

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/28/2025
NAME OF PROVIDER OR SUPPLIER  Aventura at Pembroke		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical records review, and staff interview, it was determined that the facility failed to follow the medication ordered by the physician for one of three residents reviewed (Resident CL1). Findings include: A review of Resident CL1's diagnosis list includes Anemia (low red blood cell count) and chronic kidney disease (progressive condition where kidneys gradually lose their ability to filter waste and fluids from the blood). The resident was admitted to the facility on [DATE]. Clinical records review revealed Resident CL1 was sent to the hospital for a blood transfusion on October 14, 2025, and October 16, 2025, for a low Hemoglobin level (an iron-rich protein that carries oxygen from the lungs to the body's tissue and organs). A review of the Physician's order, dated November 24, 2025, revealed an order for Aranesp (A medication used to treat anemia) 200 mcg/ml, inject 200 mcg intramuscularly (injection of a substance into a muscle) one time a day every Thursday. A review of Resident CL1's November and December 2025 Medication Administration Record (MAR) revealed that the Aranesp was not administered to the resident on the following dates: November 27, 2025, December 4, 2025, and December 11, 2025. Nursing progress notes dated November 27, 2025, at 11:34 a.m., revealed Aranesp medication awaiting from pharmacy. Nursing progress notes dated December 4, 2025, at 11:24 a.m., Aranesp medication Awaiting from pharmacy, pharmacy called needs to be approved due to high cost, DON (Director of Nursing) was made aware. Nursing progress notes dated December 11, 2025, at 11:24 a.m., revealed Aranesp medication awaiting from pharmacy. An interview was conducted with the DON on December 24, 2025, at 1:00 p.m. The DON reported that they were notified of the medication needing approval due to its cost. The DON reported giving approval via phone to the pharmacy on December 5, 2025, for the medication to be sent, but was unable to provide the name of the person they spoke to and was unable to provide documented evidence that the approval was made. The DON also confirmed that a follow-up was not made on December 11, 2025, when the medication was not sent by the pharmacy. Clinical records review failed to reveal that the physician was notified of the missed Aranesp dosage. The resident was discharged home on December 17, 2025. The facility failed to ensure physician's medication order to treat Resident CL1's Anemia was followed. 28 Pa. Code 211.5(f) Clinical Records Previously cited 8/25/25, 11/3/2025 28 Pa. Code 211.12(d)(1)(5) Nursing Services Previously cited 8/25/25, 11/3/25</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, facility documentation review, as well as staff and resident interviews it was determined the facility failed to ensure water temperatures were maintained at a safe level in resident care areas for three of three units in the facility resulting in immediate jeopardy to the residents. (1st, 2nd and 3rd floors) Findings Include: Observation of the staff and visitor bathroom on the ground floor on December 23, 2025, at approximately 11:15 a.m. revealed while the surveyor was washing their hands the water was observed to be very hot, steaming, and left red mark covering approximately 50% of both hands after four seconds of exposure to the water. Nursing Home Administrator (NHA) and Maintenance Director were contacted, the surveyors accompanied the Nursing Home Administrator and the Maintenance Director while water temperatures were recorded on all units of the facility with the following water temperature results of December 23, 2025, at 11:20 a.m.: room [ROOM NUMBER]- water temperature registered 132 degrees Fahrenheit (F) room [ROOM NUMBER]- 127 degrees [NAME] 100- 126 degrees [NAME] 100- 126 degrees F 1st floor shower room- 116 degrees [NAME] 119- 127 degrees [NAME] 125- 127 degrees F 2nd floor shower room sink 115 degrees [NAME] 221- 118 degrees [NAME] 317- 131.2 degrees [NAME] 323- 127.6 degrees [NAME] 315- 132.9 degrees F 3rd floor shower room sink- 115.7 degrees F Interview conducted with the Maintenance Director on December 23, 2025, at 11:45 a.m. revealed the facility was unaware of the water temperatures registering the high temperatures. The Maintenance Director revealed maintenance staff monitor the temperature of the water coming out of the mixing valve to the units every day and random room checks are performed on the units once a week. The Maintenance Director was asked to provide verification of the temperature readings through documentation logs when temperatures were monitored but staff were unable to provide any temperature logs, and it was unknown when the last time water temperatures were recorded for the monitoring of the facility water temperatures. Interview conducted on December 23, 2025, at 11:45 a.m. with nursing Employees E4 and E5 revealed they check the water temperature by running it first on their wrist to make sure it is not too hot then place the resident into the water and ask them if it is comfortable for them. Observations of the shower room on the first and third floor failed to reveal working thermometers in the shower rooms and observations of all three floors failed to reveal a log/recording of water temperatures prior to providing residents with showers. Interview with the Nursing Home Administrator on December 23, 2025, at 11:50 a.m. revealed the facility has no policies and procedures for monitoring the water temperatures and no policies and procedures for how staff should ensure a safe water temperature prior to providing care to a resident. An Immediate Jeopardy (IJ) situation was identified to the Nursing Home Administrator on December 23, 2025, at 12:05 p.m. and an immediate action plan was requested. The Immediate Jeopardy template was provided to the facility. On December 23, 2025, at 2:39 p.m. an acceptable action plan was approved which included the following interventions: Implemented immediately upon identification of IJ- Maintenance responded onsite.- Hot water was turned off at 1:30 p.m. on 12/23/2025.- All resident-accessible sinks and shower rooms with hot water temperatures were audited. Any exceeding 110 F (Fahrenheit) were immediately addressed.- Nursing staff provided direct supervision and assistance with all bathing and hygiene needs as needed.- Education was initiated to all staff regarding water temperatures and safety requirements.- Skin assessments on all residents were initiated.- Hot water temperatures are in the process of being re-tested using a calibrated thermometer at all resident accessible sinks and shower rooms on all nursing floors.- Any affected outlets will be returned to resident use only after verification and documentation of compliant temperatures. Protective Measures Following implementation of immediate interventions, residents were not exposed to unsafe hot water temperatures. All bathing and showering occurred only at outlets verified to be within the acceptable temperature range, with staff supervision provided as indicated.