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	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbeyville Skilled Nursing and Rehabilitation Cent	100 Abbeyville Road Lancaster, PA 17603

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33840 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that written notices of emergency transfers to the hospital were provided to the Office of the State Long Term Care Ombudsman for 6 of 24 residents reviewed (Resident 78, 111, 112, 119, 126 and 146). Findings include: Review of Resident 78's clinical record revealed Resident 78 was hospitalized on [DATE] and was readmitted to the facility on [DATE]. No documentation was provided indicating the Office of the State Long Term Care Ombudsman was notified. Review of Resident 111's clinical record revealed Resident 111 was hospitalized on [DATE] and was readmitted to the facility on [DATE]. No documentation was provided indicating the Office of the State Long Term Care Ombudsman was notified. Review of Resident 112's progress note of October 28, 2023, revealed that the resident wanted to go to the hospital. The on-call physician was notified and ordered that the resident be sent to the hospital. Review of Resident 119's progress note of January 8, 2024, revealed that the CRNP ordered the resident to be sent to the hospital secondary to wound/drainage and elevated temperature. Resident was admitted with early stage osteomyelitis (bone infection). Review of Resident 126's clinical record revealed a progress note indicating that the resident was sent to the hospital on January 20, 2024, for seizure like activity. No further documentation stating that the Office of the State Long Term Care Ombudsmans was notified. Review of Resident 146's progress note of January 13, 2024, revealed resident was unresponsive and was transported to the hospital. Interview with Nursing Home Administrator on March 3, 2024, at 1:00 p.m. confirmed that the facility did not send notifications to the Office of the State Long Term Care Ombudsman's office when residents were transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 33840 Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure that assessments accurately reflected the resident's status for one of 32 residents reviewed (Resident 79). Findings include: Review of Resident 79's clinical record revealed a quarterly Minimmal Data Set (MDS- a tool used to identify plan of care) dated December 1, 2023, identified a new pressure ulcer. Further review of Resident 79's clinical record revealed no further documentation of the pressure ulcer. An interview with the licensed employee E3, on March 8, 2024, at 9:49 a.m., revealed that the resident did not have a pressure ulcer during the review for the MDS, and it was incorrectly coded. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(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. 41765 Based on observations, clinical records review, and staff interviews, it was determined that the facility failed to ensure residents with an order for fluids restrictions were monitored for their fluid intake for three of the 32 residents reviewed (Residents 76, 108, and 124). Findings include: Review of Resident 76's physician orders revealed an order for Fluid restriction 1800 ml daily [milliliters] Further review of Resident 76's clinical records failed to reveal documented evidence that Resident 76's fluid restrictions were monitored according to physician's orders. Clinical records review revealed Resident 108 was readmitted from the hospital on January 16, 2024, with a diagnosis of Hyponatremia (low sodium level). Review of the physician order dated January 18, 2024, revealed an order for Fluid restriction 1800/24 hrs. Review of Resident 108's clinical records failed to reveal Resident 108's fluid intake was monitored from January 18, 2024, until February 1, 2024. Review of Resident 124's physician orders revealed an order for Fluid restriction 2000 ml [milliliters] daily. Further review of Resident 124's clinical records failed to reveal any documented evidence that Resident 124's fluid restrictions were monitored according to physician's orders. Review of the progress notes dated January 17, 2024, revealed blood works were reviewed by NP (nurse practitioner), a new order for fluid restriction of 1800 ml/24 hr., and repeat blood work was ordered. Interview with the NHA conducted on March 8, 2024, at 11:30 a.m., confirmed that there was no documentation indicating Residents fluid intake was monitored. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on observation, clinical records review and staff interview it was determined that the facility failed to provide respiratory service and treatment for one of the 32 residents reviewed (Resident 42). Findings include: Review of Resident 42's diagnosis list includes Obstructive sleep apnea (Which means breathing stops for short periods during sleep due to a blocked/partially blocked airway). Observation conducted on March 6, 2024, revealed a CPAP (Continuous positive airway pressure - A machine that uses mild air pressure to keep breathing airways open while you sleep) machine on Resident 42's bedside table. Review of Resident 42's physician's order sheet dated November 21, 2022, revealed an order for CPAP @ pressure 15cm H2O every night shift for Sleep Apnea. Review of Resident 42's clinical records revealed Resident 42 was hospitalized on [DATE], due to Acute Encephalopathy (An acute/subacute functional alteration of mental status due to systemic factors) and returned to the facility on [DATE]. Review of Resident 42's hospital discharge summary dated January 4, 2024, revealed an order for CPAP pressure of 15 cm H2O. Review of Resident 42's admission physician order failed to reveal an order for the CPAP. An interview with the Director of Nursing on March 8, 2024, at 10:30 a.m., was conducted. The DON confirmed Resident 42 had an order for the CPAP before the hospitalization but nursing staff failed to place the CPAP order when the resident was readmitted to the facility on [DATE]. The physician was not notified of the missed CPAP order from readmission to the facility until questioned by the surveyor. The above information was conveyed to the Nursing Home Director on March 8, 2024, at 11:19 a.m. The facility failed to ensure CPAP order for Resident 42 was followed. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical record review, pharmacy record review, and staff interview it was determined the facility failed to ensure medications were available for residents for two of the 32 residents reviewed (Resident 42, and 85). Findings include: Review of Resident 42's physician order dated September 3, 2023, revealed an order for Linezolid Oral Tablet (antibiotic) 600mg one tablet by mouth every 12 hours for UTI (Urinary Tract Infection). Review of Resident 42's September 2023 Medication Administration Record (MAR) revealed Linezolid ordered on September 3, 2023, was not administered to the resident until the evening of September 5, 2023. Review of the pharmacy delivery report revealed Resident 42's Linezolid medication ordered on September 3, 2023, was not delivered to the facility until September 5, 2023. Review of Resident 85's nursing progress notes dated January 19, 2024, revealed resident was observed with redness and swelling to the left eye, the NP (nurse practitioner) was notified and ordered Erythromycin ointment (eye antibiotic) to the left eye and Prednisone tablet. Review of Resident 85's physician order dated January 19, 2024, revealed an order for Erythromycin Ophthalmic Ointment 5 mg/gm. Instill 5 mg in the left eye two times daily for red rash around the left eye for five days. Review of Resident 85's January 2024 MAR revealed Erythromycin eye ointment ordered on January 19, 2024, was not administered to the resident until January 23, 2024. Review of the nursing progress notes dated January 20, 2024, at 8:51 p.m., revealed waiting for delivery from the pharmacy (for Erythromycin eye ointment). Review of the nursing progress notes dated January 22, 2024, at 8:56 a.m., revealed awaiting (Erythromycin eye ointment medication) arrival from a pharmacy, call was placed to the pharmacy. Review of the pharmacy delivery record revealed Erythromycin eye ointment ordered on January 19, 2024, was delivered to the facility on [DATE]. Interview with the Director of Nursing conducted on March 8, 2024, at 10:30 a.m., confirmed that the above medications were not timely administered to the residents due to the unavailability of the medications from the pharmacy. The facility failed to ensure medications ordered for Residents 42 and 85 were available. 28 Pa. Code 211.5(f) Clinical records (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on observations, a review of medication manufacturer's guidelines, and staff interviews, it was determined that the facility failed to ensure medications were properly stored and labeled for two of the three units observed ([NAME] and [NAME]). Findings include: Review of the facility's policy titled Storage and Expiration Dating of Medications, Biologicals, dated January 2022, revealed that once a medication or biological package is opened, the facility should follow manufacturer/supplier guidelines concerning the expiration date for opened medication. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. The same policy also revealed that the facility should ensure that the medications are stored in the containers in which they were originally received. Review of the manufacturer's storage guidelines for Insulin Lispro (Humalog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. Review of manufacturers' storage guidelines for Lantus Insulin Pen (long-acting insulin) revealed that the medication may be stored at room temperature and must be discarded within 28 days after opening. Review of the manufacturer's guidelines for Latanoprost (used to treat high pressure in the eye), revealed that once a bottle is opened for use it may be stored at room temperature for six weeks. Review of the Olopatadine manufacturer's storage guidelines revealed to discard each bottle four weeks after it has been opened. Review of the Tobramycin Eye Solution (A medication to treat eye infection) manufacturer's guidelines revealed not to use the medication stored at room temperature for more than 28 days. Review of same guidelines indicated Loteprednol Etabonate Ophthalmic Solution (used to treat eye inflammation). Discard any unused contents 28 days after first opening the bottle. Observation on [NAME] Nursing unit, front medication cart was conducted on March 6, 2024, at 8:57 a.m., in the presence of licensed nurse Employee E5. The following were observed: One Insulin Lispro pen, opened and undated; One Lantus vial opened and undated; One bottle of Latanoprost eye drop, opened and undated; One bottle of Olopatadine eye drop, opened and undated; One bottle of Tobramycin eye drops, opened and undated; and One bottle of Loteprednol Etabonate eye drops, opened and undated. Interview with Employee E5 on March 6, 2024, at 9:00 a.m., was conducted. Employee E5 was unable to determine when the medications listed above were opened. Employee E5 confirmed that the medications listed should have been dated once opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the [NAME] front medication cart conducted on March 6, 2024, at 9:05 a.m., revealed 12 Omeprazole (medication that treats certain conditions where there is too much acid in the stomach) lying on the top-drawer cart without its original container. Interview with Employee E6 was conducted on March 6, 2024, at 9:07 a.m. Employee E6 was unable to say who the medication belonged to. Employee E6 confirmed that medications should be in their original container. Observation of the [NAME] back medication cart conducted on March 6, 2024, at 9:15 a.m., revealed 18 scattered medications of different sizes, shapes, and colors. The above information was conveyed to the Director of Nursing on March 8, 2024, at 1:30 p.m. The facility failed to ensure medications on [NAME] and [NAME] Units were property stored and labeled. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502 Based on observations, and staff interview, it was determined that the facility failed to follow acceptable infection control practices related to proper ice handling on 3 of 4 units ([NAME], [NAME], and Roosevelt). Findings include: Observation on March 5, 2024, at 11:25 a.m. on [NAME] unit revealed that the ice scoop was in a covered plastic container. The container had a washcloth placed in the bottom with the ice scoop resting directly on the washcloth which was wet. Observations on March 8, 2024 between 10:05 a.m. and 10:07 a.m on the [NAME] unit and Roosevelt unit, respectively, revealed that the ice scoops were in covered plastic containers. The containers had a washcloth in the bottom with the ice scoop resting directly on the washcloth in approximately one inch of water. Interview with the DON and Employee E4, Infection Preventionist, on March 8, 2024, at 1:30 p.m., confirmed that the washcloth should not be in the container with the ice scoop. 28 Pa Code 201.18(b)(3) Management 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services