

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/27/2024
NAME OF PROVIDER OR SUPPLIER  Aventura at Terrace View		STREET ADDRESS, CITY, STATE, ZIP CODE  260 Terrace Drive Peckville, PA 18452	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26142</p> <p>Based on observations, review of clinical records, select facility policy, facility investigative reports, and staff interviews, it was determined the facility failed to ensure adequate staff supervision and effective safety measures for a newly admitted resident who expressed exit seeking behaviors and was identified as a wandering risk. The failure resulted in the elopement for one resident (Resident 1) out of 10 residents reviewed. Following this elopement the facility further failed to promptly identify the resident's absence and identify supervisory, and safety needs to prevent unsupervised exits from the facility, which placed residents in immediate jeopardy of unsupervised exits from the facility and the potential for serious bodily injury or death.</p> <p>Findings included:</p> <p>A review of facility policy entitled Wandering and Elopements last revised September 2022 revealed the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>A review of the clinical record of Resident 1 revealed admission to the facility on [DATE], with diagnoses, which included vascular dementia with mood disturbances (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to your brain).</p> <p>A review of an annual Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 26, 2024, revealed that Resident 1 is severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0 -7 indicates severely impaired cognition)</p> <p>A review of the resident's preadmission hospital paperwork dated November 19, 2024, revealed the resident required 1:1 supervision (direct observation by one staff to one resident), was aggressive, and had disruptive behaviors.</p> <p>A review of a Wandering Risk Assessment, completed by the facility, dated November 20, 2024, revealed the resident was at high risk for wandering behaviors.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's plan of care initially dated November 20, 2024, revealed the resident has the potential to wander and is at risk for elopement. Further review revealed planned interventions which included; staff to be aware of the resident's tendency to wander, attempt to redirect wandering behavior by initiating conversation, observe the resident's whereabouts throughout the day, use of a wander guard (a device that will alarm and alert staff if the resident tries to exit the unit through an alarmed door) to his right wrist, and to ensure a safe environment.</p> <p>A review of a nursing progress note written by Employee 1 (LPN 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM) dated November 20, 2024, at 6:19 PM revealed the resident's wander guard was found on his bedside table. Staff indicated they placed it back on his right wrist. The resident was noted to be wandering around the unit asking staff about his truck stating he needs to park it elsewhere.</p> <p>A review of a nursing progress note written by Employee 1 (LPN) dated November 21, 2024, at 12:33 AM indicated a call was received from Employee 5, (RN supervisor 11:00 PM to 7:00 AM) informing the staff the resident was in the custody of the police. Staff went to the resident's room and the resident could not be located. The staff proceeded to search the unit to attempt to locate the resident. Staff found a window fully opened at the end of the hallway of the nursing unit, with the screen pushed to the outside of the building.</p> <p>A review of a nursing progress note written by Employee 5 (RN) November 21, 2024, at 1:15 AM revealed at 12:33 AM the facility received a call from 911 dispatch inquiring if Resident 1 resided at the facility, she confirmed Resident 1 did reside at the facility and subsequently checked his bed and discovered he was not present, but he had arranged the blankets to give the appearance that someone was lying in the bed.</p> <p>The resident was returned to the facility escorted by two police officers at approximately 12:55AM. Upon his return, the resident was noted to be wet from the rainy weather conditions and he admitted to exiting the facility through a window.</p> <p>A review of a facility investigative report dated November 21, 2024, at 12:33 AM revealed the resident was last seen walking around the unit at 11:45 PM on November 20, 2024, the staff on the unit received a phone call from Employee 5 (RN) that the resident was in custody of the police. Staff went to the resident's room, and he was not there. Staff then went to search the unit and observed an open window at the end of the hallway with the screen pushed out, leading directly to the outside of the building.</p> <p>A review of a witness statement from Employee 1 LPN (licensed practical nurse 3:00 PM to 11:00 PM and 11:00 PM to 7:00AM) dated November 21, 2024, revealed around 11:45 PM on November 20, 2024, the resident had been walking around the unit looking to move his furniture and asking where his truck was. The resident became upset the employee did not have his truck. The employee tried to redirect the resident by offering him a snack, but the resident refused. The employee indicated the resident went to his room and closed his door and did not see him again after the interaction.</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 - Some</p>	<p>A review of a witness statement from Employee 2 NA (nurse aide 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM) dated November 21, 2024, revealed the employee stated the resident was pacing back and forth on the unit asking about his truck saying he needed to call someone about getting the truck. The employee indicated the resident began getting loud and walked behind the nursing station. The employee stated at that time the resident was told that his truck was not at the facility, and he should try to get some rest. At that time the resident went to his room. The employee further stated the last time she saw the resident was at 11:45 PM.</p> <p>A review of a witness statement from Employee 3 NA (11:00 PM to 7:00 AM) dated November 21, 2024, revealed the employee stated the resident was pacing the floor asking about his truck saying he needed to call someone to get it for him. The employee indicated the resident began to get loud and walked behind the nursing station. The employee indicated the resident was told at that time that his truck was not there and to go to his room to rest. The employee stated he went to his room then came out shortly after and was walking around the unit around midnight and that was the last time she saw the resident.</p> <p>A review of a witness statement from Employee 4 (RN 3:00 PM to 11:00 PM) no date or time indicated as to when the statement was received, revealed the employee stated the oncoming nursing supervisor, Employee 5 (RN) informed her that Resident 1 was missing from the C1 unit. Employee 4 (RN) indicated by her statement she went to help search for the resident and was informed the resident had left the facility through a hallway window.</p> <p>An interview with Employee 4 (RN) conducted on November 26, 2024, at approximately 8:30 AM revealed when the employee first came on shift on November 20, 2024, the resident was wandering around the unit going in and out of rooms. The employee stated during shift change she was notified by Employee 5 (RN) that Resident 1 was missing. She indicated she went to the C1 unit to help look for the resident and noticed the window was opened in the hall and the screen was broken. The employee stated two police officers had found the resident and brought him back to the unit late that night.