- The facility implemented a hot water temperature monitoring process requiring: o Daily random water temperature checks in resident rooms, shower rooms, and common areas for 7 days. o Then weekly water temperature checks in resident rooms and shower rooms and common areas for 4 weeks. o Then ongoing monthly water temperature checks in resident rooms and shower rooms and common areas. o Use of a thermometer, not hand tested. o Documentation on a Water Temperature Monitoring Log.- The facility clearly defined the requirement to include: o Maximum allowable temperature of 110 F o Monitoring frequency o Immediate corrective action for out-of-range temperatures- Facility staff education was initiated and to be provided to staff prior to start of their shift. o Acceptable hot water</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations and staff interview it was determined the facility failed to label and date oxygen and suction tubing for two of two residents reviewed (Resident 1 and 2). Findings Include: Observations of Residents 1 and 2 on December 23, 2025 at 9:45 a.m. revealed both residents had a tracheostomy (a surgical procedure creating an opening (stoma) in the neck into the windpipe (trachea) to provide a direct airway for breathing, often using a tube, used for blockages, long-term ventilation, or secretion clearance) with a trach collar (a soft strap that secures a tracheostomy tube in place around the neck, preventing it from moving or dislodging, while also providing a way to deliver humidified oxygen or manage airflow directly to the airway opening) in place. Further observations revealed that both residents had suctioning set up at their bedside. Observations of the tubing for the oxygen and the suctioning and for the disposable canister for the suctioning revealed there was no date last indicating when it should have been changed. Interview with the DON on December 23, 2025 at 10:30 a.m. revealed that the tubing should be dated with the date it was last changed. 28 Pa code: 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to ensure laboratory tests for Urinalysis (A set of tests that looks at the appearance of the urine and checks for blood cells, proteins, and other substances in it) ordered by the physician were timely followed (Resident CL1). Findings include:A review of the facility's policy titled Lab and Diagnostic Test Results-Clinical Protocol, undated, revealed that the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process the test requisitions and arrange for tests.A review of Resident CL1's Physician order dated October 13, 2025, revealed an order for Urinalysis, culture, and sensitivity one time only for frequency, irritation related to acute kidney failure.A review of the October 2025 Treatment Administration Record (TAR) revealed that the order for the urinalysis was done on October 13, 2025.A review of the laboratory report dated October 14, 2025, revealed Specimen received, unlabeled.Clinical records review failed to reveal that the urinalysis test was completed. The record revealed that no follow-up was done, and the resident's urine was not collected for re-testing since the initial urine was not tested due to improper labeling. The records also revealed that the physicians were not notified of the missed urine test until October 20, 2025. A new order to collect urine for urinalysis with culture and sensitivity was made on October 20, 2025.A review of the laboratory report dated October 21, 2025, revealed Resident CL1's urine was positive for an organism Klebsiella Pneumoniae ESBL, with a colony count of above 100,000 (indicating an active infection).The physician ordered Augmentin (antibiotic) 875 mg 1 tablet twice daily for seven days for Urinary tract infection (UTI).An interview with the Director of Nursing was conducted on December 23, 2025. The DON confirmed that Resident CL1's urine was not tested by the laboratory due to improper labeling. The DON also confirmed that follow-up with the urine test was not done until October 20, 2025.The facility failed to ensure Resident CL1's urine test order was timely followed, which resulted to delay in treatment on the resident's urinary tract infection.28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 8/25/25, 11/3/202528 Pa. Code 211.12(d)(1)(5) Nursing ServicesPreviously cited 8/25/25, 11/3/25</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on the review of job descriptions, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure the safety of residents due to hot water temperatures. This failure resulted in an Immediate Jeopardy situation. Findings Include: Review of the job description for the Nursing Home Administrator (NHA) states position purpose: Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents. Further review of the NHA position description revealed the Essential Function: Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. Review of the job description for the Director of Nursing (DON) states Position Purpose: Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents. The findings in this report identified the facility failed to maintain the safety of the residents from hot water temperatures by ensuring that there was a system in place to monitor the water temperatures and that staff were ensuring the water was a safe temperature prior to providing care to the residents. Refer to F689 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on facility policy review, observations and staff interviews it was determined the facility failed to provide PPE and signage for residents who require enhanced barrier precautions for four resident rooms and one resident (115, 108, 104, 102, and Resident 2) Findings Include: Review of facility policy titled Infection Prevention and Control, effective February 24, 2025, revealed Use EPB (enhance barrier precautions) for residents with wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (multi-drug resistant organism).post notice outside the resident room when on EBP. Observations of rooms 102, 104, 108, and 115 on December 23, 2025, at 9:45 a.m. revealed hanging from each door was a storage system with PPE (Personal Protective Equipment) Sucha as gowns, gloves and mask. Further observations revealed there were no signs on the door to post notice of the need for the PPE. Observation of Resident 2 on December 23, 2025 at 9:50 a.m. revealed the resident had a Tracheostomy (a surgical procedure that creates a new airway by making a hole (stoma) in the neck directly into the windpipe (trachea) to help with breathing) and tube feeding (provides liquid food, fluids, and medicine directly into the GI tract via a soft tube when someone can't eat or swallow safely). Further observations revealed there was no PPE in the room and there was no sign for EBP. These findings were relayed to the Nursing Home Administrator and the Director of Nursing on December 23, 2025, at 2:45 p.m. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services</p>		