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	08/22/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interviews, it was determined that the facility failed to create a comprehensive hospice care plan with interventions for one of two residents reviewed (Resident 13).Findings include: Review of Resident 13's face sheet revealed medical diagnoses that included Chronic Congestive Heart Failure (impairment with the heart's ability to fill with and pump blood). Review of Resident 13's clinical records revealed physician orders dated July 10, 2025, for hospice evaluation and treatment. Review of Resident 13's Minimum Data Set (MDS) (tool for implementing standardized assessment and for facilitating care management in nursing homes), dated July 21, 2025, documented the resident was enrolled in hospice care on July 10, 2025. Review of the facility's Hospice Communications Book revealed Resident 13 was certified with Bristol Hospice from July 10, 2025, through October 9, 2025, due to decline in health. Review of Resident 13's clinical records failed to reveal a care plan for hospice. Interview on August 21, 2025, at 2:10 p. m., with Licensed Nurse Employee E3, confirmed that Resident 13 was receiving hospice care since July 10, 2025, but did not have a care plan for hospice care. 28 Pa. Code 211.5(f) Clinical records28 Pa Code 211. 11(d) Resident care plan28 Pa. Code 211.12(d)(1)(5) Nursing services

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 - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Number of residents sampled: Number of residents cited: Based upon clinical record review and interview, it was determined that the facility failed to ensure that physician orders were followed regarding fluid restrictions for two of four dialysis residents (Resident 2 and Resident 82).Findings include:Review of Resident 2 diagnosis list revealed diagnoses including End Stage Renal Disease (ESRD - failure of kidney function to remove toxins from blood) and congestive heart failure (CHF - excessive body/lung fluid caused by a weakened heart muscle).Review of Resident 2's care plan revealed Resident 2 has hemodialysis (process of removing waste products and excess water from the body) with the potential for infection, fluid volume excess/deficit, pain, trauma, ESRD. Further review of Resident 2's care plan revealed interventions including dialysis in house and fluid restriction as ordered. Review of Resident 2's physician orders revealed the following order: Fluid Restriction total 1500 ml (milliliters) daily - Nursing total 540 ml - 7-3 - 240 ml. 3-11- 240 ml; 11-7 - 60 ml. Dietary total 960 ml - breakfast 360 ml; lunch 240 ml and dinner 360 ml.Review of Resident 2's clinical record failed to reveal evidence that the fluid restriction was accurately documented to ensure the fluid restriction was being followed according to physician's orders.Review of Resident 82's diagnosis list revealed diagnoses including End Stage Renal Disease and congestive heart failure.Resident 82's care plan revealed Resident 82 may be at risk for malnutrition related to history of chronic kidney disease, hemodialysis, CHF.Further review of Resident 82's care plan revealed interventions including fluid restriction - 1500 ml.Review of Resident 82's physician orders revealed an order for Fluid Restriction - 1500 ml. Nursing total 540 ml - 7-3 240 ml; 3-11 240 ml; 11-7 60 ml; Dietary total 960 ml - breakfast 360 ml; lunch - 240 ml; dinner - 360 ml.Review of Resident 82's clinical record failed to reveal evidence that the fluid restriction was accurately documented to ensure the fluid restriction was being followed according to physician's orders.Interview with Licensed Employee E3 on August 22, 2025, at 11:00 a.m. confirmed that the facility failed to accurately follow and document Resident 2 and Resident 82's fluid consumption daily per physician orders. 28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 7/25/2024 28 Pa, Code 211.12(d)(1)(3)(5) Nursing ServicesPreviously cited 7/25/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Number of residents sampled: Number of residents cited: Based on observation, review of facility policy, clinical record review and interview with staff, it was determined that the facility failed to ensure that appropriate catheter treatment and services were provided for one of three residents reviewed (Resident 3).Findings include:Observation of Resident 3 on August 25, 2025, at 1:50 p.m. revealed that the resident had a urinary catheter (tube used to drain urine from the bladder).Review of facility policy, Catheter Care, Urinary, revised August 2022, indicated that facility procedures should be followed for measuring and documenting input and output. Additionally, the following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 5. Any problems or complaints made by the resident related to the procedure. 