STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395414	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Terrace View	260 Terrace Drive Peckville, PA 18452

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of select facility policy, clinical records, grievances filed with the facility, and staff interviews, it was determined that the facility failed to demonstrate timely and adequate efforts to resolve resident grievances for one out of 34 residents sampled (Residents C1). The findings include: A review of facility policy entitled Complaints and Grievances, Filing and Investigating Resident and Family last revised [DATE] revealed the resident or person filing the complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problem. Such report will be made orally by the grievance official or their designee within five working days of the filing of the grievance. A review of clinical record revealed Resident C1 was admitted to the facility on [DATE], with diagnoses which included overactive bladder and muscle weakness. A Grievance Summary filed by Resident C1's responsible party on [DATE], on behalf of the resident revealed the resident was urine soaking three to four pairs of pants a day and the resident's responsible party was concerned the resident was not being changed frequently enough. Further review of the Grievance Summary revealed the complaint was not resolved until [DATE], 73 days after the grievance was filed. The summary of the investigation, findings, and actions taken to resolve the grievance just indicate resident deceased . The resolved note stated the resident is deceased and no further follow up can be completed. There was no indication the facility had timely evaluated the resident's complaints regarding improper incontinence care. There was no documented evidence at the time of the survey ending [DATE], the resident's grievance was addressed or investigated by the facility. At the time of the survey ending [DATE], the facility was unable to provide documented evidence that it had determined if the resident and the resident's responsible party felt that the grievance had been resolved through any efforts taken by the facility in response to the responsible party's expressed concerns about proper incontinence care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on [DATE], at approximately 3:00 PM, confirmed the facility failed to demonstrate timely and adequate efforts to resolve resident grievances. Cross refer F585 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, selected facility policies, and staff interviews, it was determined the facility failed to thoroughly investigate an injury of unknown origin (a bruise) and an allegation of physical abuse to rule out abuse, neglect, or mistreatment as the potential cause for one of 34 sampled residents (Resident A 16). Findings include: A review of facility policy entitled Abuse last reviewed July 10, 2024, revealed, upon receiving an incident or suspected incident of resident abuse, neglect, misappropriation of resident property or injury of unknown source, the Administrator/DON/designee will conduct an investigation to include but not limited to the following: interview the persons reporting the incident interview any witnesses to the incident interview the resident interview the resident's attending Physician and review of the resident's record interview staff members (across all shifts) having contact with the resident during the period of the alleged incident interview the resident's roommate, family members and visitors interview other residents to which the accused employee provides care or services and review all circumstances surrounding the incident witness statements shall be in writing or typed. Witnesses will be required to sign and date such reports. The policy also indicated the facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation. A review of the clinical record of Resident A 16 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 the brain). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 A 16 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) 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), due to aggressive and disruptive behaviors. A review of a facility investigative report dated December 27, 2024, at 6:30 P.M. revealed that Resident A 16 was sitting at the nurse's station. Employee A3 (nurse aide) physically restrained Resident A 16 by grabbing the resident's arms and holding them above his head while attempting to remove the resident from behind the nurses' station. Employee A4 (agency LPN) intervened, informing Employee A3 that their treatment of the resident was unacceptable. An altercation ensued between Employees A3 and A4, involving yelling and profanity in the presence of residents and staff. The RN supervisor was notified the incident. Employee A3, NA left the building immediately without speaking to anyone. Administrative staff attempted to contact Employee A3 by phone immediately after the incident, but Employee A3 did not answer or return calls. The facility failed to suspend Employee A3 immediately pending an investigation as required by the facility's abuse prevention policy. A review of a witness statement dated December 27, 2024, at 11:11 P.M., revealed Employee A4 documented that upon returning from break at approximately 3:15 PM, she observed. Employee A3 NA behind the nurses' station with resident A 16. Employee A3 was reportedly holding resident A 16 in a chokehold. Employee A. agency LPN stated that she immediately instructed Employee A3 to release the resident and not to touch him. Employee A3 continued to restrain resident A 16 and stated the resident was not allowed behind the nurses' station. Employee A4 informed Employee A3, that Resident A 16 had been behind the nurses' station throughout the day and was pleasant and compliant with care. Employee A3 reportedly responded with profanity, calling employee. A4 names and continued to curse. Employee A4 also reported that Employee A5 NA and another unidentified nurse aide attempted to move Resident A 16 by pulling /dragging him by his arms. Employee A4 directed them to stop and instructed them not to touch the resident. The RN supervisor arrived and intervened to deescalate the situation. As the RN supervisor escorted Employee A4, LPN to her office, Employee A3 NA allegedly threatened Employee A4 stating You're lucky you're a woman, I will beat you're a** and I will kill you and your husband!, this was said in the presence of the RN supervisor. Employee A4 (agency LPN) was scheduled continue to work on the 2nd shift on December 27, 2024, and requested to leave the facility following the incident. This request was denied by nursing administration and Employee A4 was reassigned to work in a different resident unit, after completing the shift, Employee A4 was prohibited from working at the facility in the future. