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	10/13/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48277 Based on a review of grievances filed with the facility and minutes from the Resident Council meetings, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to promptly resolve continued resident complaints and grievances expressed during resident group meetings, including those voiced by five of the five residents (Residents 84, 48, 79, 26, and 85) attending a group meeting. Findings include: A review of Resident Council meetings minutes from the July 2024 through September 2024, revealed that residents in attendance at these meetings voiced their concerns regarding the facility's nursing services. During the July 23, 2024, Resident Council meeting, the residents relayed concerns that evening snacks are neither being received nor being offered to residents. Residents reported snacks are left at the nurses station. It was documented in the meeting minutes the administrator would look into the issue. During the August 20, 2024, Resident Council meeting, the residents stated the nighttime snacks are not being passed to their rooms, but instead, are being left at the nurses station. They stated staff were passing snacks and then stopped. They reported that receiving snacks is sporadic, sometimes they are passed and sometimes they are not. It was documented in the meeting minutes that nursing administration would investigate the concern and find a solution to the issue. Review of a grievance report dated August 22, 2024, revealed that a grievance was filed by the Director of Social Services on behalf of the Resident Council regarding the nighttime snacks not being passed out consistently. Snacks are often left at the nurses station. Actions taken to address the concern: The concern was discussed in morning meeting on August 27, 2024. the dietary department will provide the HS (hour of sleep) snack for each resident and nursing will be responsible to pass out the HS snacks. The dietary manager has a signature sheet where nursing will sign when the HS snacks have been received by the dietary department. This was discussed with the Resident Council President who expressed satisfaction with the plan. Follow up will occur at the September Resident Council meeting. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the September 17, 2024, Resident Council Meeting, the residents stated snacks are being delivered to the units but are not being passed out to the residents. This ongoing concern was documented on the grievance report by the Director of Social Services. During a group meeting, with the survey team, held on October 2, 2024, at 10:30 AM with five alert and oriented residents (Residents 84, 48, 79, 26, and 85), all residents in attendance stated they have attended Resident Council Meetings in the past. All residents in attendance stated evening snacks are not consistently offered or received over the last few months. The residents reported this issue has continued without resolution to date. At the time of the survey ending October 4, 2024, the facility was unable to provide documented evidence that it had determined if the residents felt that their complaint or grievance had been resolved through any efforts taken by the facility in response to the residents expressed concerns regarding not consistently being offered and receiving evening snacks raised during Resident Council Meetings. During an interview on October 4, 2024, at approximately 1:00 PM., the Director of Nursing (DON) was unable to provide documented evidence the facility had followed up with the residents to ascertain the effectiveness of the facility's efforts in resolving their complaint regarding nursing services and provision of HS snacks. 28 Pa. Code 201.29 (a) Resident rights

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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** 26142 Based on a review of the facility's abuse prohibition policy, select investigative reports and clinical records, and interview with staff it was determined the facility neglected to provide the care and services necessary to avoid physical harm and maintain physical health for one resident out of 26 residents sampled, resulting in the resident receiving lacerations to her head and a subsequent hospitalization with an allergic reaction. (Resident 224). Findings include: A review of the facility's Resident Abuse policy, last revised [DATE], revealed the facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in the policy. A review of the clinical record revealed that Resident 224 was admitted to the facility on [DATE], with diagnoses, which included dementia, and atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart) and the need for assistance with personal care. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated [DATE], indicated the resident required the assistance of two staff members for activities of daily living (ADL's), including bed mobility. A review of a physician's order dated [DATE] revealed, Warfarin Sodium (blood thinning medication) 2 MG, by mouth one time a day for atrial fibrillation. A review of a care plan for decreased ADLs self care performance initiated: [DATE] and revised on [DATE] revealed, Resident 224 is an assist of two staff with a Hoyer lift (a mechanical lift) for transfers to and from a bed to chair, and an assist of two staff for bed mobility. A review of a witness statement dated [DATE] (no time identified) Employee 1, NA stated I was doing care on Resident 224. I pulled the pad that was underneath her and when I pulled her, she continued to roll onto her side. I was not able to stop her from falling from the bed. On her way to the ground, she hit her head on the table next to the bed. She landed on the floor mat next to her bed. I got the nurse and went back to the resident to apply pressure to the wound. The RN Supervisor came to assess the resident. I waited with the resident until the ambulance came. A review of a witness statement dated [DATE], Employee 2 NA stated, I was giving care to another resident at the time of the incident, indicating she did not assist Employee 1 with Resident 224. A review of a witness statement dated [DATE] Employee 3, licensed practical nurse (LPN) stated unaware. This employee was noted to be on duty on the unit Resident 224 resided at the time of the resident's fall. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of nursing documentation dated [DATE] at 7:50 PM revealed, Resident 224 had rolled on to floor out of bed while PM care was being provided. The resident was observed laying on the floor on her back next to her bed. Employee 1, NA who was assigned to the resident, witnessed the fall and stated Resident 224 fell on to her right side. Two lacerations were noted to resident's right side of her head. Employee 1 NA and the resident stated she hit her head off of the bed side table. First aid was administered to the resident's lacerations. A review of a facility transfer form (form used to communicate condition of resident prior to transfer to hospital or other entity) dated [DATE] at 7:58 PM, revealed Resident 224 had a witnessed fall with head trauma. She is currently taking Warfarin Sodium. She incurred a laceration measuring 3 cm x 0. 1cm x 0. 1cm to the right side of her head and was transferred to the hospital. A review of hospital documentation dated [DATE] at 9:41 PM revealed, the resident was admitted to the emergency department with a 1.5 cm laceration to scalp and a second area measuring 1 cm superficial laceration to her scalp. The hospital trauma team applied 3 staples to the resident's laceration. A CT scan (computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) of the brain with contrast (scans with contrast use a special dye called contrast material. The dye appears bright on images, making certain areas of the body easier to see) was performed and completed by 10:53 PM. Shortly after the completion of the CT scan, hospital emergency room documentation dated [DATE] at 12:18 AM revealed the physician was called to the bedside by nursing staff and was informed the resident had an episode of rapid atrial fibrillation with RVR (A-fib with RVR have disorganized electrical signals that make their upper heart chambers/atria contract in an uncoordinated way. These signals travel down to the lower chambers/ventricles and tell them to beat in an irregular way. People who have A-fib with RVR also have an issue in their lower heart chambers. They have a heart rate of 100 beats per minute or more). The resident was started on a cardiac medication IV (intravenous) to slow down and regulate her heart rate and Oxygen was also administered via BIPAP (bilevel positive airway pressure a machine that pushes air at a higher pressure into the airway to assist in breathing during an emergency situation). Additional hospital documentation indicated at 1:18 AM the physician reassessed the resident. At that time it was discussed with the resident's daughter that her mother may be having an allergic reaction to IV contrast (dye). The resident was treated for an allergic reaction as follows: At 1:21 AM, 0.3 mg of Epinephrine (medication is used in emergencies to treat very serious allergic reactions to insect stings/bites, foods, drugs, or other substances) was given to the resident. At 1:22 AM 125 mg of Solumedrol (a steroid injection provides relief for inflamed areas of the body. It is used to treat a number of different conditions, such as inflammation/swelling or severe allergies) was administered to the resident. At 1:23 AM a Norepinephrine drip (Norepinephrine, also known as noradrenaline, is both a neurotransmitter and a hormone. It plays an important role in the body ' s fight-or-flight response. As a medication, norepinephrine is used to increase and maintain blood pressure in limited, short-term serious health situations) was implemented. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 5:13 AM the resident was admitted to the PCU (Progressive Care Units, also known as step-down units or intermediate care units, are specialized healthcare settings designed to accommodate patients who require a level of care between that of a general medical-surgical unit and an ICU). Upon admission to the PCU, the resident's physician ordered Levophed (similar to adrenaline. It is used to treat life-threatening low blood pressure/hypotension that can occur with certain medical conditions or surgical procedures. This medicine is often used during CPR -cardio-pulmonary resuscitation). The resident continued to deteriorate while in the PCU and subsequently ceased to breathe at 11:50 PM on [DATE]. Facility staff failed to utilize sufficient staff during bed mobility for Resident 224 resulting in fall from bed and resulting in two head lacerations requiring testing. She was transported to the emergency where she received 3 sutures to her head. A CT scan with IV contrast dye was performed subsequently the resident developed A-FIB with RVR possibly caused by an allergic reaction to the CT contrast IV dye. The resident continued to deteriorate and subsequently expired. An interview with the Director of Nursing on [DATE], at approximately 1:00 PM confirmed Resident 224 required assistance of two staff members for bed mobility. She confirmed that Employee 1, NA rolled Resident 224 out of bed during care, resulting in the resident receiving lacerations to her head and a subsequent hospitalization with an allergic reaction. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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	395414	A. Building B. Wing	10/13/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and select facility policy, and staff interview, it was determined the facility failed to conduct periodic re-evaluations to continue to clinically justify the continued use of physician restraints for one resident of 26 sampled (Resident 78). Findings Include: A review of the facility's policy titled Right to be Free from Restraints Policy and Procedure last reviewed by the facility on June 19, 2024, revealed when a physical restraint must be used, the facility will use the least restrictive restraint for the least amount of time, and provide on-going re-evaluation on the need for the physical restraint. The physician shall document the reason for the initial restraint order and shall review the continued need for the use of the restraint order by evaluating the resident. If the order is to be continued, the order shall be renewed by the physician every 30 days, or sooner, if necessary, the interdisciplinary team shall review and re-evaluate the use of all restraints ordered by a physician. Clinical record review revealed that Resident 78 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease (kidneys lose the ability to remove waste and balance fluids in the blood), dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood), and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs such as mania or hypomania and lows such as depression). A quarterly Minimum Data Assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 6, 2024, indicated the resident is cognitively intact with a BIMS (brief interview for mental status) score of 13 (13-15 indicates cognitively intact responses), has impairments on both sides of her upper extremities (arms), requires maximal assistance from staff for activities of daily living, uses a limb restraint daily, and receives dialysis treatments. Review of a physician order dated March 4, 2024, revealed an order to monitor left upper chest hemodialysis catheter site (dialysis access site) for bleeding/infection and document in PCC (Point Click Care- electronic medical record). Review of a physician order dated March 15, 2024, revealed an order for protective mittens on at hours of sleep and during times of agitation related to bipolar disorder and conduct disorders (aggressive, destructive and deceptive behavior) to prevent resident from pulling at dialysis catheter. The mittens are to be removes every 2 hours for a skin assessment. Clinical record review revealed a re-evaluation titled Physical Restraint Reduction Evaluation dated June 13, 2024, indicating the last date the facility evaluated the resident's restraint. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility regulatory compliance history, revealed the same deficient practice involving the same resident was cited by the State Survey Agency during a survey on February 9, 2024, whereas the facility failed to ensure ongoing evaluation of a resident's need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptoms. At that time, the facility reported that the problem was corrected by assessing all residents to determine the least restrictive method and audits and education regarding restraint evaluations implementation and monitoring. There was no documented evidence the physical restraints, mittens worn on both hands, were re-evaluated by the facility every 30 days to clinically justify the continued use of physical restraints as per facility policy. During an interview with the Director of Nursing (DON) on October 2, 2024, at 2:00 PM the facility was unable to provide documented evidence the interdisciplinary team conducted a re-evaluation of the physical restraints worn by resident 78 every 30 days as per facility policy. The DON confirmed the facility failed to implement their restraint policy accordingly. 28 Pa. Code 211.8 (c.1)(1)(2)(3)(i)(ii)(f) Use of restraints 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10 (a) Resident care policies 28 Pa. Code 201.29 (a) Resident rights.

