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	08/20/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, investigative documentation provided by the facility, and resident and staff interviews, it was determined the facility displayed past non-compliance by failing to protect one of four sampled residents (Resident 3) from neglect by not implementing the individualized care plan intervention for transfers, resulting in actual harm in the form of a mid-humerus fracture. Findings Include: A review of the facility policy titled Identifying Types of Abuse, last reviewed by the facility on September 26, 2024, revealed that abuse of any kind against residents is strictly prohibited. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety results in physical harm, pain, mental anguish, or emotional distress. A clinical record review revealed Resident 3 was originally admitted to the facility on [DATE] , with diagnoses that included chronic respiratory failure with hypoxia (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and 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). A review of a significant change in status Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 7, 2025, revealed that Resident 3 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).A review of the individualized care plan revealed Resident 3 had an activity of daily life self-care deficit related to decreased mobility initiated on October 25, 2023. Interventions developed to assist Resident 3 with this deficit included employees utilizing a mechanical lift with the assistance of two staff for transfers initiated on October 25, 2023.A review of the Kardex (a reference tool providing a concise, quick overview of a resident's essential information for nursing staff) dated July 29, 2025, revealed Resident 3 required a mechanical lift and the assistance of two staff members for all transfers.A review of facility provided investigative documentation revealed a written witness statement dated July 29, 2025, provided by Employee 1, Nurse Aide (NA), which indicated Employee 1, NA, was in the shower room getting ready to transfer Resident 3 from the shower chair to her wheelchair. Employee 1, NA, indicated that she put her arms around Resident 3, and when Resident 3 picked her arm up, they heard a cracking sound. Employee 1, NA, indicated she then went to get help. Employee 1, NA, reported Employee 2, Licensed Practical Nurse (LPN), was also present.A written witness statement dated July 29, 2025, provided by Employee 2, Licensed Practical Nurse (LPN), revealed she was asked by Employee 1, NA, to help with a transfer. She indicated Employee 1, NA, wanted her to clean Resident 3 and pull up her brief as Employee 1, NA, assisted her to a standing position. Employee 2, LPN, indicated she heard a pop as Employee 1, NA, lifted Resident 3. Resident 3 was assisted back down and began stating she could not move her arm. Employee 1, NA, left to get assistance. Employee 2, LPN, described specifically that Employee 1, NA, put her arms under Resident 3's arms so that they were chest to chest. As Employee 1, NA, began to stand with Resident 3, they heard the pop.An investigation document provided by the facility dated July 29, 2025, at 10:33 AM revealed Employee 1, NA, attempted to manually lift Resident 3 after completing a shower. Employee 1, NA, heard a crack, lowered Resident 3 back to her chair, and alerted additional staff for further assessment. The certified registered nurse practitioner assessed Resident 3's left arm to have notable swelling and bruising. Resident 3 was guarding her arm and complained of severe pain. The document indicated Employee 1, NA, was suspended pending an investigation.A progress note dated July 29, 2025, at 10:23 AM revealed a call was placed for a stat (immediate) x-ray of Resident 3's left arm.A progress note dated July 29, 2025, at 11:25 AM revealed Resident 3 was transferred to the community hospital by way of ambulance for left arm pain. The resident representative and physician were made aware.A review of x-ray results titled XR Humerus 2 or More Views, dated July 29, 2025, at 12:59 PM revealed three views of the left shoulder and three views of the left humerus (the large arm bone between the shoulder and the elbow). Shoulder views revealed Resident 3 sustained a fracture in the mid-diaphysis humerus (the long, cylindrical shaft or body that forms the middle section of the bone). No dislocation noted. Probable old, healed fracture of the proximal humerus. Views of the left humerus revealed a spiral oblique displaced fracture (a bone broken into at least two pieces