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview conducted on January 8, 2025, at 1:00 PM, Employee A4 (agency LPN) stated that on December 27, 2024, she was scheduled to work both the 7:00 AM to 3:00 PM and the 3:00 PM to 11:00 PM shifts. She took a break between the shifts and left the C1 (dementia) unit at approximately 3:00 PM. Employee A4 reported returning to the unit at approximately 3:10 PM and observed Resident A 16 behind the nurses' station. Employee A3 (nurse aide) was reportedly holding Resident A 16' s' arms above his head and had his hands around the resident's neck in what Employee A4 described as a choke hold. This was reportedly an attempt to remove the resident from the nurses' station. Employee A4 stated that Resident A 16 had been seated behind the nurses' station with her during the day shift without issue. Upon observing the incident, Employee A4 immediately directed Employee A3 to release the resident. According to Employee A4, Employee A3 began cursing at and threatening her in front of other residents and staff members on the C1 unit. Shortly thereafter, Employee A3 left the unit and the facility. In a witness statement dated December 31, 2024, Employee A3 (nurse aide) provided their account of the events on December 27, 2024. Employee A3 stated he entered the building to work an overtime shift and returned to their usual unit. Upon arrival, he observed Resident A 16 behind the nurses' station. Employee A3 reported asking Resident A 16 to leave the area, at which point the resident rudely pushed past them. Employee A3 stated that they turned around and asked the resident to leave again. According to Employee A3, Employee A4 (agency LPN) approached shortly afterward and accused them of abusing the resident. Employee A3 alleged that Employee A4 began cursing at them and continued until Employee A3 left the building. Employee A3 stated they did not observe a 1:1 staff member supervising Resident A 16 at the time and that, as a regular staff member familiar with the resident, they were aware that Resident A 16 had a history of elopement attempts and often sought ways to leave the unit. Employee A3 asserted that Employee A4, as an agency nurse, did not know the resident's history. Employee A3 denied making physical contact with the resident, stating he never would allow their hands to touch the resident at all. He alleged that Employee A4 had accused them of abuse without directly witnessing any contact and refused to listen to other nurse aides on the unit. Employee A3's statement highlighted concerns regarding inconsistent 1:1 supervision for Resident A 16, as required by preadmission documentation due to the resident's cognitive impairments and history of elopement and disruptive behaviors. The survey team attempted to contact Employee A3 during the investigation but was unable to reach him for a statement. Additional interviews were conducting during an onsite visit on January 23, 2025, which resulted in the following telephone and in person interviews.: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview January 23, 2025, at 1 P.M., Employee A6 agency LPN was assigned to 1 to 1 supervision for resident A 16 on December 27, 2024, from 7:00 AM to 3:00 PM. He reported that resident A-16 wandered throughout most of the day attempting to walk behind the nurse's station multiple times. He stated when redirection was attempted, Resident A16, became aggressive. At 3:00 PM, employee A6 left, resident A16, seated in a chair outside of the resident's room, which is located near the nurse's station. This employee handed off the 1 to 1 supervision responsibility to Employee A7, the agency nurse aide, at 3:00 PM. After completing his shift, Employee A6 left the floor and saw Employee A4 Agency LPN in the parking lot taking a break between shifts. During an interview January 23, 2025, at 2 P.M., Employee A3 NA arrived at the facility around 2:50 PM on December 27th, 2024, even though he was not scheduled to work, he chose to show up and ask if he could work. The scheduler allowed him to work and directed him to report to the nursing supervisor. He arrived at his usual unit around 3:05 PM and went behind the nurse's station to put his belongings away. As he exited the room and entered the area behind the nurse's station, Resident A16 approached and walked towards him. Employee A3 stated the resident put his hands on him, prompting him to pivot away from the resident. Employee A3 described himself as a boxer and knew how to avoid the situation. Employee A3 stated that Resident A16, was angry and yelling at staff when the resident pushed him. Employee A3 claimed he did not touch the resident. Employee A4, the agency LPN, then approached yelling at Employee A3 to get his hands off the resident. Employee A3 described Employee A4 as threatening and cursing at him. Employee A3 left the floor and the facility not returning to complete his shift. Employee A3 described the unit as his home floor and stated he knew the residents and their routines. In contrast, he claimed Employee A 4 was an agency nurse who didn't know the residents and allowed resident A 16 to sit behind the nurse's station, which he said was against facility policy. He also noted that regular staff members are more familiar with the residents and routines, while agency staff often do not listen to regular staff. A telephone interview, January 23, 2025, at 1:15 P.M., Employee A 5 (NA) stated that on December 27, 2024, she was seated behind the nurse's desk around 3:05 PM, while Employee A7, the agency LPN, was on the other side of the nursing station. Resident A 16 had wandered behind the nurse's station. Employee A3 then approached and told Resident A 16 to leave the area. Resident A16 became aggressive, grabbing Employee A3's arms Employee A3 tried to move away. At that moment employee A4, the agency nurse, started yelling and cursing at Employee A3 telling him to get his hands off the resident. Employee A 5 confirmed that employee A3 did not push the resident and stated that Employee A3 left the floor immediately after the incident. Multiple attempts to contact Employee A 7 (agency NA) were made but no contact was successful. The lack of immediate protective measures, such as suspending Employee A3 pending investigation, allowed for conflicting staff accounts and failure to ensure a timely and thorough investigation. The absence of clear, consistent supervision and staff awareness of Resident A 16' s' care plan further demonstrated systemic deficiencies in the facility's ability to safeguard residents from abuse and prevent escalation of incidents among staff. The conflicting statements from Employee A3 and other witnesses, combined with the facility's failure to ensure appropriate supervision and staff adherence to abuse prevention policies, illustrate a breakdown in the facility's systems to protect Resident A 16 from the potential of abuse, ensure a safe environment, and maintain professional staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated December 30, 2024, at 11:00 A.M. documented that during Resident A 16' s' shower, a nurse aide reported the presence of a bruise on the resident's right hip to licensed nursing staff. Documentation indicated that the Director of Nursing (DON), the Nurse Practitioner, and the resident's responsible party were notified, and a stat X-ray was ordered. At the time of the survey ending January 8, 2025, there was no documented evidence the facility had conducted an investigation into the potential origin of the bruise. Specifically, the facility failed to: Interview the staff member who discovered the bruise. Interview other staff members who had contact with the resident. Interview the resident's attending physician. Document witness statements, as required by the facility's abuse policy. During an interview with the Director of Nursing on January 8, 2025, at 12:00 P.M., the DON was unable to provide evidence that an investigation was conducted to rule out abuse, neglect, or mistreatment as the potential cause of Resident A 16' s' injury of unknown origin. This failure to investigate injuries of unknown origin compromises the facility's ability to identify and address potential abuse, neglect, or mistreatment, thereby jeopardizing the safety and well-being of residents under the facility's care. The facility failed to properly investigate an injury of unknown origin and failed to conduct a thorough investigation into the allegation of abuse. Despite the presence of conflicting staff statements and concerns regarding the supervision of Resident A 16. The facility did not take appropriate action to determine the cause of the unknown injury (bruise) or to rule out abuse, neglect or mistreatment. 