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	395414	A. Building B. Wing	10/13/2024

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records, facility-initiated transfer notices, and staff interview, it was determined the facility failed to provide copies of written notices of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for two out of 26 residents reviewed (Residents 102 and 70). Findings include: Regulatory requirements indicate that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to the resident and/or resident's representative and to a representative of the Office of the State Long-Term Care Ombudsman. A review of the clinical record revealed that Resident 102 was transferred to the hospital on July 20, 2024, and returned to the facility on [DATE]. Resident 102 was also transferred to the hospital on July 28, 2024, and returned to the facility on [DATE]. A review of the clinical record revealed that Resident 70 was transferred to the hospital on August 19, 2024, and was readmitted to the facility on [DATE]. Although written notices were provided to the residents and resident representatives of the facility-initiated transfers, there was no documented evidence the facility sent copies of written notices of these facility-initiated transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the Nursing Home Administrator (NHA) on October 3, 2024, at approximately 2:00 PM failed to provide documented evidence that copies of the facility-initiated transfers notices were sent to a representative of the Office of the State Long-Term Care Ombudsman. The NHA further confirmed there was no evidence that copies were sent to a representative of the Office of the State Long-Term Care Ombudsman during the months of July through September 2024. 28 Pa. Code 201.14(a) Responsibility of Licensee

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	395414	A. Building B. Wing	10/13/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 21738 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 26 sampled (Resident 68). Findings include: According to the RAI User's Manual (helps facility staff to gather definitive information on a resident ' s strengths and needs, which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident ' s status) dated October 2023, Section A 1500 Preadmission Screening and Resident Review (PASRR a federally required assessment that helps decide if a nursing facility is the best place for a person with a behavioral, intellectual or developmental disability) is to be completed if the type of assessment is an admission assessment, significant change, or annual assessment. The annual MDS Assessment of Resident 68 dated May 2, 2024, revealed Section A 1500 was coded as 0, indicating the resident was not considered by the state to require a Level II PASRR process, to have serious mental illness, and/or intellectual disability, mental retardation, or a related condition. A review of Resident 68's clinical record revealed that a Level I PASRR (identifies whether an individual applying for admission into an nursing facility has or is suspected of having an serious mental illness or intellectual disability,or both. was completed on April 11, 2019, indicating the resident met the criteria for a Level II PASRR indicating the resident requires specialized rehabilitation services A further review of the resident's clinical record, revealed a letter of determination dated April 23, 2019, indicating the resident met the criteria for specialized services. An interview with the director of nursing on October 4, 2024, at 12:50 PM confirmed that Resident 68's annual MDS Assessment Section A 1500 related to the PASRR, dated May 2, 2024, was inaccurate. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records, review of select facility policy, hospital records, observation and staff interview it was determined that the facility failed to timely and consistently provide person-centered care and planned services to include timely and thorough assessments of pressure ulcers to promote healing and prevent worsening of existing pressure ulcers to the extent possible for one resident resulting in harm as evidenced by infection, osteomyelitis and hospitalization (Resident 24) and failed to implement adequate interventions to prevent the development of a pressure ulcer for one resident (Resident 27) out of four sampled residents with skin integrity concerns. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of the facility Wound Care Management Policy dated June 19, 2024, indicated that all residents that sustain a loss of skin integrity will be assessed and monitored for the effectiveness of treatment and the plan of care adjusted to optimize healing. Physician document weekly on wounds seen in facility. If the physician is unable to see the resident facility will document on progress of wound. Documentation will include the length, width, depth, and appearance of the wound. If any changes in the wound or treatment orders, resident or resident representative will be notified. Care plan will be updated to include current treatments and interventions. A review of the clinical record revealed that Resident 24 was admitted to the facility on [DATE], and had diagnoses which included spastic quadriplegic cerebral palsy (a permanent neuromuscular disorder causing limitation on all four limbs following a lesion on the developing brain). (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) dated June 6, 2024, revealed that the resident was cognitively intact with a BIMS (Brief Interview Mental Screener) score of 15 (a score of 13-15 indicates cognitively intact), required extensive assistance with the assistance of two people with bed mobility (how the resident moves about in bed) and transferring (how the resident moves between the bed and the chair), was at risk for developing pressure sores, had three