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	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of select facility policy, facility investigative reports, clinical records, and interview with facility staff it was determined the facility failed to ensure that one received the necessary care and services to prevent physical harm and maintain physical health for one resident out of 14 residents sampled (Resident 1). Findings include: A review of facility policy titled Abuse Policy revealed it is the policy of the facility that acts of physical, verbal, psychosocial, and financial abuse directed against residents is absolutely prohibited. Each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, exploitation, and misappropriation of property. The policy indicated residents shall not be subjected to abuse by anyone including but not limited to staff, other residents, consultants, volunteers, family members, friends, or other individuals A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A Quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated January 23, 2025, revealed the resident was severely cognitively impaired with a BIMs score of 7 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00-07 equates severe cognitive impairment). The assessment further revealed the resident was fully dependent on staff for transfers from the bed to a chair. A review of the resident's current plan of care, initially developed on June 16, 2016, included a care plan for decreased ADL (activities of daily living) self-care performance due to immobility, weakness, and cognitive impairment. An intervention initiated on November 9, 2024, stated that the resident was to be transferred with the assistance of two staff members. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of facility documentation, including an incident note and a facility investigation report dated March 10, 2025, at 6:05 AM, revealed that at approximately 6:00 AM, Resident 1 sustained a deep skin tear/tendon injury while being moved from bed during morning care. Employee 1, a nurse aide (NA), reported the injury to the nurse on duty, stating that the resident's leg was bleeding. Upon assessment, the nurse observed a large amount of blood pooled next to the bed and on the floor mat, with multiple large clots present. The resident had a significant laceration on the anterior shin with active bleeding. A pressure dressing was applied, and 911 was called for emergency medical assistance. A witness statement from Employee 1, dated March 10, 2025, revealed that the employee was providing morning care and transferred the resident to a wheelchair without assistance. The employee indicated that she must have hit the resident's leg on the wheelchair but did not notice the injury until she saw blood pooling on the floor. A review of facility documentation confirmed that Employee 1 failed to follow the resident's care plan by transferring the resident alone instead of with two staff members as required. The employee was subsequently terminated for failure to adhere to the resident's established care interventions. A review of hospital records revealed that Resident 1 was evaluated in the emergency department on March 10, 2025. The resident was found to have a 6-centimeter laceration on the anterior left lower leg. The wound was explored, cleaned, and treated with Dermabond (a sterile, liquid, skin adhesive that holds wound edges together) and Steri-Strips (thin, adhesive strips used to help close wounds) due to the skin being too fragile for sutures. The resident also received a tetanus vaccine and was placed on a 7-day course of antibiotics. A progress note dated March 20, 2025, at 5:40 PM, documented the resident's left lower extremity was swollen, red, warm to the touch, and painful. The resident complained of burning pain, and the physician was notified. The resident was subsequently transferred to the hospital for further evaluation. A review of hospital documentation revealed that upon emergency department evaluation, the resident was found to have an 8 cm x 10 cm area of swelling filled with subcutaneous fluid (fluid collected under the skin). A procedure was performed to drain the accumulated fluid using an 18-gauge needle (a wide needle to withdraw fluid). Further hospital records noted that the resident had sustained a closed degloving injury (a condition in which a shearing or crushing force causes the skin and underlying tissues to detach from the deeper tissues, leaving a space beneath the skin). An interview with the Nursing Home Administrator and Director of Nursing on February 16, 2024, at approximately 12:45 PM confirmed the facility failed to ensure that Resident 1 received the services necessary to avoid harm and Employee 1 neglected to ensure adherence to the resident's plan of care for safe transfers resulting in serious injury, hospitalization s, and complications. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services

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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. 41581 Based on a review of controlled drug shift count records, and staff interview, it was determined the facility failed to implement procedures to promote accurate controlled medication records on one of three medication carts observed. Findings include: A review of facility policy entitled Inventory Control of Drugs revealed controlled drugs are inventoried and documented under proper conditions in regard to security and state/federal regulations. Further the policy indicates Scheduled II medications are counted by the oncoming nurse and outgoing nurse at the change of each shift and documented on the shift count sheet for narcotics. A review of the facility Control Substance Shift to Shift Count Sheet from the D unit medication cart revealed the following: March 19, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. An interview on March 19, 2025, at approximately 12:45 PM the Nursing Home Administrator 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 28 Pa Code 211.5(f)(x) Clinical records