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 201.18(1)(3) Management 28 pa. code 211.12(c)(d)(1)(2)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and staff interview it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address the resident's needs for pressure sore prevention for one out 3 residents with pressure areas sampled. (Resident A 17). Findings include: A review of clinical record revealed that Resident A 17 was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated December 12, 2024, revealed that the resident had a BIMS score of 7 (brief interview of mental status test is used to get a quick snapshot of cognitive function. A score of 0 to 7 indicates severe cognitive impairment) was severely cognitively impaired. The resident was identified as at risk for skin breakdown due to decreased mobility and required staff assistance for activities of daily living. A review of the resident's plan of care for, potential for skin breakdown related to decreased mobility was initiated on March 31, 2022, and was revised and discontinued on June 06, 2024. No preventative interventions were documented in the care plan from June 6, 2024, to December 12, 2024, prior to the development of pressure-related skin issues. A review of clinical documentation dated December 12, 2024, at 10:25 P.M. revealed, an area was found on the resident's left heel measuring 2.5 cm by 2cm, red non blanchable (when you push the skin, the normal reaction would be that the area turns white and then returns to its original skin color, indicating circulation), scant amount of dry blood noted on bed sheets. A bruise was also documented on the great toe, although the specific toe was not identified in the clinical record. No documentation regarding the great toe bruise was available during the survey. On December 13, 2024, the physician-initiated treatment orders for the left heel and first toe, including wound care with normal saline, application of calcium alginate with silver, and a low-air-loss mattress. The treatment plan was revised on December 17, 2024, and updated on December 18, 2024, for continued wound management. Preventative measures such as repositioning, use of pressure-relieving devices, or routine skin assessments were not implemented or documented prior to the development of the noted skin issues, despite the resident's documented risk for pressure sore development. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview January 8, 2025, at 2:00 PM the Director of Nursing confirmed the facility failed to ensure that comprehensive care plans included preventative interventions tailored to the resident's risk for pressure sore development. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 determined the facility failed to provide nursing services consistent with professional standards of practice by failing to follow physician's orders and ensure that licensed nurses accurately administered prescribed medication to one resident of three residents sampled for medication administration. (Resident B4). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. Review of the facility policy titled, Administering Medications, last reviewed by the facility in June 2024, revealed the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. A review of the clinical record revealed Resident B4 was admitted to the facility on [DATE], with diagnoses to include metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid or pus, causing symptoms such as cough, fever, chills and trouble breathing), and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). An Admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated December 2, 2024, revealed the resident was severely cognitively impaired with a BIMS score of 3 (BIMS-Brief Interview for Mental Status, section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information. A score of 0-7 indicates severe cognitive impairment). A review of facility provided investigation documentation indicated the incident occurred on Sunday, December 1, 2024, at 9:33 AM. The type of incident was identified as a medication incident which was reported by Employee B16 (licensed practical nurse) on December 1, 2024, at 9:33 AM. The medication incident details indicated the type of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	error was the wrong resident. Resident B4 was administered Seroquel 25 mg. (antipsychotic medication that balances the levels of dopamine and serotonin in the brain), Xanax 1 mg (antianxiety medication), and Gabapentin 300 mg (anticonvulsant medication used to treat seizures and nerve pain). The effect the medication error had on the resident was increased fatigue. Resident B4 did not have physician orders for any of these medications. A review of the witness statement provided by Employee B16 (no date or time indicated) revealed that while administering medications in the morning, Employee B16 accidently administered the wrong medications to Resident B4. Employee B16 stated that she relied on the names and photos on the doorway and failed to independently verify the resident's identity before administering medications. Employee B16 stated that she relied on the names and photos on the doorway and failed to independently verify the resident's identity before administering medications. The error was discovered when Resident B15, the intended recipient, alerted the nurse that he had not received his morning medications. Following the medication error, neurochecks were initiated, and Resident B4 exhibited increased fatigue but no immediate adverse effects. The physician and the resident's family were notified, and the resident was monitored throughout the shift. Interview with the Director of Nursing (DON) on January 8, 2025, at approximately 1:30 PM confirmed that Employee B16 failed to follow professional standards and physician orders during medication administration. The DON acknowledged that Resident B4 was incorrectly given Resident B15's medications, which constituted a medication error and a failure to follow acceptable nursing practices. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5 (f)(i) Medical records