Stage 3 pressure ulcers [Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) and/or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed] present upon admission, and had a pressure reducing device for the chair and bed. Review of the resident's Wound Outpatient Follow-up Note dated July 31, 2024, noted that the resident was evaluated for follow-up of bilateral buttock and right ischial (bone in lower pelvis that absorbs weight when sitting) wounds. The right buttock was a Stage 3 pressure ulcer and measured 7 cm length by 2cm width by 0.3 cm in depth, with 1-25% fibrinous slough, 51-75% granulation tissue, mild sanguineous (bloody) drainage, peri-wound intact; erythematosus (reddened), and no evidence of infection. The right ischium wound was 3.5 cm in length by 6 cm in width by 0.1 cm in depth, with 100% granulation tissue, mild sanguineous drainage, intact peri-wound, and no evidence of infection. The left buttock wound was 14 cm in length by 4 cm in width by 0.1 cm in depth, with 100% granulation tissue, mild sanguineous drainage, and no evidence of infection. The Wound Outpatient note further noted that no debridement (removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process) was performed and that two of the three ulcers have decreased in size and the third remains the same. The assessment/plan included to continue Xeroform gauze (pressure ulcer treatment) with ABD (high absorbency pad) and Hypafix tape (flexible tape used to secure wound dressings) on all of the ulcers. Dressings are to be changed three times per week. Follow-up with resident in four weeks. Review of the clinical record revealed no further detailed assessment other than a weekly measurement on every Tuesday of the resident's pressure ulcers between the dates of the outpatient wound noted on July 31, 2024, and August 14, 2024. Review of a Wound Outpatient Note dated August 14, 2024, noted that the resident was seen for follow-up of bilateral buttock and right ischial pressure ulcers. The right buttock measured 5 cm in length by 6.5 cm in width by 0.1 cm in depth with moderate serosanguinous (liquid part of blood) drainage, 100% granulation tissue, and no evidence of infection. The right ischium measured 5 cm in length by 3 cm in width by 0.1 cm depth, 100% granulation tissue, and moderate serosanguinous drainage. The left buttock wound was 17 cm length by 5 cm in width by 0.1 cm depth, 100% granulation tissue, moderate serosanguinous drainage, and no signs of infection. The Wound Outpatient Note further noted to continue dressing the ulcers with Xeroform gauze, 4 x 4 ABD, and tape. Dressings to be changed three times per week. Follow-up in four weeks. (continued on next page)

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	10/13/2024

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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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of a quarterly MDS dated [DATE], indicated that Resident 24 now had three Stage 4 pressure ulcers [Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epiboly (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location]. A CRNP progress note dated September 10, 2024, noted that the resident had a Stage 4 pressure ulcer of the right buttock, chronic ulcer of the buttock. Review of the resident's Outpatient Wound Note on September 11, 2024, noted that the resident was seen for Stage 3 pressure injury of the buttock and Stage 3 right ischial pressure ulcer. A note to return in about four weeks (around October 9, 2024) was noted. There were no measurements or assessment of the resident's pressure ulcers included. A nurses note dated September 11, 2024, noted that the resident returned from wound care. A new order was noted to discontinue Xeroform. Apply Aquacel AG (pressure ulcer treatment) to bilateral buttocks and right ischium wounds on Monday, Wednesday, and Fridays and as needed. Cover with ABD. Follow-up appointment on October 9, 2024. Resident representative made aware of new orders. Review of the Resident's September and October 1 through October 2, 2024 Treatment Administration Record (TAR) revealed that staff continued to sign off that the treatment of Xeroform was completed in addition to the Aquacel AG treatment being completed despite the Xeroform treatment being discontinued. Further review of the resident's October TAR noted that on October 1, 2024, employee 10 (LPN) measured the resident's pressure ulcers and the measurements were as follows: Left buttock 12 cm length by 5 cm width by 0.1 cm depth Right buttock 11 cm length by 2cm width by 0.1 cm depth Right ischium 4 cm length by 3 cm width by 2 cm depth. Interview with employee 5 (LPN) on October 4, 2024, at 9:30 AM confirmed that wound measurements for the resident are completed weekly by the licensed practical nurse but a detailed assessment, description, and evaluation of the wound for improvement or worsening is not documented. Employee 5 (LPN) confirmed that pressure ulcer measurements were completed on days that do not coincide with physician ordered treatment changes. As a result, staff must gently remove the treatments, complete the measurement, and then reapply the physician ordered treatment. Employee 5 confirmed that the Xeroform gauze treatment was discontinued on September 11, 2024, despite staff signing that it was still being completed in addition to the current treatment order. An interview with the Director of Nursing (DON) on October 4, 2024, at approximately 10:00 AM confirmed the facility was unable to demonstrate that the facility effectively monitored and evaluated Resident 24's pressure ulcers to prevent worsening and promote healing to the extent possible. The DON was unable to demonstrate the involvement of the registered nurse in the assessment of Resident 24's pressure ulcers. The resident remained hospitalized at the conclusion of the