6. How the resident tolerated the procedure. 7. If the resident refused the procedure, the reason(s) why and the intervention taken. 8. The signature and title of the person recording the date.Review of Resident 3's progress note of August 16, 2025, revealed that resident was readmitted from the hospital and had a foley (catheter) that is draining yellow urine.Review of Resident 3's progress note of August 20, 2025, revealed that the resident returned from urology appointment and that the foley catheter was removed during the visit.Further review of the clinical record revealed there were no physician's orders for the catheter care. Additionally, there was no documentation regarding input and output or catheter care.Interview with licensed staff, Employee E3, on August 22, 2025, at 10:15 A.M. confirmed that there was no documentation regarding the catheter from August 16-20, 2025.28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 7/25/2428 Pa. Code 211.10(c) Resident care policiesPreviously cited 7/25/2428 Pa. Code 211.12(d)(1)(5) Nursing ServicesPreviously cited 7/25/24

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based upon facility policy and procedure, clinical record review and interview, it was determined that the facility failed to ensure that an admission weight was accurately obtained and failed to ensure accurate weights were monitored for one of nine residents reviewed (Resident 4).Findings include:Review of facility policy and procedure titled Weight Policy, revised December 2022, revealed New and re-admission residents' weight will be obtained within 24 hours of admission. The resident's height will be obtained on admission as well and charted on the admission Assessment Record and the resident record of weights. Further review of this policy revealed any resident displaying a significant change in weight of greater than or equal to 5 percent gain/loss in one month will be reported to the Registered Dietitian and reweighed.Further review of this policy revealed The Registered Dietitian will review the medical record of residents with significant weight changes (i.e. 5% loss/gain in one month, 7.5% loss/gain in 3 months and 10% loss/gain in 6 months). Dietary interventions will be recommended as needed. All significant weight changes will be reported to the MD.Review of Resident 4's diagnosis list revealed diagnoses including cerebral infarction (stroke), dysphagia (inability/difficulty swallowing), tracheostomy dependence and PEG tube (feeding tube). Review of Resident 4's Nutritional Risk assessment dated [DATE], revealed an admission weight of 126.8 pounds.Review of Resident 4's Weight Summary revealed a weight of 126.8 pounds on June 11, 2025. Further review of Resident 4's Weight Summary revealed a weight of 124 pounds on June 20, 2025, and a weight of 124 pounds on June 26, 2025.Further review of Resident 4's Weight Summary revealed a weight of 107 pounds on June 27, 2025, with a re-weight on June 27, 2025, revealed a weight of 105.8 pounds. Further review of Resident 4's Weight Summary revealed that the June 11, June 20 and June 26, 2025, weights were struck out of the record on July 10, 2025, as incorrect documentation.Interview with Licensed Employee E6 on August 21, 2025, at 10:00 a.m. revealed that Licensed Employee E6 struck out the weights of June 11, June 20 and June 26, 2025, due to a hospital weight of 108 pounds received on June 26, 2025. This interview further confirmed that an accurate admission weight was not obtained upon admission on [DATE] and Resident 4's nutritional status and tube feeding were based upon an inaccurate weight from June 11, 2025 until July 10, 2025 resulting in the inability to determine if Resident 4 had a significant weight loss from June 11, 2025 through July 10, 2025 and the inability to determine if Resident 4's tube feeding rate and volume were sufficient to meet resident needs. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing ServicesPreviously cited 7/25/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review, clinical record review, and interview with staff it was determined that the facility failed to ensure that residents receiving enteral feeding (also known as tube feeding - method of delivering nutrition directly to the gastrointestinal tract when a person cannot eat safely or adequately by mouth) received the amount ordered by the physician for five of eight residents reviewed (Residents 3, 4, 5, 111, and 115). Review of Resident 3’s admission physician’s orders of July 8, 2025, indicated that the resident was NPO (nothing by mouth). Review of physician’s enteral feed order of July 10, 2025, revealed that the resident was to receive Glucerna 1.5 at 63 milliliters (mL) per hour for 20 hours for a total volume of 1260 ml. Review of Resident 3’s July 2025 Medication Administration Record (MAR) revealed that the daily total volume recorded ranged from 742 mL to 2382 mL. The total volume recorded was not 1260 mL on 13 of 19 occasions. Review of Resident 3’s August 2025 MAR revealed that the daily total volume recorded ranged from 316 – 1282 mL. The total volume recorded was not 1260 mL on seven of 10 days. Further review of Resident 3's clinical records revealed no documentation addressing the discrepancy between the total volume received compared to the total volume ordered. Interview with licensed staff, Employee E3, on August 22, 2025, at 10:20 A.M. confirmed that there was a discrepancy between the total volume received versus the total volume ordered. Review of Resident 4’s diagnosis list revealed diagnoses including cerebral infarction (stroke), dysphagia (inability/difficulty swallowing), tracheostomy dependence and PEG tube (feeding tube). Review of Resident 4’s physician orders revealed an order for Osmolite 1.5 to be infused via PEG tube at 60 ml/hour for 20 hours per day for a total volume infused of 1200 ml per day. Review of Resident 4’s care plan revealed Resident 4 is at risk for malnutrition related to a history of tube feeding with interventions including Osmolite 1.5, 60 ml/hour times 20 hours for total volume of 1200 ml per day. Review of Resident 4’ s July 2025 Medication Administration Record revealed Resident 4 failed to receive 1200 ml of Osmolite via PEG tube on July 1, 2025, July 4, 2025, 2025, July 14, 2025, July 15, 2025, July 17, 2025, July 18, 2025, July 19, 2025, July 23, 2025, July 25, 2025, July 26, 2025, July 27, 2025, July 28, 2025, July 30, 2025 and July 31, 2025. Review of Resident 4’ s August 2025 Medication Administration Record revealed Resident 4 failed to receive 1200 ml of Osmolite via PEG tube on August 2, 2025, August 3, 2025, August 5, 2025, August 11, 2025, August 13, 2025, August 14, 2025, August 16, 2025, August 17, 2025, Augus 19, 2025 and August 20, 2025. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4’s clinical record failed to reveal documented evidence that Resident 4 was receiving 1200 ml per day of Osmolite. Interview with Licensed Employee E3 on August 22, 2025, at 11:00 a.m. confirmed that Resident 4 did not receive 1200 ml of Osmolite per day as ordered by Resident 4’s physician. Review of Resident 5’s admission physician’s orders of March 6, 2024, indicated that the resident was NPO (nothing by mouth). Review of physician’s enteral feed order of March 6, 2024, revealed that the resident was to receive Jevity 1.5 at 75 ml per hour with a total volume of 1200 ml. Review of Resident 5’s July 2025 Medication Administration Record (MAR) revealed that the daily total volume recorded ranged from 0 ml to 1200 ml. The total volume recorded was not 1200 ml on 7 of 31 occasions. Review of Resident 5’s August 2025 MAR revealed that the daily total volume recorded ranged from 0 – 1200 ml. The total volume recorded was not 1200 ml on 10 of 23 days. Further review of Resident 5’s clinical records revealed no documentation addressing the discrepancy between the total volume received compared to the total volume ordered. Interview with licensed staff, Employee E3, on August 21, 2025, at 2:10 p.m. confirmed that there was a discrepancy between the total volume received versus the total volume ordered. Review of Resident 111’s physician’s orders indicated that the resident was NPO. Review of physician’s enteral feed order of July 3., 2025, revealed that the resident was to receive Jevity 1.5 at 70 mL per hour for 20 hours for a total volume of 1400 mL. Review of Resident 111’s July 2025 MAR revealed that the daily total volume recorded ranged from 876 – 1400 mL. The total volume recorded was not 1400 mL on 20 of 27 days. Review of Resident 111’s August 2025 MAR revealed that the daily total volume recorded ranged from 1064 – 2614 mL. The total volume recorded was not 1400 mL on 12 of 20 days. Further review of Resident 111’s clinical records revealed no documentation addressing the discrepancy between the total volume received compared to the total volume ordered. Interview with licensed staff, Employee E3, on August 22, 2025, at 10:20 A.M. confirmed that there was a discrepancy between the total volume received versus the total volume ordered. Review of Resident 115’s diagnosis list revealed