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on clinical record review, review of select facility policy, and staff interview, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for two residents out of 34 residents sampled (Residents B1 and B2). Findings include: Review of the facility Restorative Nursing Services Policy last reviewed by the facility on June 19, 2024, indicated that residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay, or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. The resident or resident representative will be included in determining goals and the plan of care. A review of the clinical record revealed Resident B1 was admitted to the facility on [DATE], with diagnoses which included heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypertension (high blood pressure), and asthma (airways of the lungs become inflamed, narrow and swell, and produce extra mucus, making it difficult to breathe). An Admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated November 23, 2024, revealed the resident was severely cognitively impaired with a BIMS score of 2 (BIMS-Brief Interview for Mental Status, section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information. A score of 0-7 indicates severe cognitive impairment) and required partial/moderate assistance for transfers and mobility. Review of Resident B1's Physical Therapy Discharge Summary dated December 5, 2024, revealed the resident had made consistent progress with skilled intervention and her prognosis to maintain her current level of functioning was excellent with participation in a RNP (Restorative Nursing Program). Resident B1 was referred for a RNP upon discharge from PT. The RNP recommendation on the Physical Therapy Discharge Summary stated, to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (Interdisciplinary Team): ambulation. (continued on next page)

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Aventura at Terrace View	260 Terrace Drive Peckville, PA 18452

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident B1's care plan, in effect at the time of the survey ending January 8, 2025, revealed a focus area of ambulation dysfunction related to hypertension, bipolar disorder, anxiety disorder, congestive heart failure and seizures with the goal for the resident to ambulate 25-50 feet using a rolling walker (walker with wheels on the front) with assistance of one staff member. Interventions included: document the distance the resident ambulates on the restorative nursing flow record; explain the ambulation task to the resident and provide assistance of a rolling walker, verbal cueing and encouragement as needed; notify the charge nurse of any changes in her gait patterns/balance or any other problems related to his ambulation goal; and report any statements given of discomfort or any nonverbal signs/symptoms of discomfort while ambulating; and restorative nursing program for ambulation. Review of the facility Kardex (a nursing information system used to obtain specific care information for each resident) in effect at the time of survey ending January 8, 2025, revealed a task for Nursing Rehab: ambulate 25-50 feet using a rolling walker with assistance of one staff member. Review of the Documentation Survey Report v2 dated January 2025 , revealed the nursing rehab (restorative nursing program) for ambulation was not provided to the resident on 5 days out of 7 days ordered, with staff documenting NA (not applicable) as a response. A review of the clinical record revealed Resident B2 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), muscle weakness, and unsteadiness on feet. An Annual Minimum Data Set assessment dated [DATE], revealed Resident B2 was severely cognitively impaired with a BIMS score of 5, and required partial/moderate staff assistance for mobility and transfers. Review of Resident B2's Physical Therapy Discharge Summary dated December 13, 2024, revealed the resident made consistent progress with skilled intervention and his prognosis to maintain his current level of functioning was excellent with participation in RNP. Resident B2 was referred for a RNP upon discharge from PT. The RNP recommendation on the Physical Therapy Discharge Summary stated, to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (Interdisciplinary Team): ambulation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident B2's current care plan, in effect at the time of the survey ending January 8, 2025, revealed a focus area of ambulation dysfunction related to transient ischemic attack (brief stroke-like attack), diabetes, moderate protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health), tremors, GERD, depressive disorder, alcohol abuse, tobacco abuse, osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down), and tardive dyskinesia (condition affecting the nervous system that results in involuntary repetitive muscle movements in the face, neck, arms, and legs, often caused by long-term use of some psychiatric drugs) with the goal for the resident to ambulate 50-75 feet using a rolling walker with assistance of one staff member. Interventions included: document the distance the resident ambulates on the restorative nursing flow record; explain the ambulation task to the resident and provide assistance of a rolling walker, verbal cueing and encouragement as needed; notify the charge nurse of any changes in her gait patterns/balance or any other problems related to his ambulation goal; and report any statements given of discomfort or any nonverbal signs/symptoms of discomfort while ambulating; and restorative nursing program for ambulation. Review of the facility Kardex in effect at the time of survey ending January 8, 2025, revealed a task for Restorative Nursing for ambulation. Review of the Documentation Survey Report v2 dated January 2025, revealed the nursing rehab (restorative nursing program) for ambulation was not provided to the resident on 6 days out of the 7 days ordered for the month of January, with staff documenting NA as a response. Interview with the Director of Rehab (DOR) on January 7, 2025, at 2:00 PM, verified that NA was not an appropriate response to document in the Documentation Survey Report v2. Interview with the Nursing Home Administrator on January 8, 2025, at approximately 12:35 PM confirmed the facility failed to consistently implement the planned restorative nursing program for Residents B1 and B2 to maintain their functional abilities and deter declines to the extent possible. 28 Pa. Code: 211.5(f)(viii) Medical records 28 Pa Code 211.12(c)(d)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, and staff interview, it was determined that the facility failed to implement individualized approaches to provide maintenance care to the extent possible for one out of 34 sampled residents (Resident C1). Findings include: A review of Resident C1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included overactive bladder and muscle weakness. A review of Resident C1's quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 20, 2024, revealed that the resident was always incontinent of bladder and bowel. A review of the resident's Elimination Continence Care Screen dated September 20, 2024, revealed the the facility failed to identify the type of incontinence the resident had and failed to identify treatment options for the resident. A review of the resident's plan of care for Incontinence Management initially dated May 31, 2024, revealed an intervention dated November 20, 2024, for the to be checked and changed as needed at least every hour while awake. A review of the resident's clinical record revealed no documentation the resident was being checked and changed every hour and as needed as outline in her plan of care. An interview with the Director of Nursing on January 8, 2025, at approximately 3:00 PM confirmed that the facility failed to provide failed to provide documented evidence that incontinence care was provided to Resident C1. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select investigative reports provided by the facility, observations, and staff interviews, it was determined that the facility failed to fully develop and consistently implement an individualized person-centered plan to address and manage dementia-related behaviors for one resident out of 34 sampled residents. (Resident A 16). Findings include: A review of the clinical record of Resident A16 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 process caused by brain damage from impaired blood flow to your brain). 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 Resident A16 was 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) 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), due to aggressive and disruptive behaviors. A review of a care plan for, Impaired cognitive function/dementia or impaired thought processes related to Vascular Dementia, short term memory loss, was initiated on November 21, 2024. Interventions included: Communicating basic needs daily. Administering medications as ordered. Using the resident's preferred name and making eye contact. Reducing distractions and providing simple directive sentences. Addressing concerns with the resident's guardian. There were no specific interventions to address Resident A16's dementia-related aggressive and wandering behaviors. A review of a Facility documentation dated November 21, 2024, at 12:33 AM revealed, Resident A16 eloped from the facility through an open hallway window. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility documentation and nursing notes from December 2024 through January 2025 documented multiple instances of verbal and physical aggression by Resident A16 toward staff and other residents, as well as continuous wandering within the unit. Despite a physician's order for 1:1 supervision, there was no evidence of consistent implementation of this intervention. A review of facility documentation dated December 27, 2024, at 6:30 P.M revealed that Resident A16 was physically restrained by a nurse aide and other staff while behind the nurses' station, including being grabbed around the neck to remove him from the area. During an interview January 8, 2025, at 1:00 PM, the Nursing Home Administrator (NHA) confirmed the facility had 2 separate dementia units, one female the D unit and one male unit C1, which both operated under the facility Dementia program that was updated after the October 13, 2024, survey. The facility's Dementia Program, updated after the October 13, 2024, survey, described dementia care units as safe, homelike environments with individualized dining and activities. Staff were noted to be trained to direct care appropriately. The program outlined the use of individualized, person-centered interventions to manage residents' dementia-related behaviors. Resident A16's care plan lacked specific, individualized dementia-care interventions to manage aggressive or wandering behaviors. Interview with the Nursing Home Administrator (NHA) on January 8, 2025, at 1:00 PM, confirmed the facility failed to Implement appropriate, individualized interventions for Resident A16 to address his documented aggressive and wandering behaviors and develop a person-centered care plan in accordance with the facility's dementia program. Cross refer F600 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 211.12 (c)(d)(5) Nursing services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, controlled drug medication sheets, controlled drug shift count records, and staff interview, it was determined that the facility failed to implement procedures to promote accurate accounting of narcotic medications for one of 34 residents sampled (C2) and failed to implement procedures to promote accurate controlled medication records on one of two medication carts observed. Findings include: A review of Resident C2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included chest pain, and alcoholic cirrhosis of the liver (a late stage of liver disease that occurs when the liver is permanently damaged by alcohol and replaced with scar tissue). A review of the resident's clinical record revealed that Resident C2 had a physician order initially dated December 27, 2024, for Oxycodone HCL (a narcotic opioid pain medication) 5 mg tablet every 6 hours as needed for chronic pain. A review of the resident's controlled substance records accounting for the above narcotic medication revealed on January 2, 2025, at 12:50 PM, and January 4, 2025, at 2:00 PM revealed that nursing staff signed out a dose of the resident's supply of Oxycodone 5 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record on those dates and times. A review of the facility Control Substance Shift to Shift Count Sheet from the B2 medication cart revealed the following: January 2, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. January 3, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. January 6, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. January 7, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. January 7, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on January 8, 2025, at approximately 3:00 PM the Director of Nursing confirmed the inconsistencies in the accounting and administration of the opioid pain medications for C2 and confirmed the facility failed to demonstrate consistent implementation of procedures for promoting accurate controlled drug records . 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service 28 Pa Code 211.9 (c)(k) Pharmacy services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that medication regimens are managed and monitored to promote or maintain the resident's highest practicable well being in regards to documented medical diagnosis related to psychoactive medications for one residents out of 30 residents sampled (Resident A 16). Findings include: A review of the clinical record of Resident A16 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). 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 A16 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) A physicians order dated November 22, 2024 for Ativan (an antianxiety medication)0.5 mg by mouth twice a day for vascular dementia with mood disturbance. A physician's order dated November 25, 2024, was noted for Seroquel [an antipsychotic medication used to treat severe agitation associated with certain mental/mood conditions such as schizophrenia and bipolar mania], give 50 mg by mouth two times per day related to vascular dementia with mood disturbance. A Physicians order dated December 13, 2024 revealed Trazadone HCL (an antidepressant medication) 50 mg by mouth at bedtime for vascular dementia with mood disturbance. The trazodone dose was increased to 100 mg by mouth at bedtime for vascular dementia with mood disturbance. Review of the physician documentation, completed by the attending physician, dated November 25, 2024 failed to meet the criteria for use of the noted psychoactive medications. There was no documentation at the time of the survey ending January 8, 2025, that the physician had provided resident-specific rationale for the continued use and of psychoactive medication. During an interview with the Director of Nursing on January 8, 2025, at approximately 1:00 p.m., she confirmed that the current physician documentation failed to include accurate resident specific details in support of the use of the psychoactive medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.9(a) (1) Pharmacy Services 28 Pa. Code 211.2(3) Medical Director

