STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395701	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abington Manor	100 Edella Road Clarks Summit, 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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for two out of two nursing units (Floors 1 and 2). Findings include: Observations made on June 3, 2025, during an on-site facility tour revealed a worn, stained, and tattered carpeting with scattered debris throughout four resident hallways on both Floor 1 and Floor 2 nursing units. At 8:48 AM, the 3-Hallway was observed with multiple white stains and scattered white paper pieces approximately the size of a fingernail. Dark discolorations and stains were noted throughout the hallway carpet, ranging in size from one inch to several feet. An observation at 8:56 AM revealed a plastic safety lancet (a medical device used for obtaining capillary blood samples, designed to prioritize safety by incorporating features that minimize the risk of needlestick injuries and accidental contamination) on the floor. The needle was retracted and locked in the protective plastic barrier. An observation at 9:08 AM revealed a white substance buildup on the rug outside of resident room [ROOM NUMBER]. At 10:41 AM, the floor on the door side of resident room [ROOM NUMBER] contained scattered orange chips, several white paper pieces, and a small solid brown object. At 10:42 AM, dark discolorations and stains measuring several inches to several feet were observed throughout the hallway outside resident rooms 301 through room [ROOM NUMBER]. At 10:44 AM, an orange substance was observed encrusted into the carpet between resident rooms [ROOM NUMBERS] During an interview conducted on June 3, 2025, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed the carpeting on both nursing units contained multiple stains, visible debris, and substance build-ups. The NHA stated the facility was aware of the condition and had solicited bids from external contractors for flooring replacement. The NHA acknowledged it is the facility's responsibility to ensure the environment remains clean and homelike for residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (e)(1)(2.1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined the facility failed to ensure that pain management was provided consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of 17 sampled residents (Resident CR1). Findings include: A review of facility policy titled Administering Medication, last reviewed September 26, 2024, revealed medications are administered in accordance with prescriber orders. A clinical record review revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses that include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and malignant carcinoid tumor (a slow-growing type of cancer that has spread to other parts of the body). Resident CR1's care plan, initiated on May 16, 2025, identified a goal for the resident to report that pain is managed within acceptable limits. The care plan included an intervention to administer pain medications as ordered by the physician. A physician's order for Resident CR1 to be administered oxycodone-acetaminophen 5 mg/325 mg (oxycodone is an opioid pain medication; acetaminophen is a pain medication) with directions to give one tablet by mouth every 12 hours as needed for pain level rated 5-10 (moderate to severe pain) for 14 days was initiated on May 21, 2025. An additional physician's order for Resident CR1 to be administered acetaminophen tablets 325 with directions to give 650 mg by mouth every 6 hours as needed for pain level rated 1-5, mild to moderate, was initiated on May 21, 2025. A review of Resident CR1's Medication Administration Record for May 2025 revealed Resident CR1 received oxycodone-acetaminophen 5 mg-325 mg on four occasions from May 21, 2025 , through May 25, 2025, outside of the parameters prescribed by the physician for the administration of the medication. May 21, 2025, the resident received oxycodone-acetaminophen 5 mg/325 mg for a documented pain level of 0 out of 10. May 22, 2025, the resident received oxycodone-acetaminophen 5 mg/325 mg for a documented pain level of 3 out of 10. May 23, 2025, the resident received oxycodone-acetaminophen 5 mg/325 mg for a documented pain level of 4 out of 10. May 24, 2025, the resident received oxycodone-acetaminophen 5 mg/325 mg for a documented pain level of 3 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These documented pain scores did not meet the required threshold (pain level 5-10) for administration of the oxycodone-acetaminophen combination, as indicated by the prescriber. During an interview on June 3, 2025, at approximately 1:00 PM, the Director of Nursing (DON) confirmed Resident CR1 received oxycodone-acetaminophen 5 mg/325 mg outside of the parameters set by the physician. The DON confirmed it is the facility's responsibility to ensure that pain management is provided to residents consistent with professional standards of practice. 