

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to provide and/or obtain informed consents for psychotropic medications for three of five residents reviewed for unnecessary medications (Resident 3, Resident 9, and Resident 154). Findings include: Review of Resident 3's medical diagnoses revealed diagnosis that include Chronic Diastolic (congestive) Heart Failure (excessive body/lung fluid caused by weakened heart muscle), Dementia (irreversible, progressive, degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Anxiety Disorder (intense, excessive, and persistent worry and fear about everyday situations), Psychosis (abnormal condition of the mind that results in difficulties telling what is real and what is not real) not due to a substance or known physiological condition, and Major Depressive Disorder. Review of Resident 3's physician orders revealed an order dated January 31, 2026, for Quetiapine Fumarate (an antipsychotic medication) Tablet 25 milligrams (mg) give 1 tablet by mouth one time a day related to unspecified psychosis not due to a substance or known physiological condition. Review of Resident 3's records revealed no Informed Consent Form (document that explains risks and benefits of taking antipsychotic medications). Review of Resident 9's physician orders revealed a prescription dated February 24, 2026, for Paroxetine HCl 20 mg to be administered in the morning for depression. Further review of Resident 9's physician orders revealed a prescription dated February 24, 2026, for Divalproex Sodium 125 mg to be administered two times a day for bipolar. Review of Resident's 9 clinical record failed to reveal informed consent. Review of Resident 154's physician orders revealed a prescription for Ativan 0.5mg twice a day for anxiety, dated July 25, 2026. Further review of Resident 154's clinical records failed to reveal evidence that informed consent had been obtained from Resident 154's responsible party. Interview with NHA (Nursing Home Administrator) and DON (Director of Nursing) on July 29, 2026 at (continued on next page)		

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	approximately 4:00 p.m. confirmed the facility did not obtain informed consent. The DON stated that informed consent forms were not being completed by the previous administration and was now part of the facility's current Quality Assurance and Performance Improvement (QAPI) plan. 28 Pa. Code 211.12(d)(5) Nursing Services		

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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 upon observation and interview, it was determined that the facility failed to ensure appropriate storage of dry goods, maintain appropriate concentration of sanitizing solutions, and maintain safe conditions within the facility's freezer. Observation of the facility's kitchen on July 26, 2026, at 9:35 a.m., reveals a buildup of ice accumulation on the PVC strip curtains at the entrance of the walk-in freezer. Further observation of the facility's kitchen on July 29, 2026, at approximately 2:00 p.m., finds containers of powder thickener and flour open to air. Observation during a tour of the facility's kitchen on July 29, 2026, at approximately 2:00 p.m., finds a bucket of liquid without a detectable level of sanitizer when tested with a pH strip, containing a cloth to wipe down tray delivery carts. Interview with the Nursing Home Administrator on July 29, 2026, at approximately 3:30 p.m. confirms the above findings. 28 Pa. Code 211.6(f) Dietary Services		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain medication administration records that were accurate and complete for eight of eight residents reviewed (Residents 2, 5, 7, 10, 11, 15, 26, and 39). Findings include: Review of the following MARs (medication administration records) revealed: For Resident 2, 30 out of 31 orders were not signed out on July 25, 2026. For Resident 5, 21 out of 26 orders were not signed out on July 25, 2026. For Resident 7, 36 out of 37 orders were not signed out on July 25, 2026. For Resident 10, 19 out of 29 orders were not signed out on July 25, 2026. For Resident 11, 18 out of 23 orders were not signed out on July 25, 2026. For Resident 15, 16 out of 16 orders were not signed out on July 25, 2026. For Resident 26, 22 out of 25 orders were not signed out on July 25, 2026. For Resident 39, 22 out of 23 orders were not signed out on July 25, 2026. Interview with Resident 26 on July 28, 2026, at approximately 9:30 a.m. revealed that Resident 26 recalled receiving medications on July 25, 2026. Interview with the NHA (Nursing Home Administrator) on July 29, 2026 at approximately 2:00 p.m. revealed that they had contacted the nurse who was assigned to that hallway on July 25, 2026, and the nurse affirmed that the medications had been administered, but the nurse reported feeling overwhelmed and did not document most of the medications. The NHA surveyed cognitively intact residents on the unit regarding whether they recall receiving medications on that day and they responded