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of select facility policy, clinical record review, medication error report, and staff interview, it was determined the facility failed to ensure accurate labeling of medication for one resident of three residents sampled for medication administration (Resident B3). Findings include: Review of the facility policy titled, Administering Medications, last reviewed by the facility in June 2024, revealed that the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. A review of the clinical record revealed that Resident B3 was admitted to the facility on [DATE], with diagnoses which included irritable bowel syndrome (IBS, an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and chronic pain syndrome. An Annual Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated September 3, 2024, revealed the resident was cognitively intact with a BIMS score of 15 (BIMS-Brief Interview for Mental Status, section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information. A score of 13-15 indicates cognitively intact responses). A review of a physician's order dated October 31, 2024, revealed an order to administer Dicyclomine HCl capsule 10 mg (treats IBS by relaxing the muscles of the stomach and bowel, which reduces cramping), give 20 mg by mouth every 6 hours related to irritable bowel syndrome. Review of a nurse's note dated November 14, 2024, at 1:26 AM revealed that Resident B3 refused her nighttime dose of Dicyclomine, stating the prior dose caused vomiting. The Licensed Practical Nurse (LPN) observed that the medication labeled as Dicyclomine was Doxycycline, an antibiotic with a similar capsule appearance but larger size. Pharmacy and the on-call physician were notified immediately, and the resident was monitored for adverse reactions. Review of facility's investigative documentation indicated the medication error occurred on November 13, 2024, at 11:45 PM. The report stated that Resident B3 was administered Doxycycline Hyclate 100 mg (antibiotic) instead of Dicyclomine 20 mg (antispasmodic) due to a pharmacy packaging error. The incident caused the resident to experience nausea and vomiting. Review of the witness statement provided by the administering nurse (Employee B17), no date or time indicated, identified the medication appeared larger than usual and verified with the resident that a prior dose caused adverse effects. Upon investigation, it was determined the medication package labeled as Dicyclomine contained Doxycycline. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the witness statement provided by Resident B3 (no date or time indicated) reported vomiting twice after the afternoon dose and subsequently refused her 6:00 PM dose. Further review of the facility investigation revealed the conclusion was the resident was administered mislabeled medication. Pharmacy was immediately notified about packaging of wrong medication and the mislabeled mediation was immediately returned and replaced with the correct medication. Pharmacy arrived and performed an audit on all medication carts in the facility. Facility performed audits on all medication carts. Staff education was provided on verifying medication labels on both the front and back of the packaging. During an interview on January 8, 2024, at 12:50 PM, the Nursing Home Administrator (NHA) confirmed that the pharmacy mislabeled the medication and that the facility failed to ensure the accuracy of medication labeling prior to administration to Resident B3. 28 Pa. Code 211.9(a)(1)(d)(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 26142 Based on observation, clinical record review, and staff and resident interviews, the facility failed to provide drinking water consistent with resident needs and preferences for one out of four units sampled. (D unit) Findings include: Facility protocol indicates night shift nursing staff, 11:00 PM to 7:00 AM are responsible for replacing residents' Styrofoam water cups and labeling them with the current date. Observation on January 7, 2025, at approximately 12:00 PM the following resident rooms on the D-female dementia unit were observed without water cups or accessible drinking water: Rooms: 115, 123 D, 126 W and 127. On January 7, 2025, at approximately 12:00 P.M., the following resident rooms were observed with Styrofoam water cups marked with outdated dates (January 6, 2025). Some cups were empty, and others contained warm water: Rooms: 116, one cup dated January 5 and a second cup dated January 6, 123 W, 118 D, 126 D and 119 W. Employee A1 (LPN): Interviewed on January 7, 2025, at 12:15 P.M., Employee A1 stated that night shift nursing staff (11:00 P.M.-7:00 A.M.) is responsible for replacing Styrofoam cups and filling them with fresh water. She could not explain why the dates on the cups were not current or why some residents did not have water. Employee A 2 (Agency Nurse Aide): Interviewed on January 7, 2025, at 12:20 PM, Employee A 2 stated that night shift staff are tasked with replacing and dating the Styrofoam cups. She also stated that nurse aide staff are expected to refill water cups during each shift. Employee A 2 confirmed that water had not been passed that morning and was unaware that cups had not been timely changed. Resident A 11' s' Daughter: Interviewed on January 7, 2025, at 12:10 PM, Resident A 11' s' daughter stated that her mother does not consistently receive fresh water in her room. She expressed concern that her mother requires encouragement to drink and would not have access to water if it was not readily available. During an interview January 8, 2025, at approximately 2:00 PM the Nursing Home Administrator confirmed that nursing staff are to provide residents fresh water on each shift of nursing duty. He stated that on the night shift the disposable Styrofoam cups are dated and replaced by the nursing staff. The facility failed to ensure the availability of drinking water consistent with resident needs and preferences. (continued on next page)

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	395414	A. Building B. Wing	01/23/2025