diagnoses including anoxic brain injury (the brain is deprived of oxygen for a prolonged amount of time), dysphagia (inability/difficulty swallowing), and PEG tube (feeding tube). Review of Resident 115’s physician orders revealed an order for Jevity 1.5 to be infused via PEG tube at 120 ml/hour for 12 hours per day for a total volume infused of 1440 ml per day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 115’ s July 2025 Medication Administration Record (MAR) revealed Resident 115 failed to receive 1440 ml of Jevity 1.5 via PEG tube on July 10, 2025, July 11, 2025, July 12, 2025, July 15, 2025, July 18, 2025, July 19, 2025, July 20, 2025, and July 23, 2025, Review of Resident 115’ s August 2025 MAR revealed Resident 115 failed to receive 1440 ml of Jevity 1.5 via PEG tube on August 1, 2025, August 2, 2025, August 4, 2025, and August 12, 2025. Review of Resident 115’s clinical record failed to reveal documented evidence that Resident 115 was receiving 1440 ml per day of Jevity 1.5 as ordered by Resident 115's physician. Interview with the Director of Nursing on August 22, 2025, at 9:35 a.m. confirmed Resident 115 did not receive 1440 ml per day of Jevity 1.5. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services Previously cited 7/25/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Number of residents sampled: Number of residents cited: Based on review of facility policy, clinical record review, and interview with staff, it was determined that the facility failed to implement non-pharmacological interventions prior to the administration of pain medication for one of two residents (Resident 3).Findings include: Review of facility policy, Administering Pain Medications, revised April 2025, indicated that non-pharmacologic interventions (e.g., positioning, warm or cold compresses, etc.) should be evaluated and the effectiveness documented.Review of Resident 3's physician's orders included an order for Roxicodone (opiod pain medication) 5 milligrams every four hours as needed for pain. Review of Resident 3's July 2025 Medication Administration Record (MAR) revealed that the Roxicodone was administered 28 times. Review of the August 2025 MAR revealed that Roxicodone was administered three times.Further review of Resident 3's clinical record revealed no evidence that non-pharmacological interventions were attempted prior to the administration of the as needed pain medication.Interview with licensed staff, E3, on August 22, 2025, at 10:15 A.M. confirmed there was no evidence that non-pharmacological interventions were attempted prior to the pain medication administration. 28 Pa. Code 211.5(f) Clinical RecordsPreviously cited 7/25/2428 Pa. Code 211.10(c) Resident care policiesPreviously cited 7/25/2428 Pa. Code 211.12(d)(1)(5) Nursing ServicesPreviously cited 7/25/24

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on facility clinical records review, and staff interviews, it was determined that the facility failed to correctly document the Medication Administration Report for one of 28 residents reviewed (Resident 1). Finding include:Review of Resident 1's face sheet revealed medical diagnoses that include Severe Protein Calorie Malnutrition (inadequate intake of protein and calories), Adult Failure to Thrive (gradual decline in health and functional abilities), Wernicke's Encephalopathy (lack of vitamin B1 essential for converting food to energy), Dysphagia (difficulty swallowing), and Achalasia of the Cardia (inability of muscle at base of esophagus to relax causing swallowing difficulties).Review of Resident 1's clinical records revealed physician orders for Enteral Feed every day and evening shift Nutren 2.0 (a nutrition supplement) 115ml per hour for 2 hours. Tube feed up at 8a.m., 12p.m., and 4p.m.Review of Resident 1's August 2025, Medication Administration Report (MAR), revealed only two options to document the tube feed was set up, day and evening. No option was provided for staff to document the resident's tube feed was set up in the afternoon. Review of Resident 1's clinical records revealed physician orders for Enteral Feed every day and evening shift Nutren 2.0 15ml per hour for 2 hours. Tube feed down at 10a.m., 2p.m., and 6p.m.Review of Resident 1's August 2025, Medication Administration Report (MAR), revealed only two options to document the tube feed was taken down, day and evening. No option was provided for staff to document the resident's tube feed was taken down in the afternoon.Interview on August 20, 2025, at 2:45 p.m., when the above was presented Registered Nurse Employee E3, confirmed the MAR was not set up for proper documentation of Resident 1's tube feeding schedule.