that they had. The medication administration was not documented accurately and completely. These findings were affirmed with the NHA and DON (Director of Nursing) on July 29, 2026, at approximately 4:00 p.m. 28 Pa. Code 211.59(f)(x) Medical Records 28 Pa. Code 211.10(c) Resident care policies 28 Pa Code 211.12 (d)(1)(5) Nursing Services		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based upon observation and interview, it was determined that the facility failed to prevent accumulations of fruits flies in the kitchen. Observation during a tour of the facility's kitchen on July 29, 2026, at approximately 2:00 p.m., reveals several fruit flies observed throughout the kitchen. Fruit flies were observed inside and around open containers of powder thickener and flour. Interview with Nursing Home Administrator confirms the above findings. 28 Pa. Code 211.6(f) Dietary Services		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for three out of three floors (First, Second and Third floor). Findings include: Observations made of resident rooms on the third floor on July 26, 2026, at 9:25 a.m. revealed clogged bathroom sinks in rooms 312, 315, 316, 321, 322, 326, 327, and 328. room [ROOM NUMBER]'s sink had standing brown water with brown substances floating in the water. The toilets in room [ROOM NUMBER] and 313 had a brown substance on the seat and the bowl. Observations made of resident rooms on the third floor July 27, 2026, at 9:19 a.m. revealed bathroom sinks remained clogged in rooms 312, 315, 316, 321, 322, 326, 327, and 328. room [ROOM NUMBER]'s sink still had standing brown water with brown substances floating in the water. The toilets in room [ROOM NUMBER] and 313 still had a brown substance on the seat and the bowl. Interview conducted with the Corporate Regional Director (CRD) on July 27, 2026, at 9:40 a.m., when the above was presented and the sink and toilet in room [ROOM NUMBER] were observed, the CRD confirmed the sink was clogged and the toilet was not clean. Observation of the bathroom sink in room [ROOM NUMBER] on July 28, 2026, at approximately 9:45 a.m. revealed standing water in the sink. Observation of the in-room sink in room [ROOM NUMBER] on July 28, 2026, at approximately 9:50 a.m. revealed that the basin drained very slowly when the basin after being filled with water. This observation was shared with the LPN (Licensed Practice Nurse) Unit Manager (E3) on July 28, 2026, at approximately 10:00 a.m. Observation of resident room [ROOM NUMBER] on July 29, 2026, at 11:30am revealed a feeding tube pole crusted with brown stains and under resident bed visible trash and dust. Licensed nurse Employee 6 on July 29, 2026, at approximately 11:35am confirmed the above observations. Observation of the bathroom sink in room [ROOM NUMBER] on July 28, 2026, at approximately 10:50 a.m. revealed standing water in the sink. Observation of room [ROOM NUMBER] on July 28, 2026, at approximately 10:35 am revealed standing (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water on the floor at the foot of unoccupied resident bed. Further observation made with Licensed nurse Employee 6 on July 28, 2026, at approximately 10:40am revealed, placed under the air conditioner unit in room [ROOM NUMBER], a gray basin overflowing with water.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, the facility failed to ensure PRN (pro-re nata or as needed) orders for psychotropic medications are limited to 14 days for one out of two residents reviewed for unnecessary medications (Resident 154). Findings include: Review of Resident 3's medical diagnoses revealed diagnosis that include Chronic Diastolic (congestive) Heart Failure, Dementia, Anxiety Disorder, Psychosis not due to a substance or known physiological condition, and Major Depressive Disorder. Review of Resident 3's physician orders revealed an order dated January 31, 2026, for Quetiapine Fumarate (an antipsychotic medication) Tablet 25 milligrams (mg) give 1 tablet by mouth one time a day related to unspecified psychosis not due to a substance or known physiological condition. Review of Resident 3's physician orders revealed an order dated November 28, 2023, for Escitalopram Oxalate (an antipsychotic medication) oral tablet 20 mg (Generic for Lexapro) give 20 mg by mouth one time a day related to Major Depressive Disorder. Review of Resident 3's Medication Management Reviews (MRR) revealed a recommendation dated September 25, 2025, noting the resident's order for Lexapro 20 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. Review of Resident 3's MRR dated March 31, 2026, noted the resident's order Lexapro 20 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. Further review of Resident 3's MRR dated July 24, 2026, noted a recommendation that the resident's order for Quetiapine 25 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. The above findings were presented to the Nursing Home Administrator on July 29, 2026, at 3:35 p.m. Review of Resident 154's current physician orders revealed: Ativan 0.5MG; give 1 