STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395166	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Pembrooke	1130 West Chester Pike West Chester, PA 19380

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of the Pennsylvania Professional Nursing Practice Act, observation, clinical records review, and staff interview, it was determined the facility failed to maintain the professional standard of practice in providing wound care for one of three residents reviewed (Resident R2).Findings include:The Professional Code, Title 49, Professional and Vocational Standards (Pennsylvania Professional Nursing Practice Act), Chapter 21.145(a) states that the Licensed Practical Nurse (LPN) is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, and experience in nursing competency. The LPN participates in the planning, implementation, and evaluation of nursing care, using focused assessment in settings where nursing takes place. Clinical records review revealed Resident R2 had a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) to the sacrum and left medial thigh MASD (Moisture-Associated Skin Damage- A skin condition caused by prolonged exposure to moisture, leading to inflammation, irritation, and potential skin breakdown).A review of the physician order dated August 23, 2025, revealed an order to cleanse the area to the left lower leg with normal saline solution, apply Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns), cover with an abdominal dressing, and Kling.A review of the physician's order dated October 30, 2025, revealed an order to cleanse the sacral wound with normal saline, apply nickel-thick Santyl, and cover with a dry dressing every day.A review of October 2025, Treatment Administration Record (TAR), revealed Resident R2's left leg MASD was treated by Licensed Nurse Employee E9 on October 30th and 31st and November 1st and 3rd, 2025.A review of the November 2025 TAR revealed Resident R2's sacral wound was treated by Nursing Employee E9 on November 3, 2025.An observation conducted on November 3, 2025, at 11:35 a.m., in the presence of licensed nurses, Nursing Employee E8 and E9 revealed that Resident R2 was lying in bed, and both legs had a wound dressing that was observed loose. The left leg dressing had a date of 10/29/25 written on it and the right leg dressing was undated. Additional observation revealed that Resident R2's sacral wound did not have a dressing and was open to air.An interview was conducted with Nursing Employee E9 on November 3, 2025, at 11:40 a.m. Employee E9 reported that they were Resident R2's nurse. Employee E9 confirmed they documented Resident R2's wound treatments for the day were done around 9:30 to 10:00 a.m., while completing the resident's behavior documents. Employee E9 confirmed that wound treatments to the sacrum and legs had not been performed for the day, despite documenting that they had already been done. Employee E9 confirmed documenting that wound treatment to the left leg was done on October 30, 31, and November 1, 2025. When asked if treatment to the left leg was done on the mentioned dates since wound dressing indicated a date of 10/29/25, Employee E9 was unable to provide an answer.The facility failed to ensure professional standards of practice were maintained in providing wound care and treatment to Resident R2.28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 8/25/2528 Pa. Code 211.12(d)(1)(5) Nursing ServicesPreviously cited 8/25/25

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, and staff interviews, it was determined the facility failed to follow a physician's order for two of five residents reviewed (Residents R1 and R2). Failure to follow Resident R2's wound care orders resulted in actual harm with deterioration of the wounds as evidenced by increased size. Findings include:Review of Resident R2's diagnosis list includes Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period of time), Peripheral Venous Insufficiency (condition that occurs when the veins in the legs do not function properly, leading to poor blood flow back to the heart), and non-pressure chronic ulcer (wound) of the right leg.Review of Resident R2's active care plan revealed actual skin integrity impairment related to immobility, chronic progressive disease, and history of bilateral extremity venous ulcers: Sacral- Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss); left medial thigh MASD (Moisture-Associated Skin Damage- skin condition caused by prolonged exposure to moisture, leading to inflammation, irritation, and potential skin breakdown); right medial thigh venous ulcer. Intervention includes treatment as ordered.Review of Resident R2's physician order dated August 23, 2025, revealed wound instructions of cleanse area to the left lower leg with normal saline solution apply Medihoney (dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) cover with abdominal dressing (large absorbent bandage) and Kling (gauze wrap). Review of Resident R2's physician order dated October 10, 2025, revealed wound instructions of Hydrogel gel (used to maintain a moist wound) apply to right medial (middle) lower leg topically one time a day after cleansing with normal saline solution (sterile salt water), then cover with abdominal dressing and Kling. Review of Resident