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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. 39929 Based on review of facility scheduled mealtimes, select facility policy, facility's plan of correction, resident council minute/audits and resident and staff interview it was determined the facility continued to fail 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 two residents of two sampled (Residents 4 and 11). Findings include: A review of the facility's policy entitled Frequency of Meals, last reviewed in June 2024, indicated the facility was required to provide at least three meals daily at regular times comparable to normal mealtimes in the community. The policy specified that the time between a substantial evening meal and breakfast the following day must not exceed 14 hours unless a nourishing bedtime snack was provided. A nourishing snack was defined as an item or combination of items from the basic food groups. A review of the facility's scheduled mealtimes revealed that on D Wing-1, the evening meal was served at 5:25 PM, and breakfast was served the following morning at 8:15 AM, resulting in an interval of 14.83 hours between meals-exceeding the 14-hour limit. During an interview on March 21, 2025, at 10:54 AM Resident 4 stated staff do not consistently provide or offer a nighttime snacks. During an interview on March 21, 2025 at 11:00 AM Resident 11 indicated that bedtime snacks are not offered nightly. During a follow-up visit on March 21, 2025, to assess compliance with F809, a review of the facility's audit for the provision of bedtime snacks was conducted. The audit indicated that a Resident Council Meeting was held on March 18, 2025, during which residents expressed ongoing concerns about not consistently receiving evening snacks. Further review of the facility's audit showed that 40 out of 111 residents reported not consistently receiving a bedtime snack. During an interview on March 21, 2025, at approximately 12:00 PM, the Nursing Home Administrator confirmed that residents continued to express concerns about the lack of consistency in receiving evening snacks, acknowledging that the issue remained unresolved despite prior corrective actions. The facility's failure to provide a nourishing snack when more than 14 hours elapsed between the evening meal and breakfast did not align with its own policy having the potential to negatively impact residents' nutritional status. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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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. 39929 Based on a review of the facility's plan of correction from the survey ending January 23, 2025, the outcome of the activities of the facility's Quality Assurance and Performance Improvement (QAPI) committee, a review of clinical records, and staff interviews, it was determined the facility failed to ensure agency staff employed and working in March 2025 received the required training on the corrective measures outlined in the facility's plan of correction. Findings include: A review of the facility's plan of correction submitted following the survey ending January 23, 2025, revealed the facility had developed a corrective plan as its allegation of compliance, which included a quality assurance monitoring component to ensure that all licensed staff received education on identified deficient practices. The plan indicated that this corrective action was to be completed and fully implemented by March 18, 2025. As part of the plan of correction, the facility was to provide immediate re-education to staff on the following policies: Resident's Right to Freedom from Abuse, Neglect, and Exploitation Comprehensive Person-Centered Care Planning Skin Care Policy Administering Medications Restorative Nursing Services Medication Utilization and Prescribing - Clinical Protocol Water Pass Frequency of Meals Infection Control However, during the follow-up visit conducted on March 20, 2025, the facility provided documentation, including a list of agency employees, post-tests from the mandatory education, and staff education sign-in sheets. A review of these documents revealed that only 12 of the 75 agency staff members employed in March 2025 had received training on the policies outlined in the plan of correction. The facility was unable to provide a plan to ensure that the remaining 63 agency staff members employed in March 2025 received the required education. Additionally, the facility failed to produce any documentation or tracking system related to the completion of training for agency personnel. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on March 21, 2025, at approximately 1:00 PM, the Director of Nursing (DON) confirmed the facility failed to implement a monitoring system to ensure agency staff received training related to the deficiencies cited in the January 23, 2025, survey. The DON acknowledged that the facility failed to identify gaps in training, failed to ensure agency staff were adequately educated before working shifts, and failed to prevent the recurrence of similar quality deficiencies in the identified areas of concern. This failure resulted in a breakdown in the facility's Quality Assurance and Performance Improvement (QAPI) program, as the facility did not ensure ongoing monitoring, implementation, and sustainability of corrective actions. Refer F600, F755,809 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(e)(1) Management