tablet as needed for anxiety twice daily, dated July 25, 2026. Further review of the MAR (medication administration record) failed to reveal an end date for the order. This finding was reviewed with the NHA on July 29, 2026, at approximately 3:00 p.m. 28 Pa. Code 211.12 (d)(5) Nursing Services		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interview with staff, it was determined that the facility failed to notify the office of the state long term care ombudsman of emergency transfers for four out of thirteen residents reviewed. (Resident 13, Resident 64, Resident 82 and Resident 123) Findings include: Review of Resident 13's clinical record revealed resident was transferred to the hospital on May 3, 2026, and admitted with a diagnosis of an ileus (medical condition where the intestines temporarily stop normal muscle contractions, preventing food, gas, and waste from moving forward). Further review of Resident 13's clinical record reveals that Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 13's transfer and admission to the hospital. Review of Resident 13's clinical record revealed that resident was transferred to the hospital on June 5, 2026, for evaluation. Further review of Resident 13's clinical record reveals that Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 13's transfer and admission to the hospital. Interview with the Nursing Home Administrator on July 29, 2026, at approximately 3:30pm confirmed the above the findings. Review of Resident 64's clinical record revealed Resident 64 was transferred to the hospital on June 6, 2026, due to sepsis (serious medical condition that occurs when your body has an extreme reaction to an infection, leading to widespread inflammation). Further review of Resident 64's clinical record revealed Resident 64 was readmitted to the facility on [DATE]. Review of Resident 64's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 64's transfer and admission to the hospital. Further review of Resident 82's clinical record reveals that Resident 82 was readmitted to the facility on [DATE]. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 82's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 82's transfer and admission to the hospital. Review of Resident 123's clinical record revealed that resident was transferred to the hospital on June 2, 2026, and admitted with a diagnosis of pneumonia (an infection that inflames the air sacs in one or both lungs). Further review of Resident 123's clinical record reveals that Resident 123 was readmitted to the facility on [DATE]. Review of Resident 123's clinical record and facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 123's transfer and admission to the hospital. Review of Resident 82's clinical record revealed that resident was transferred to the hospital on June 15, 2026, for evaluation and treatment. Interview with the Nursing Home Administrator on July 29, 2026, at approximately 3:30pm confirmed the above the findings. 28 Pa. Code 211.5(b) Medical Records		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to accurately assess a Resident's health status for one of eight residents reviewed (Resident 39). Findings include: Review of Resident 39's admission MDS (Minimum Data Set - mandatory assessment of a resident's physical condition and care needs) dated July 2, 2026, revealed Resident 39 was admitted on [DATE]. Review of Section M of the MDS labelled Skin Conditions revealed no pressure ulcers present on admission/entry. Review of Resident 39's TAR (treatment administration record) revealed the following order dated June 26, 2026: Wound Care every 12 hours for Wound Care Sacrum (triangular shaped bone at the base of the spine), cleanse w/ NSS (normal saline solution), pat dry, apply Venelex ointment (a prescription dressing used to treat chronic skin wounds) followed by oil emulsion gauze (a non-stick gauze dressing). Cover with foam dressing (an absorbent, cushioned adhesive dressing). Review of the admission skin assessment dated [DATE], revealed Resident 39's skin was intact. Review of Section N of the MDS labelled Medications revealed that the facility coded 1 in item N0300 Record the number of days that injections of any type were received during the last 7 days since admission. Review of Resident 39's MAR (medication administration record) revealed the following order dated June 27, 2026: Heparin (a medication to prevent blood clots) Sodium Injection Solution 5000 Unit/ML (milliliter). Inject 1ML subcutaneously (under the skin) every 8 hours for DVT (blood clot) prophylaxis (prevention). Review Resident 39's June 2026 MAR revealed the order was signed out as administered on June 27, 2026, June 28, 2026, June 29, 2026, and June 30, 2026. Review of Resident 39's July 2026 MAR revealed the order was signed out as administered on July 1, 2026, and July 2, 2026. These findings were shared with the NHA (Nursing Home Administrator) on July 29, 2026, at approximately 3:00 p.m. 