R2's wound physician consult dated October 28, 2025, revealed right leg venous ulcer's measurement of 1.5 x 1.0 cm (centimeters) with partial thickness and moderate serosanguinous (mixture of clear fluid and blood) drainage. Wound progress was documented as deteriorating. A new treatment of Medihoney daily was ordered. Left leg MASD had a measurement of 3.0 x 2.5 cm, with partial thickness and moderate serosanguinous drainage. Wound progress was documented as deteriorating, remained on Medihoney treatment daily.Review of Resident R2's October 2025, Treatment Administration Record (TAR), revealed Hydrogel treatment for the right leg was discontinued on October 29, 2025. Further review of resident's TAR revealed the Medihoney treatment recommended by the wound physician on October 28, 2025, was not transcribed to the TAR. Review of Resident R2's clinical records revealed Resident R2's right leg venous ulcer was not treated from October 30, 2025, until November 2, 2025. Review of the same TAR revealed Resident 2's left leg MASD was treated on October 30, October 31, November 1, November 2, and November 3, 2025.Observation conducted on November 3, 2025, at 11:35 a.m., in the presence of licensed nurses Employees E8 and E9 revealed Resident R2 was lying in bed, both legs had a wound dressing that was observed loose. The right leg dressing did not have a date written on the dressing, but the left leg dressing had a date of 10/29/25.Interview conducted with licensed nurse, Employee E9 on November 3, 2025, at 11:40 a.m. revealed Employee E9 was Resident R2's nurse. Employee E9 confirmed they documented Resident R2's wound treatments were done around 9:30 to 10:00 a.m., while completing resident's behavior documents. Employee E9 confirmed wound treatments to bilateral legs had not been performed for the day despite documenting, the treatment was completed. Employee E9 confirmed documenting the wound treatment to the left leg was done on October 30, October 31, and November 1, 2025. When asked if treatment to the left leg was done on the previously mentioned dates as wound dressing indicated a date of 10/29/25, Employee E9 was unable to provide an answer. Observation of the wounds was conducted in the presence of the Direct of Nursing (DON) on November 3, 2025, at 12:15 p.m. Right and left leg wounds were measured by the DON and revealed the following: Right leg venous ulcer had a measurement of 9.5 x 7.5 cm and left leg MASD wound had a measurement of 8.5 x 2.5 cm. Surrounding area of both wounds were reddened. Interview conducted with the DON on November 3, 2025, at 3:00 p.m., confirmed Resident's R2's bilateral leg wound treatment was not administered from October 30, 2025, until November 2, 2025.The facility failed to ensure wound treatment order for Resident R2's right leg venous ulcer and left leg MASD was followed which resulted in actual harm with further deterioration of both wounds as evidenced by increased in size.Review of Resident R1's clinical records revealed resident was readmitted to the facility on [DATE], with diagnosis of wound infection. Review of the physician's order dated September 30, 2025, revealed the following: Ertapenem Sodium (Antibiotic) one gram intravenously (administered into a

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, clinical records review, and staff interview, it was determined the facility failed to follow the wound treatment order for a sacral, Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) for one of three residents reviewed (Resident R2).Findings include:A review of Resident R2's wound consult dated October 28, 2025, revealed Resident R2 had a Stage four pressure injury to the sacrum that measures 1.2 x 0.8 x 0.2 cm (centimeters), with moderate serous (clear liquid) drainage.A review of Resident R2's physician order dated October 30, 2025, revealed an order to cleanse the sacral wound with normal saline (sterile salt water), apply nickel-thick Santyl (ointment used to decrease dead tissue in the wound), and cover with a dry dressing every day.A review of November 2025, Treatment Administration Record (TAR) revealed the resident's sacral wound was treated on November 3, 2025 (day shift). Further review revealed that sacral wound treatment was not done on November 2, 2025.A sacral wound observation was conducted on November 3, 2025, at 11:35 a.m., in the presence of licensed nurses, Employee E8 and E9. When asked to open the resident's incontinence brief, a large bowel movement was observed. Further observation revealed the resident's sacral wound had no dressing.An interview was conducted with Employee E9 on November 3, 2025, at 11:40 a.m. Employee E9 reported that they were Resident R2's nurse. Employee E9 confirmed they had documented Resident R2's wound treatments for the day were done around 9:30 to 10:00 a.m., while completing the resident's behavior documents. Employee E9 confirmed the wound treatments to the sacrum had not been performed for the day, despite documenting they had already been done.An interview with the Director of Nursing (DON) was conducted on November 3, 2025, at 3:00 p.m. The DON was unable to provide an answer as to why sacral wound treatment was not done on November 2, 2025.The facility failed to ensure Resident R2's sacral wound treatment order was followed as ordered by the physician. 28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 8/25/2528 Pa. Code 211.12(d)(1)(5) Nursing ServicesPreviously cited 8/25/25