28 Pa. Code 211.5 (f)(xi) Medical records. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident clinical records, select facility policy, staff, and staff interview, it was revealed the facility failed to ensure that one of the 17 residents sampled was free of a significant medication error. (Resident 2). Findings include: A review of facility policy titled Administering Medication, last reviewed September 26, 2024, revealed medications are administered in accordance with prescriber orders. The policy indicates the individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and a recent left femur fracture (thigh bone). A physician's order for oxycodone 5 mg with directions to give one (1) capsule by mouth every 8 hours as needed for pain management for five days was initiated on May 6, 2025. The medication order was discontinued on May 7, 2025. During an interview on June 3, 2025, at approximately 11:00 AM, the Director of Nursing (DON) revealed the medication dosage was reduced because the resident was responding negatively to the medication. A physician's order for oxycodone 5 mg with directions to give a half (2.5 mg) tablet by mouth every 8 hours as needed for pain management for 14 days was initiated on May 7, 2025. A review of Resident 2's Medication Administration Record (MAR) for May 2025 revealed the resident received oxycodone 5 mg on May 9, 2025, at 8:23 AM. However, facility-provided investigative documentation revealed that the medication administered was not the ordered dose. Employee 1, a licensed practical nurse (LPN), administered the full 5 mg dose rather than the ordered 2.5 mg (half tablet). On May 9, 2025, a physician's order for Narcan (naloxone, an opioid antagonist used to reverse the effects of opioid overdose) 4 mg/0.1 ml nasal spray was initiated for use as needed for opioid reversal. A progress note dated May 9, 2025, at 8:45 AM documented that Resident 2 experienced a sudden change in mental status. The resident appeared diaphoretic (excessively sweating), had a blank stare, and was initially unresponsive. The registered nurse was notified and completed an assessment. Vital signs at that time included blood pressure 107/65 mmHg, oxygen saturation 100% on 2 LPM nasal cannula, temperature 97.9°F, and heart rate 70 bpm. A blood glucose (Accu-check) result was 184. New medical orders were obtained from Employee 2, Certified Registered Nurse Practitioner (CRNP), and the resident began responding within five minutes. The resident asked for ginger ale and was subsequently alert. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although the MAR indicated that Narcan was administered at 10:05 AM, a progress note from the same date reported that the naloxone nasal spray was administered at 8:45 AM in response to the resident's unresponsive episode. Further documentation indicated that a peripheral IV was started in the resident's right lower arm at 9:05 AM, and a CRNP note from that morning stated the unresponsive episode lasted approximately 10 minutes following the administration of oxycodone 5 mg. The CRNP documented that Narcan was administered, and oxycodone was discontinued. A progress note dated May 9, 2025, at 10:45 AM, revealed the resident was alert, the resident's pupils were equal and reactive to light, the resident's hand grasps equal, and the resident's pain response was appropriate. Vital signs included 98/63 (BP), 19 bpm (respirations per minute), 91 (heart rate), 97.7 (temperature), and 98% (oxygen saturation). The resident voiced no complaints of pain. An employee witness statement dated May 9, 2025, submitted by Employee 1, LPN, confirmed that the nurse forgot to split the oxycodone tablet, resulting in administration of the incorrect dose. During an interview on June 3, 2025, at approximately 1:00 PM, the Director of Nursing (DON) confirmed Employee 1, LPN, administered the wrong dose of oxycodone to Resident 2 on May 9, 2025, resulting in the resident having an unresponsive episode and requiring the use of Narcan (naloxone) nasal liquid 4 mg/0.1 ml. The DON stated that a contributing factor in the resident's response was the resident's poor renal clearance (the body's process of removing substances from the blood through the kidneys and excreting them in the urine), as identified by the physician. The DON confirmed it is the facility's responsibility to ensure residents are free of significant medication errors. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services.