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. Based on a review of clinical records and staff interviews, it was determined that the facility failed to provide quality care for three of 28 residents reviewed (Resident 8, Resident 28, and Resident 82). Findings include: Review of Resident 8's clinical record revealed diagnoses including acute congestive heart failure (CHF) (excessive body/lung fluid caused by a weakened heart muscle) and chronic kidney disease (medical condition referring to damage to the kidney due to chronic high blood pressure). Review of Resident 8's physician's orders dated July 17, 2026, and discontinued July 18, 2026, revealed an order for daily weights every day shift for health monitoring (CHF). Notify MD (medical doctor) if 4 lb (pounds) or greater weight gain. Review of Resident 8's clinical record revealed recorded weights of 259.2 pounds on July 14, 2026, and 326.4 pounds on July 17, 2026. Further review of Resident 8 clinical record and facility records revealed no evidence that the physician had been notified as per order. Interview with Employee E5 on July 29, 2026, at approximately 1:20pm confirmed the above findings. Resident 28 has medical diagnoses that include Dementia, Joint Disorder, Osteoarthritis, and Lower Back Pain. Review of Resident 28's care plan revealed a focus revised June 22, 2026, for Resident 28 having potential for falls related to impaired balance during transitions and medications. Review of Resident 28's progress notes revealed a note dated June 20, 2026, documenting the resident was lowered to the floor after attempting to transfer from his/her wheelchair without assistance, causing their wheelchair to tip up. Further review of Resident 28's progress notes revealed a note dated June 22, 2026, documenting the Interdisciplinary Team discussing Resident 28's post fall lowered to floor. Physical therapy and request for anti-tippers (a safety device attached to the rear of a wheelchair to prevent it from tipping backward) were recommended. Observations of Resident 28's wheelchair on July 29, 2026, at 10:07 a.m., revealed the resident had one anti-tipper on the left side of his/her wheelchair. During interview conducted with Occupational Therapist, Employee E8, on July 29, 2025, at 11:52 a.m., E8 confirmed the resident only had one anti-tipper and confirmed there should be two. Employee E8 stated another one would be ordered. Resident 82 has a medical history significant for end stage renal disease (occurs when kidneys lose (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	85% to 90% of their function and can no longer remove wastes and extra fluid), peripheral vascular disease (a blood circulation disorder that narrows, blocks, or spasms blood vessels outside the heart and brain), congestive heart failure (a condition where the heart muscle does not pump blood well, causing blood and fluid to back up), and an open wound of the left foot. Review of Resident 82's orders reveals a physician order dated November 20, 2025, for heel boots (pressure relieving foot guard) to be worn every shift for skin prevention. Review of Resident 82's progress notes on July 22, 2026, at 10:54 p.m., reveals that Resident 82, returned from her doctors appointment with the wound doctors . Resident is to continue to use the heel boot to the left heel at all times. Observation of Resident 82 on July 28, 2026, at 9:46 a.m., finds the resident in her bed without a heel boot in place. Further observation of Resident 82 on July 29, 2026, at 9:17 a.m., finds the resident at dialysis without a heel boot in place. Interview with facility employee, E9, on July 29, 2026, at 11:57 a.m., reveals that Resident 82 frequently refuses to wear the heel boots as ordered and that refusals are documented in the resident's electronic health record. Review of Resident 82's clinical record does not reveal documentation of refusals to have heel boots placed on July 28, 2026, or July 29, 2026. Interview the Nursing Home Administrator on July 29, 2026, at approximately 3:30 p.m. confirmed the above findings.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent the risk of accident by leaving patient medication unattended at the bedside for one out of eight residents reviewed (Resident 46). Findings include: Observation of Resident 46's room on July 28, 2026, at approximately 9:50 a.m., revealed a plastic medication cup containing two pills sitting on the bedside table belonging to Resident 46. Resident 46 was not observed in the room. Interview with the LPN Unit Manager (E3) on July 28, 2026, at approximately 10:00 a.m. confirmed that the medication belonged to Resident 46, Resident 46 was at an appointment, and Resident 46 did not have a physician's order to self-administer medications. Review of Resident 46's active physician orders for July 2026 revealed that Resident 46 did not have orders to self-administer medication. Interview with the NHA (Nursing Home Administrator) revealed that the medications found in the cup were Sevelamer Carbonate Oral Tablet, 800 MG and Cinacalcet HCl Oral Tablet 30 MG. 28 Pa. Code 211.10(d) Resident Care Policies 28 Pa. Code 212. 12 (d)(1)(5) Nursing Services		

