 201.18 (e)(1)(6) Management</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>13456</p> <p>Based on review of clinical records and select reports and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for one of four sampled residents (Resident 1).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct. (a) A licensed practical nurse shall: (5) Document and maintain accurate records. (b) A licensed practical nurse may not: (8) Falsify or knowingly make incorrect entries into the patient's record other related documents.</p> <p>Employee 3, a licensed practical nurse (LPN), wrote in an witness statement that she went to Resident 1's room at 4:30 PM on March 31, 2024 to get his Accucheck and she noticed that his lunch tray was on his bedside table untouched. She stated she asked some of the nurse aides if they knew where the resident was and they said no. She looked into the LOA book to see if he signed out for the day and there was nothing signed out. She then went to the RN supervisor, Employee 5, and told her she could not find Resident 1.</p> <p>A review of Resident 1's MAR (medication administration record) dated for March 31, 2024 revealed Employee 3, an LPN (licensed practical nurse) administered Resident 1's Aspirin 81 mg by mouth and Metformin HL 500 mg one tablet by mouth at 5:00 PM as indicated by her initials indicating they were administered.</p> <p>However, according to interviews with facility staff on April 3, 2024, and a review of the facility's documentation and resident clinical record revealed that Resident 1 was not in the facility at 5 PM on March 31, 2024, and did not receive any medications after 6 AM on that date. Employee 3 reported resident's absence to the RN Supervision on March 31, 2024, at approximately 4:30 PM but documented that she administered his medications at 5 PM when the resident was not present in the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Abington Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Edella Road South Abington Towns, PA 18411	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the ADON (assistant director of nursing) on April 3, 2024, at 3:00PM confirmed that Employee 3 did not administer the 5 PM medications to Resident 1 as documented on the resident's MAR.</p> <p>Refer F725</p> <p>28 Pa. Code 211.5 (f) Medical records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		