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews, it was determined the facility failed to provide adequate supervision during resident care resulting in actual harm to Resident R1 who sustained a fall and an Acute Subarachnoid Hemorrhage (life-threatening condition where bleeding occurs in the space between the brain and the membrane that covers the brain) for one of five residents reviewed (Resident R1). Findings include:Clinical record review revealed Resident R1 had a diagnosis of Paraplegia (loss of motor or sensory functions in the lower half of the body) post spinal injury.Review of Resident R1's Annual Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated May 9, 2025, revealed the resident was determined to be cognitively intact. The same MDS assessment revealed Resident R1 had an impairment on both sides of the upper and lower extremities. Further review revealed Resident R1 was dependent on staff for the following activities: shower/bathing, upper and lower extremity dressing, personal hygiene, toileting, transferring, and rolling left to right.Review of the MDS dated [DATE], revealed Resident R1 required extensive with two-person assistance for bed mobility and toileting.Review of the Quarterly MDS dated [DATE], revealed Resident R1 remained with impairment on both sides of upper and lower extremities and remained dependent on staff assistance with shower/bathing, upper and lower extremity dressing, personal hygiene, toileting, transferring, and rolling left to right.Review of Resident R1's care plan failed to reveal information regarding Resident R1 requiring extensive/dependent with two-person assistance with bed mobility as documented on MDS assessments.Interview was conducted with the LNAC (License Nurse Assessment Coordinator) Employee E3 on November 3, 2025, at 3:40 p.m., and confirmed Resident R1's requiring two-person assistance with bed mobility was not reflected in the resident's care plan. When asked for an explanation, Employee E3 responded, I don't have an answer. Review of Resident R1's nursing progress note dated September 11, 2025, at 9:59 a.m., revealed resident was observed lying in a supine position on the floor on next to [his/her] bed, blood was observed under resident's back and left arm, and the resident reported hitting [his/her] head. The physician was in-house and assessed the resident and ordered them to be transfer to the hospital for evaluation. (Not direct quote). Review of Resident R1's nursing progress note dated September 11, 2025, at 2:44 p.m., revealed a follow-up call made to the hospital, the resident was admitted to the ICU (Intensive Care Unit) with a diagnosis of Subarachnoid Hemorrhage.Review of the facility's investigation, revealed unlicensed Employee E4's statement dated September 11, 2025, indicated I was changing (Resident R1's) sheets when the left side of the mattress lifted up and tilted, causing the resident to roll off the bed.Additional review of facility investigation revealed a statement by Employee E4, taken by the DON (Director of Nursing) on September 16, 2025, revealed Employee E4 was on the left side of the resident's bed and turned the resident on their right side towards the door to wash their back. The aide also stated that they were changing the resident's bottom sheet while the resident was turned over, the mattress lifted, and the resident fell on the floor. Interview conducted with Resident R1 on November 3, 2025, at 2:00 p.m. revealed when questioned regarding the incident, the Resident responded, That is what I want to know, how did I fall? The resident was unable to articulate what caused the fall but confirmed there was only one staff member providing care during the incident. When asked if they can turn on their side, the resident responded, I cannot roll. Further interview with Resident R1 revealed that there are usually two staff providing care, but sometimes only one. The resident stated, I should probably need two staff because I cannot roll.Interview was conducted with Nursing Assistant (NA), Employee E5 on November 3, 2025, at 3:00 p.m. Employee E5 reported that they had been caring for the resident for a few years. Employee E5 reported that Resident R1 requires two-person assistance with bed mobility. Employee E5 stated, (Resident R1) cannot do anything.Interview conducted with licensed nurse Employee E6 on November 3, 2025, at 3:05 p.m. Employee E6 reported not being on the unit consistently but had been caring for Resident R1 when assigned to work on the unit. Employee E6 reported Resident R1 required two-person assistance with bed mobility. Employee E6 further stated, (Resident R1) cannot do anything, they're dependent.Interview conducted with NA Employee E7 on November 3, 2025, at 3:05 p.m. Employee E7 indicated they were on the unit consistently and had been caring for Resident R1. Employee E7 confirmed Resident R1 required two-person assistance with bed mobility. Employee E7 stated, (Resident R1) cannot do anything, even with eating, they need help.Interview conducted with the NHA (Nursing Home Administrator) on November 3, 2025, at 3:00 p.m. The NHA