

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Prospect		STREET ADDRESS, CITY, STATE, ZIP CODE 815 Chester Pike Prospect Park, PA 19076	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, observation, review of clinical records, interview with staff and residents, it was determined the facility failed to ensure that medications were administered in accordance with professional standards for two of five residents reviewed (Resident R1 and Resident R2).</p> <p>Findings include:</p> <p>Review of facility policy on administering medication with last revision date of August 2022 revealed that under policy statement: medications are administered in a safe and timely manner and as prescribed. Under policy interpretation and implementation: The Director of Nursing Services, supervises, and directs all personnel who administer medications and or have related functions. #4. Medications are administered in accordance with prescriber orders. Including any required time frame. #5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: A. enhancing optimal therapeutic effect of the medication. B. preventing potential medication or food interactions and c. honoring residents' choices and preferences consistent with his or her care plan. #7. Medications are administered within one hour of their prescribed time, unless otherwise specified. For example, before and after meal orders. #22. The individual administering the medication initials the residents MAR (medication administration record) on the appropriate line after giving each medication and before administering the next one. #27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. #29 New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility.</p> <p>Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure with Hypoxia, Generalized Anxiety Disorder, Tracheostomy Status, Diabetes and Morbid Obesity.</p> <p>Review of Resident R1's physician's order revealed that there was no order for self-medication.</p> <p>(continued on next page)</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of physician's orders revealed an order for Oxycodone HCl Oral Tablet 5 milligrams (mg) (Oxycodone HCl), Give 7.5 mg by mouth every 6 hours as needed for sever pain 7-10, Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation)) 1 dose inhale orally two times a day for Bronchodilation and Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML (Albuterol Sulfate) 1 dose inhale orally four times a day for Respiratory bronchodilation-</p> <p>Observation of Resident R1's room conducted on February 5, 2023, at 11:06 a.m. revealed one unopened packet Budesonide inhalation suspension 0.5 milligrams per two ml. was on top of Resident R1's overhead table. Further observation also revealed that an unopened packet of Albuterol Sulfate inhalation solution 0.083%. 2.5 milligrams per 3ml. was also on top of Resident R1's overhead table.</p> <p>Interview with Resident R1 conducted at the time of the observation revealed that the nurse came in and gave her one packet of Budesonide and Albuterol sulphate and did not explain what she should do with it. Further interview with Resident R1 revealed that she did not know what to do with the medication.</p> <p>Interview with Licensed nurse, Employee E3 conducted at the time of the observation confirmed that one unopened packet Budesonide inhalation suspension 0.5 milligrams per two ml. and one unopened packet of Albuterol Sulfate inhalation solution 0.083%. 2.5 milligrams per 3ml. was on top of Resident R1's overhead table. Further Employee E3 revealed that the Budesonide and the Albuterol should not have been with the resident.</p> <p>Review of Resident R2's physician's order revealed and order for Methylphenidate HCl Oral Tablet 20 MG (Methylphenidate HCl), give 1 tablet by mouth three times a day related to attention deficit hyperactivity disorder with a start date of December 12, 2023.</p> <p>Review of Resident R2's January 2024 Medication Administration Record (MAR) revealed that on January 14, 15 and 16, 2024 the medication Methylphenidate HCl Oral Tablet 20 MG (Methylphenidate HCl) was coded with #16.</p> <p>Review of MAR's chart code revealed that #16 was the code for Hold/See nurses notes.</p> <p>Review of January 14, 2024, time stamped 10:24 p.m. nurse note revealed that: Methylphenidate HCl Oral Tablet 20 MG Give 1 tablet by mouth three times a day related to Atytention-Deficit Hyperactivity Disorder waiting for prescription.</p> <p>Review of nurses note dated January 15, 2024, time stamped at 2:12 p.m. revealed that Note Text: Nurse practitioner was in today will call pharmacy to order Methylphenidate script into pharmacy to be delivered.</p> <p>Review of nurses note dated January 15, 2024, time stamped 2:56 p.m. revealed that Note Text: Methylphenidate HCl Oral Tablet 20 MG Give 1 tablet by mouth three times a day. Waiting on delivery.</p> <p>Review of physician services note dated January 16, 2024, time stamped 1:08 p.m. revealed the following: Medical management, atrial fibrillation, breast mass, COPD, anemia, HTN (Hypertension), hypothyroidism, anxiety, methylphenidate refill. Seen at bedside, upset, hasn't had her methylphenidate in 3-days; discussed a new script was written yesterday but will not be in stock until possibly tomorrow.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of nurses note dated January 16, 2024, time stamped 10:14 p.m. revealed that Note Text: Methylphenidate HCl Oral Tablet 20 MG Give 1 tablet by mouth three times a day related to Attention-Deficit Hyperactivity Disorder. Waiting for delivery from pharmacy. Physician aware.</p> <p>Review of Physician orders revealed that there was no order to Hold or DC (discontinue) the Methylphenidate HCl Oral Tablet 20 MG Give 1 tablet by mouth three times a day related to Attention-Deficit Hyperactivity Disorder during the time that the medication was not available for Resident R2.</p> <p>Interview with Resident R2 revealed that - missed 3 days of Methylphenidate. Further Resident R2 revealed that the facility didn't order the medication on time when she was starting to ran out of it. Further Resident R2 also revealed that the pharmacy ran out of stock.</p> <p>Interview with Licensed staff, Employee E3 conducted on February 5, 2024, at 1:12 p.m. confirmed that Resident R2 did not receive Methylphenidate HCl Oral Tablet 20 MG, on January 14, 15 and 16, 2024 because they ran out of her medication supply.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		