

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/24/2026
NAME OF PROVIDER OR SUPPLIER Abington Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy entitled Cleaning and Sanitizing Dietary Areas and Equipment last reviewed by the facility on April 29, 2026, indicated that all kitchen areas and equipment shall be maintained in a sanitary manner and be free of build-up of food, grease, or other soil. The facility will provide sanitary food services that meet state and federal regulations. The initial tour of the dietary department, conducted and confirmed with the facility's Certified Dietary Manager (CDM) on July 21, 2026, at 10:35 AM, revealed multiple unsanitary conditions that had the potential to contaminate food and food contact surfaces, increasing the risk of food-borne illness. Upon entering the dietary department, the dish room service area contained two brooms and one dust broom stored on the floor rather than in a designated storage holder. The insect attractor light located in the dish room contained a significant accumulation of deceased insects inside the collection compartment. The ice scoop holder attached to the ice machine contained the ice scoop resting in approximately one-quarter inch of standing water. An accumulation of debris was also present alongside the ice machine. The black lids of the four-compartment bulk cereal dispenser felt sticky and had an accumulation of debris. Observations of the second-floor pantry on July 23, 2026, at 9:11 AM, revealed the ice chest contained approximately one-quarter inch of standing water with a black speckled substance and emitted a mildew odor. Debris had accumulated on each shelf of the mobile plastic cart used to hold the ice chest. Observations of the third-floor pantry on July 23, 2026, at 9:25 AM, revealed the top of the ice chest felt sticky and had accumulated debris. Debris had also accumulated on each shelf of the mobile plastic cart used to hold the ice chest. During an interview on July 23, 2026, at 10:40 AM, the Nursing Home Administrator (NHA) reviewed and confirmed the above findings. I actually prefer this version for a CMS-2567. It reads more naturally, avoids repetitive references to surveyors, maintains active voice, and presents the findings in a clear, chronological sequence from the dietary department to the pantry areas and finally the facility's confirmation. 28 Pa. Code 201.18 (e) (2.1) Management. 28 Pa Code 211.10 (c) Resident care policies.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure licensed nurses accurately administered medication in accordance with physician orders for three of 25 residents reviewed (Resident 40, Resident 5, and Resident 9). Findings include: A review of the facility policy titled Administering Medications last reviewed by the facility on April 29, 2026, revealed that medications are administered as prescribed in a safe, timely manner. Medications are administered in accordance with prescriber orders, and information is verified prior to administering medication including vital signs (measurements of basic body functions such as blood pressure, pulse, temperature, and breathing), are verified prior to administering medications when parameters are ordered. A clinical record review revealed Resident 40 was admitted to the facility on [DATE], with diagnoses that included diastolic congestive heart failure (happens when the heart can still squeeze blood out but can't fill properly during each beat). A review of Resident 40's Significant Change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 7, 2026, revealed that Resident 40 was cognitively intact with a BIMS score of 15 (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 reflects normal cognition and no difficulty with memory, orientation, or recall). Resident 40 was interviewed on July 22, 2026, at 10:30 AM and stated she was expecting to be discharged from the facility, but was concerned about her blood pressure fluctuating from high to low and vice versa. A review of the physician's order dated June 3, 2026, directed staff to administer Midodrine HCl (medication used to treat low blood pressure) 10 milligrams (mg) orally three times a day for orthostatic hypotension (a sudden drop in blood pressure occurring within 3 minutes of standing or shifting to an upright position which may cause dizziness or fainting). The physician's order specified to hold (not give) the medication if the systolic blood pressure (top number in a blood pressure reading, representing pressure when the heart contracts) was greater than 130 millimeters of mercury (mm/Hg) or greater. A review of the July 2026 MAR (medication administration record) revealed Midodrine was administered four times when the medication should not have been given according to the physician's order of systolic blood pressure 130mm/Hg or greater. The following blood pressure readings were documented at the time the medication was administered: July 2, 2026, at 6:00 AM blood pressure reading of 137/78 mm/Hg July 5, 2026, at 10:00 PM blood pressure reading of 131/83 mm/Hg July 15, 2026, at 6:00 AM blood pressure reading of 131/76 mm/Hg July 22, 2026, at 6:00 AM blood pressure reading of 130/70 mm/Hg. Despite the presence of criteria for Midodrine to be held, the medication was administered on the above four occasions during the month of July 2026. The above findings were reviewed with the Nursing Home Administrator on July 22, 2026, at 11:30 AM. The NHA acknowledged the medication was administered and not withheld when the physician-ordered parameters to hold the medication were present. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that included sick sinus syndrome (a condition when the heart beats too slowly, too quickly, or erratically). A review of Resident 5's Quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 5 was cognitively intact with a BIMS score of 15. A review of the physician's order dated June 4, 2026, directed staff to administer Midodrine HCl 5 milligrams (mg) daily due to renal dialysis (a process that filters the blood and removes waste, extra water, and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	certain chemicals when the kidneys no longer work) daily every Monday, Wednesday, and Friday at 8:00 AM. The physician's order specified to hold (not give) the medication if the systolic blood pressure was greater than 130 millimeters of mercury (mm/Hg) or greater. A review of the June 2026 MAR revealed Midodrine was administered 10 times without documentation of a blood pressure reading prior to administration, as required by the physician's order, on the following dates: June 5, 2026 June 8, 2026 June 10, 2026 June 12, 2026 June 17, 2026 June 19, 2026 June 22, 2026 June 24, 2026 June 26, 2026 June 29, 2026 Administration of Midodrine without obtaining the required blood pressure reading prevented nursing staff from determining whether the medication was safe to administer according to the physician's ordered parameters. A review of the clinical record reveal that Resident 9 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (also known as an ischemic stroke, is the irreversible death of brain tissue caused by a blockage in the blood vessel that disrupts oxygen and blood flow to the brain) and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for a prolonged period of time). A review of the clinical record revealed a physician's order initially dated May 5, 2026, for Carvedilol oral tablet 3.125 milligrams, (a beta blocker used to treat heart failure and hypertension) with instructions to give one tablet one time a day for HTN (hypertension), Hold for SBP (systolic blood pressure) less than 100 mm/Hg and a heart rate of less than 60 BPM (beats per minute) . The medication was scheduled to be given at 9:00 AM. A review of Resident 9's May 2026 to July 2026 Medication Administration Record (MAR) revealed that Carvedilol was administered 59 times without documentation of a blood pressure reading or a pulse prior to administration as required by the physician order on the following dates: May 7, 2026, at 9:00 AM May 9, 2026, at 9:00 AM May 10, 2026, at 9:00 AM May 11, 2026, at 9:00 AM May 12, 2026, at 9:00 AM May 13, 2026, at 9:00 AM May 14, 2026, at 9:00 AM May 15, 2026, at 9:00 AM May 16, 2026, at 9:00 AM May 18, 2026, at 9:00 AM May 19, 2026, at 9:00 AM May 20, 2026, at 9:00 AM May 21, 2026, at 9:00 AM May 22, 2026, at 9:00 AM May 24, 2026, at 9:00 AM May 26, 2026, at 9:00 AM May 27, 2026, at 9:00 AM May 28, 2026, at 9:00 AM May 30, 2026, at 9:00 AM May 31, 2026, at 9:00 AM June 3, 2026, at 9:00 AM June 4, 2026, at 9:00 AM June 5, 2026, at 9:00 AM June 6, 2026, at 9:00 AM June 7, 2026, at 9:00 AM June 8, 2026, at 9:00 AM June 9, 2026, at 9:00 AM June 10, 2026, at 9:00 AM June 11, 2026, at 9:00 AM June 12, 2026, at 9:00 AM June 13, 2026, at 9:00 AM June 14, 2026, at 9:00 AM June 15, 2026, at 9:00 AM June 16, 2026, at 9:00 AM June 17, 2026, at 9:00 AM June 18, 2026, at 9:00 AM June 19, 2026, at 9:00 AM June 20, 2026, at 9:00 AM June 21, 2026, at 9:00 AM June 22, 2026, at 9:00 AM June 23, 2026, at 9:00 AM June 24, 2026, at 9:00 AM June 25, 2026, at 9:00 AM June 26, 2026, at 9:00 AM June 27, 2026, at 9:00 AM June 28, 2026, at 9:00 AM June 29, 2026, at 9:00 AM June 30, 2026, at 9:00 AM July 1, 2026, at 9:00:AM July 3, 2026, at 9:00:AM July 8, 2026, at 9:00 AM July 9, 2026, at 9:00 AM July 10, 2026, at 9:00 AM July 13, 2026, at 9:00 AM July 14, 2026, at 9:00 AM July 15, 2026, at 9:00 AM July 16, 2026, at 9:00 AM July 17,2026, at 9:00 AM July 18, 2026, at 9:00 AM July 19,2026, at 9:00 AM Administration of Carvedilol without obtaining the required blood pressure or pulse reading prevented nursing staff from determining whether the medication was safe to administer according to the physician's ordered parameters. ^The above findings were reviewed with the Director of Nursing (DON) on July 24, 2026, at 11:25 AM. The DON acknowledged the medication was not administered according to the physician order or the facility policy. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. ^ 28 Pa Code 211.10 (c)(d) Resident care policies. ^ 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.10 (c)(d) Resident care policies.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, medication administration records, and staff interview, it was determined the facility failed to document that individualized non-pharmacological interventions were attempted prior to the administration of an as needed (PRN) psychotropic medication for one of 25 residents reviewed (Resident 6). Findings include: Federal requirements for the use of psychotropic medications expect that psychotropic medications are used only when necessary to treat a specific, documented condition. Non-pharmacological interventions are used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. The resident's medical record should include documentation of this evaluation and the rationale for chosen treatment options. When clinically appropriate, these interventions should be attempted and documented prior to administering PRN psychotropic medication. A review of the facility's policy titled Psychoactive Medication Use reviewed April 29, 2026, indicated that all residents receiving psychoactive medications will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a gradual dose reduction of psychoactive medication monitored and documented. The policy revealed that individualized non-pharmacological approaches are