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Aventura at Terrace View	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.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48277 Based on observation, review of facility scheduled mealtimes, select facility policy, and resident and staff interview it was determined the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack when greater than 14 hours elapses from the dinner meal to breakfast the next day for residents including nine residents of 10 sampled (Residents B15, B 6, B 7, B8, B 9, B150, B 11, B12, and B 13). Findings include: Review of the facility's policy entitled Frequency of Meal last reviewed by the facility in June 2024, indicated it is the facility's policy to provide at least three meals daily, at regular times comparable to normal mealtimes in the community. The time between a substantial evening meal and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. A nourishing snack is defined as items from the basic food groups, whether singly or in combination with each other. Review of the facility's scheduled mealtimes revealed 14.83 hours between the evening meal and the next day's breakfast meal (D wing-1: dinner 5:25 PM, breakfast 8:15 AM) During an interview on January 8, 2025, at 10:40 AM Resident B15 stated that staff do not provide or offer a nighttime snack. He stated, they used to bring a tray (of snacks) and put it on the nurses station, but not anymore, not for months. During an interview on January 8, 2025, at 10:54 AM Resident B 6 stated staff do not provide or offer a nighttime snacks. She stated that her family brings her food, so she has something to snack on. During an interview on January 8, 2025, at 10:57 AM Resident B 7 stated that snacks are provided sometimes, it's hit or miss, but mostly miss. During an interview on January 8, 2025, at 11:00 AM Resident B8 stated that staff do not provide or offer snacks at bedtime and added I would like one if they gave it to me. During an interview on January 8, 2025, at 11:02 AM Resident B 9 stated that the dietary staff bring a snack tray and leave it at the nurses station, but the snacks are not passed out to the residents. During an interview on January 8, 2025, at 11:05 AM Resident B150 stated that the snack tray is left on top of the counter at the nurses station, but the snacks are not passed out to the residents. She added that when she asked for a snack, a staff member provided one but only when she asked. Snacks are not provided or offered otherwise. During an interview on January 8, 2025, at 11:10 AM Resident B 11 stated that snacks are not provided or offered. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 8, 2025, at 11:25 AM Resident B12 stated Snacks used to be provided, but not anymore. I enjoy a nighttime snack. I wish they would start that again; I'd like a snack at night. During an interview on January 8, 2025, at 11: 32 AM Resident B 13 stated , Sometimes they do (pass snacks) and sometimes they don't. But mostly they don't. During an interview on January 8, 2025, at approximately 12:40 PM the Nursing Home Administrator was unable to explain why the residents were not routinely offered and provided with an evening/bedtime snack. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations, clinical record review, and staff and family interviews, the facility failed to ensure the provision of appropriate assistive devices for dining as prescribed, affecting 1 of 34 residents sampled. (Resident A11) Findings include: Clinical record review revealed that Resident A11 was admitted to the facility on [DATE], with diagnosis to include dementia and dysphagia (difficulty swallowing). An annual Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 27, 2024, revealed a BIMS score of 6 (Brief Interview for Mental Status, a structured evaluation aimed at evaluating aspects of cognition in elderly patients. A score of 0-7, indicating severe cognitive impairment) and required staff assistance for activities of daily living to include eating. Physician's orders dated January 3, 2025, revealed, regular diet, dysphagia/advanced consistency with extra sauce/gravy (chopped, bite sized foods ordered for difficulty chewing/swallowing), thin liquids, spouted, sip cup for all liquids and no use of straws. On January 7, 2025, at 12:00 PM, during lunch in the D Unit dining room, Resident A11 was observed seated at a table with her meal tray in front of her. The tray contained a 4-ounce hard plastic cup with red juice, a 6-ounce plastic cup with a liquid nutritional supplement, and a straw. A spouted sippy cup, as ordered by the physician, was not present. The resident did not attempt to feed herself during this observation. During an interview on January 7, 2025, at 12:00 PM, Resident A11's daughter stated that her mother had been having trouble drinking at mealtimes and required a handled sippy cup as per the physician's order. The daughter reported that nursing staff had been providing a straw to the resident, despite the resident's inability to use a straw. She further stated that she had informed facility administration of the issue, but no corrective actions had been taken. During a tour of the facility kitchen, the following adaptive equipment was available for resident use: 1 Kennedy cup (spill-proof drinking cup) 1 sippy cup (plastic cup with a spout, lid, and handles) 3 nosey cups (cups with a nose cutout for proper head and neck positioning) Facility documentation revealed the following adaptive equipment requirements for residents: 4 residents required two-handled cups (2 cups per meal per resident, 8 cups total). (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6 residents required Kennedy cups at all meals. 3 residents required nosey cups. The current inventory of adaptive equipment was insufficient to meet the needs of all residents requiring such devices. During an interview on January 8, 2025, at 11:00 AM, the corporate dietary manager confirmed that the facility did not maintain an adequate supply of adaptive dining equipment. She stated that the dietary services were outsourced to an external vendor, but the facility remained responsible for obtaining necessary equipment. The dietary manager was unable to provide information on how the dietary department ensured quality assurance for adaptive equipment availability. During an interview on January 8, 2025, at 11:00 AM, the corporate dietary manager confirmed that the facility did not maintain an adequate supply of adaptive dining equipment. She stated that the dietary services were outsourced to an external vendor, but the facility remained responsible for obtaining necessary equipment. The dietary manager was unable to provide information on how the dietary department ensured quality assurance for adaptive equipment availability. 28 Pa Code 208.18(b) (1) Management