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 07/29/2026
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)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based upon clinical record review and interviews, it was determined that the facility failed to ensure that medication irregularities were appropriately acted upon by a physician for one of five residents reviewed (Resident 3). Findings include: Review of Resident 3's medical diagnoses revealed diagnosis that include Chronic Diastolic (congestive) Heart Failure, Dementia, Anxiety Disorder, Psychosis not due to a substance or known physiological condition, and Major Depressive Disorder. Review of Resident 3's physician orders revealed an order dated January 31, 2026, for Quetiapine Fumarate (an antipsychotic medication) Tablet 25 milligrams (mg) give 1 tablet by mouth one time a day related to unspecified psychosis not due to a substance or known physiological condition. Review of Resident 3's physician orders revealed an order dated November 28, 2023, for Escitalopram Oxalate (an antipsychotic medication) oral tablet 20 mg (Generic for Lexapro) give 20 mg by mouth one time a day related to Major Depressive Disorder. Review of Resident 3's physician orders revealed an order dated October 5, 2023, for Melatonin oral tablet 5 mg, give by mouth at bedtime for insomnia. Review of Resident 3's physician orders revealed an order dated April 21, 2022, for Sudafed 12 hr tablet extended release give one tablet by mouth every 12 hrs. as needed for cough and congestion. Review of Resident 3's Medication Management Reviews (MRR) revealed a recommendation dated September 25, 2025, noting the resident's order for Lexapro 20 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. Review of Resident 3's MRR dated February 25, 2026, revealed a recommendation to discontinue the resident's Sudafed as needed order due to non-usage. No physician response or signature was observed on the form. Review of Resident 3's MRR dated March 31, 2026, noted the resident's order Lexapro 20 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. Review of Resident 3's MRR dated April 26, 2026, revealed a recommendation that the resident's order for Melatonin 5 mg was due for annual assessment. No physician response or signature was observed on the form. Further review of Resident 3's MRR dated July 24, 2026, noted a recommendation that the resident's order for Quetiapine 25 mg was due for assessment in accordance with CMS guidelines for psychopharmacologic medication regarding a gradual dose reduction (GDR). No physician response or signature was observed on the form. The above findings were presented to the Nursing Home Administrator on July 29, 2026 at 3:35 p.m.		

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 07/29/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure that transmission-based precautions were adhered to for two of 27 residents reviewed (Resident 7 and Resident 72). Findings include: Facility policy titled Isolation-Categories of Transmission Based Precautions documents when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance and on the front of the chart so that personnel and visitors are aware of the need for and type of precaution. CDC (The Centers for Disease Control) recommendations for contact precautions (an infection prevention technique used for patients with known or suspected infections that represent an increased risk for contact transmission), dated April 3, 2024, recommends that staff wear gowns and gloves for all interactions that may involve contact with the patient or the patient's environment. Observation of room [ROOM NUMBER] on July 28, 2026, at approximately 9:30 a.m. revealed a contact precaution sign outside the room and a nurse (E4), who was not wearing any personal protective equipment, administering medication to Resident 7. Review of Resident 7's care plan revealed that Resident 7 was placed on contact precautions due to an infection, effective July 27, 2026. Resident 72 has medical diagnoses that include Obstructive and Reflex Uropathy (blockage in the urinary tract that impedes urine flow). Review of Resident 72's physician orders revealed an order dated November 26, 2025, for a foley catheter (a flexible tube inserted into the bladder to drain urine) to straight drainage as needed related to Obstructive and Reflux Uropathy. Further review of Resident 72's physician orders revealed an order dated November 25, 2026, for Enhanced Barrier Precautions (EBP) every shift for foley catheter. Resident 72's Medication Administration Reports for June and July 2026, documents EBP are in place. Observations made of Resident 72's room on July 26, 2026, at 10:45 a.m., July 27, 2026, at 9:19 a.m., and July 29, 2026, at 11:17 a.m., revealed no EBP sign on the resident's door or in the resident's room. The above information was discussed with the Nursing Home Administrator on July 29, 2026, at 3:30 p.m. 28 Pa. Code 211.10(c) Resident care policies		