provided as part of a supportive physical and psychological environment and are directed toward preventing, relieving, or accommodating a resident's distressed behavior. A clinical record review revealed Resident 6 was admitted to the facility on [DATE], with diagnoses that included diastolic congestive heart failure (a condition in which the heart muscle continues to pump normally but does not relax enough to fill properly between heartbeats). A review of Resident 6's Significant Change Minimum Data Set (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 7, 2026, revealed that Resident 6 was cognitively intact with a BIMS score of 15 (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 reflects normal cognition and no difficulty with memory, orientation, or recall). A review of physician orders revealed an order dated November 18, 2025, for Alprazolam 0.25 milligrams (an anti-anxiety medication classified as a psychotropic medication) to be administered every eight hours as needed for anxiety. A review of the electronic Medication Administration Record (eMAR, a computerized record that documents medications ordered and administered) revealed staff administered Alprazolam 0.25 milligrams on the following dates and times: November 22, 2025, at 5:39 AM November 23, 2025, at 9:00 PM November 26, 2025, at 6:12 PM November 27, 2025, at 5:27 PM A review of the clinical record failed to identify documentation that staff attempted or that individualized non-pharmacological interventions were ineffective before administering the PRN psychotropic medication on any of the four occasions. Therefore, the facility could not demonstrate that less restrictive interventions were considered before administering the medication. During an interview on July 22, 2026, at 1:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the clinical record did not contain documentation of non-pharmacologic interventions prior to the administration of the psychotropic medication on the four identified occasions.28 Pa. Code 211.2(3) Medical director.28 Pa. Code 211.5(ii)(xi) Clinical records.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on facility policy reviews, clinical record reviews, and staff interviews, it was determined that the facility failed to provide appropriate care and services to residents receiving enteral feedings for one of 25 residents reviewed (Resident 1). Findings include: Review of the facility policy, titled Enteral Tube Feeding via Continuous Pump, reviewed April 29, 2026, provides guidance for enteral feedings (instead of eating or drinking by mouth, food is delivered in liquid form through a small tube placed into the stomach) including verification of a physician's order for the procedure and checking the label (date and time the formula was prepared) with the order prior to administration. A clinical record review revealed Resident 1 was admitted to the facility September 30, 2024, with diagnoses that included esophageal obstruction (blockage in the food pipe that makes it hard or impossible for food and drinks to move from your mouth down into the stomach) and dysphagia, pharyngeal phase (difficulty swallowing). A review of Resident 1's Significant Change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 17, 2026, revealed that Resident 1 had moderate cognitive impairment with a BIMS score of 12 (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 8-12 reflects moderate cognitive issues indicating the individual may have some trouble with memory, orientation, or recall). Review of Resident 1's care plan identified the use of enteral feeding to support Resident 1's nutritional needs. The care plan dated February 9, 2026, and most recently revised June 17, 2026 revealed interventions which included but were not limited to administering the tube feeding formula, hydration, and flushes according to the physician's order. Review of Resident 1's clinical record revealed a physician order dated June 28, 2026, for Glucerna 1.2 Full Strength via pump (delivering a diabetes-approved, calorie-rich nutrition drink through a feeding pump into the stomach) at 40 milliliters (mL)/ hour (hr) for 22 hours. The feeding was to be held for two hours for therapy according to the physician order. Further clinical review revealed a physician's order dated February 16, 2026, for the enteral feed to be initiated at 12:00 PM and end at 10:00 AM daily. Review of Resident 1's July 2026 electronic medication administration record (eMAR, digital checklist that shows what medications a resident is supposed to receive and what time the medication was administered) confirms daily administration of Glucerna 1.2 as ordered. Documentation in the eMAR confirmed that the enteral feeding was started at 12:00 PM and ended at 10:00 AM every day. During an observation on July 21, 2026, at 10:23 AM, the enteral feeding was infusing and labeled July 20, 2026, at 5:00 AM. Review of the eMAR showed the required task to change the feeding bottle and tubing daily lacked documentation confirming completion throughout the entire month of July 2026. On July 22, 2026, at 1:40 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the enteral feeding had been labeled in a manner that did not follow facility policy. On July 23, 2026, at 11:00 AM, the DON confirmed that the enteral feeding in use was labeled July 20, 2026, at 5:00 AM, and acknowledged it was not being administered as ordered. The DON could not provide a rationale for why a feeding labeled July 20, 2026, at 5:00 AM was still infusing more than 24 hours later, and the observed infusion time of 10:23 AM did not correspond with the physician's prescribed feeding schedule. 28 Pa. Code 201.18 Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		