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26142 Based on a review clinical records, facility provided documents, the facility's plan of correction from the survey ending October 13, 2024, and the outcome of the activities of the facility's quality assurance committee it was determined the facility failed to develop and implement a quality assurance plan, which was able to identify and correct ongoing quality deficiencies related to the implementation of interventions to prevent resident abuse, dementia care and use of psychoactive medications and to ensure that plans were designed and implemented to improve the delivery of care and services were in place and to deter future quality deficiencies. Findings include: During the survey ending October 13, 2024, deficient facility practice was identified related to the facility's failure to prevent resident abuse, dementia care and unnecessary psychiatric medications. The facility developed a plan of correction that was to be completed and functioning by November 11, 2024, that included a QA (quality assurance) monitoring plan to ensure that solutions were sustained. However, during this revisit survey completed on January 8, 2025, continued deficiencies were identified under these same requirements. Deficient practice was identified under this same requirement at the time of this survey ending January 8, 2025, whereas the facility failed to implement procedures to prevent resident abuse, dementia care and unnecessary psychoactive medications. The facility did not implement effective interventions to prevent incidents of abuse, as evidenced by an incident involving Resident A16 on December 27, 2024, where the resident was physically mishandled by staff. The incident, which escalated into verbal threats and inappropriate staff conduct, was not identified as abuse or appropriately addressed by the QAPI committee. Quality assurance interventions to include staff education to include abuse and neglect. Nursing staff training regarding following the residents plan of care. A directed plan of correction was to be conducted by the facility for all staff regarding abuse and neglect training. Audits to include observations and interviews to be completed daily for 30 days. Resident A16, who exhibited aggressive and disruptive behaviors with documented cognitive impairments, did not receive care aligned with his plan of care, including 1:1 supervision. Facility interventions were inadequate to address the resident's behaviors and care needs, resulting in repeated incidents of wandering, aggression, and unsafe situations. Quality assurance interventions to ensure dementia care for residents included a policy update defining dementia programing, staff reeducation regarding dementia care and behaviors and audit 10 % of care plans for residents residing on dementia units monthly for 2 months. Nursing staff training regarding following the residents plan of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure physician documentation met criteria for the continued use of psychoactive medications prescribed to Resident A16. There was no resident-specific rationale or evidence of compliance with gradual dose reduction requirements. Quality assurance interventions to ensure residents are free of unnecessary psychoactive medications for residents included a review of all residents on antianxiety/mood stabilizer medications was conducted to assure the attending physician has documented clinical justification/rational for the continued administration of antianxiety/mood stabilizers. An audit of gradual dose reduction justification will be conducted monthly times two months by nursing administration. There was no indication on the plan of correction that the criteria for the use of psychoactive medications was met. Despite implementing a directed plan of correction after the survey ending October 13, 2024, the facility failed to sustain corrective measures as indicated such as, monitoring plans to audit abuse prevention, dementia care interventions, and psychoactive medication use did not identify ongoing deficiencies. Staff re-education, policy updates, and audits were not effectively implemented, resulting in repeated failures to ensure compliance with regulatory requirements and quality care standards. Interviews with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on January 8, 2025, at 1:00 PM, confirmed the QAPI committee did not adequately identify root causes, analyze trends, or implement sustained corrective actions to address the continued deficiencies related to abuse prevention, dementia care, and psychoactive medication management. As a result, the facility's failure to develop and maintain effective QAPI processes placed residents at risk of harm and failed to prevent recurrence of quality deficiencies. The facility's quality assurance monitoring plans designed to ensure solutions were sustained, failed to identify the continuing deficient practice with these quality requirements and prevent recurrence of similar deficient practice as cited during the survey of October 13, 2024 Refer F600, F744, F758 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(e)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 26142 Based on clinical record review, facility policy, facility infection control documents and staff interview, it was determined that the facility failed to timely implement effective interventions to prevent the spread of infections for 15 of 34 residents reviewed. (Residents A1, A2, A3, A4, A5, A6, A7, A8, A9, A10, A11, A12, A13, A14 and A15) Findings include: A review of facility infection control logs dated January 2025 revealed the following residents exhibited gastro/intestinal symptoms (vomiting and diarrhea): Thursday January 2, 2025, D unit Resident A1, C unit Resident A2 Friday January 3, 2025, D unit Resident A3, A4, A5, A6 Saturday January 4, 2025,D unit Resident A7, A8, A9 Sunday January 5, 2025,D unit Resident A10, A11 Monday January 6, 2025, D unit Resident A12, A13, A14 Tuesday January 7, 2025, B unit Resident A15 A review of the facility's infection prevention interventions dated January 6, 2025, revealed the following actions were implemented on that date: Resident activities, therapy services, and dining were restricted to each unit. Housekeeping services were increased, focusing on high-touch surfaces. Staff inservicing regarding handwashing and hand hygiene was conducted for D Unit staff. It was noted that the D Unit is a locked dementia unit, self-contained with residents receiving most services, including dining, activities, and therapy, on the unit. A review of infection control prevention interventions dated January 6, 2025, revealed that on this date, resident activities, therapy services and dining moved to on unit, an increase in housekeeping services to high touch surfaces and staff education regarding handwashing and hand hygiene to staff on the D unit staff. There was no evidence that timely and effective interventions were implemented to prevent the spread of gastrointestinal symptoms to other residents in the facility. Although symptoms were first identified on January 2, 2025, the documented interventions were not initiated until January 6, 2025, when the symptoms had already affected additional residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 7, 2025, at 3:00 PM the facility's Infection Preventionist (IP) stated she had assumed the role in mid-December 2024 and was still learning the position. The IP reported that a consultant nurse was primarily performing infection prevention duties, including maintaining infection logs. She stated she was not on duty during the weekend when most gastrointestinal symptoms were reported. When she returned to work on January 6, 2025, she became aware of the symptoms and conducted in servicing on the D Unit. The IP could not explain why interventions were not initiated on Friday, January 3, 2025, when the symptoms began. 28 Pa code 211.12 (c)(d)(1)(5) Nursing services