</p> <p>An observation of the C1 unit on November 26, 2024, at approximately 8:35 AM revealed 2 large windows at the end of the hallway on the nursing unit. The windows lead to an outside ramp in the back of the building. Measurements from the windowsill to the ground measured 62 inches.</p> <p>An interview with the Maintenance Director on November 26, 2024, at approximately 10:30 AM revealed he received a call from the facility at approximately 1:00 AM on November 20, 2024, informing him a resident had eloped from the facility through a window. The Maintenance Director indicated he came to the facility that night to check all the doors and windows in the facility. The Maintenance Director conducted an inspection of the facility's, doors and windows and determined that all windows in the C1 and B1 units and three windows on the B2 unit were not secured. It was noted the windows could be opened completely, creating a potential risk for residents to exit through them.</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 - Some</p>	<p>A review of a law enforcement communication record revealed on November 21, 2024, at 12:13 AM a call came in to 911 from a bystander that an older male was walking in the rain wearing pajamas. The resident was located approximately 1 mile away from the facility by the police. The communication record indicated the resident was picked up by two police officers and returned to the facility at 12:56 AM.</p> <p>Immediate Jeopardy was called on November 26, 2024, due to the facility's failure to timely identify a resident's absence from the facility and prevent an elopement and failed to provide a safe environment with having secured windows beginning on November 21, 2024, at 12:30 AM when the facility received a call from the police stating Resident 1 was located outside of the facility.</p> <p>The facility was notified of the Immediate Jeopardy on November 26, 2024, at 11:30 AM and the IJ template was provided to the facility.</p> <p>The facility's corrective action plan included:</p> <ol style="list-style-type: none"> <li>1. Upon return to facility on November 21, 2024, resident was given a full RN assessment and placed on 1:1.</li> <li>2. Wandering risk assessments were completed by Unit Managers on November 21, 2024, for all residents and updated where necessary.</li> <li>3. The window identified as the residents exit point was immediately secured so it could not be open more than 7 inches. All other facility windows were checked and/or secured to ensure they could not be opened more than 7 inches on November 21, 2024.</li> <li>4. Environmental rounds will be conducted 5 days per week by maintenance department to ensure all windows remain secure.</li> <li>5. At 1:30pm November 26, 2024, facility began staff education for the 7am-3pm shift and 3pm-11pm shift on the updated facility elopement policy and resident safety checks. The 11pm-7am shift will be educated when they arrive before their scheduled shift. This education will be completed by 11/27/2024. All nonscheduled staff will be educated prior to their next scheduled shift, and no staff will be permitted to work until they have received the education.</li> <li>6. All new admissions assessed as high risk for elopement will be placed on 15-minute safety checks for the first 24 hours.</li> <li>7. Facility QAPI committee will convene on November 27, 2024, to review and complete this plan.</li> </ol> <p>This plan will be fully completed by November 27, 2024.</p> <p>Following verification of the implementation of the corrective action plan, a tour of the facility and review of education, the Immediate Jeopardy was lifted at on November 27, 2024, at 10:15 AM.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>41581</p> <p>Based on a review of clinical records, select investigative reports, and employee job descriptions and staff interview it was determined the facility's administration failed to effectively use its resources to promote resident safety and maintain the highest practicable physical and mental functioning of residents in the facility by failing to monitor one resident's whereabouts (Resident 1) and prevent an elopement for one out of 10 sampled residents.</p> <p>Findings included:</p> <p>Based on review of clinical records and select facility policy, observations, and staff and resident interviews it was determined the facility failed to provide necessary supervision and effective safety measures to monitor a resident's whereabouts and prevent an elopement by one resident (Resident 1) out of 10 sampled residents, placing the 29 residents out of 146 residents residing in the facility, identified at risk for elopement, in immediate jeopardy to their health and safety.</p> <p>A review of the job description for the Administrator (undated) revealed the administrator is responsible for directing day-to-day functioning of the facility in accordance with current federal, state, and local standards governing long term care facilities to ensure that the highest degree of quality resident care and services are delivered and maintained. He we'll ensure all personnel are treated fairly and consistent with company policy and applicable laws.</p> <p>The position responsibilities include, create, and maintain an atmosphere of warmth and personal interest by ensuring a positive and calm environment throughout the facility. Ensure that each resident receives the necessary nursing, medical, and psychological services to attain and maintain highest possible mental and physical functional status. Ensure compliance with all facility policies and procedures by all employees, residents, families, visitors, governing agencies, and public. Ensure the facility and surrounding grounds are maintained and are in good repair.</p> <p>The Job Description for Direction of Nursing Services (undated) noted the director of nursing is responsible for assisting the executive director and the implementation and attainment of nursing department goals and objectives. She will direct the operations and staff of the nursing department, provide leadership, direction, and evaluation of the delivery of nursing care and services within program models and ensuring strict compliance with federal, state, and local regulatory requirements.</p> <p>The position responsibilities include assist the executive director in the development of short- and long-term goals in collaboration with other direct care departments. Establish and implement action plans to ensure the attainment of departments goals and objectives. Develop, implement, and maintain a continuous performance improvement program and tools to remain in compliance with customer satisfaction objectives and governmental regulations. Provide leadership and direction for the delivery of nursing care and services and directs the overall operation and ongoing activities of the nursing department. Ensures that all individual care plans are instituted and updated according to regulatory guidelines. Maintains and promotes high standards of professional nursing and long-term care in accordance with standards of practice.</p> <p>(continued on next page)</p>		

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