survey on October 4, 2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of current physician orders revealed the resident had a physician order dated May 31, 2024, for urology surgery on October 3, 2024. A nurses note dated October 3, 2024, at 9:05 AM noted that Resident 24 departed the facility for a urology appointment. A nurses note dated October 3, 2024, at 12:35 PM noted that Resident 24's resident representative contacted the facility to state that urology could not complete the scheduled procedure due to the resident's bilateral buttock wounds. The resident was transferred from urology to the hospital for evaluation. A nurses note dated October 3, 2024, at 3:47 PM noted that the emergency department staff noted the resident is admitted with diagnosis of buttock ulceration. The residents hospital record was requested for review on October 4, 2024 but was not obtained until October 13, 2024. A review of the medical records for this resident obtained from the hospital reviewed on October 13, 2024 revealed the following: The report stated: Resident 24 was admitted to the out patient hospital operating room for preoperative care. Upon arrival, nursing staff attempted to roll the resident over to remove additional sheets that were underneath her. While rolling the resident, she started to yell out in pain. An adult brief with blood on it as well as an incontinence pad that was covered in drainage was underneath her. Nursing staff then started to remove the brief to find multiple, dried, crusted dressings that were adhered to the buttocks area of the resident. The dressing was pulled off slowly and her skin started bleeding. The dressings had foul smelling, old dried and new green drainage noted. The resident was crying that she was in pain and stated, Please don't make me go back there(to the facility). Patient remained tearful and in pain. Nursing applied dressings to all affected areas. An IV was placed in resident's right hand and she was medicated for pain. The physician was made aware of the cancellation on October 3, 2024 for an outpatient urological procedure (urinary bladder related). The case was canceled and she was transferred to the ED (emergency department). The resident was diagnosed with osteomyelitis (infection in the bone) meeting sepsis (an infection spreading throughout the body) criteria and admitted to the hospital for further management. The resident reported she still has pain when she was placed on her right side. A review of progress notes written by the consulting urologist (the appointment for the urology procedure that was canceled on October 3, 2024) revealed, Resident 24 on was seen October 03, 2024 1355. At 10:25 A.M the resident was admitted for a urological procedure today. The resident presented writhing in pain and nursing staff discovered stage 4/unstagable decubitus ulcers (sacral). The resident's surgery was immediately canceled and steps were taken to stabilize the resident and address her pain prior to transferring her to the ED for further treatment. Protective agencies were contacted regarding the residents status. A CT scan (computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) of the abdomen, pelvis with IV (intravenous) contrast was ordered (October 3, 2024 at 1:05 P.M. Results to include: (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. Evidence of a right gluteal soft tissue ulcer extending to the right inferior pubic ramus with evidence of acute osteomyelitis of the right inferior pubic ramus. No soft tissue abscess of the right gluteal soft tissues. 2. Evidence of left gluteal and sacral decubitus ulcers without evidence of associated soft tissue abscess or definitive acute osteomyelitis of the sacrum or left inferior pubic ramus. The resident was subsequently admitted to the hospital and did not return to the facility as of October 4, 2024. Review of Resident 27's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of a dementia (a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), dysphagia (difficulty swallowing), hypertension. A review of a quarterly MDS dated [DATE], revealed that Resident 27 had pressure reducing devices for her bed and chair, did not have any pressure ulcers, was not on a turning/repositioning program, and was at risk for pressure ulcer development. Further review revealed that the resident was on hospice services, was dependent on staff for all activities of daily living (turning/repositioning, bathing, toileting), and required supervision or touching assistance with eating (helper provides verbal cues or touching/steadying assistance as resident completes activity). A review of the resident's care plan initiated March 27, 2019, revealed that the facility identified that the resident was at risk for skin alteration related to end of life process, impaired mobility, and poor oral intake. Interventions planned at that time were to encourage fluids with and between meals, keep environment well lit and clutter free, keep nails trimmed and filed, lotion to extremities as needed for dryness, move resident using palms of hands not fingers, treatments as ordered, to use a life sheet for turning and positioning, dietary supplements per physician order, provide incontinence care as needed and apply barrier cream as ordered, and observe skin condition daily during care and report skin issues/reddened, open areas to physician/nurse. Further review of the resident's care plan revealed additional interventions implemented on May 2024, which included Prostat (oral liquid nutritional supplement) for wound healing, a low air-loss mattress (a mattress designed to distribute the patent's body weight over a broad surface area and help prevent skin breakdown), and a L hand carrot on at all times, remove for hygiene and range of motion, check skin integrity every shift. A review of facility incident report dated September 3, 2024, at 2:30 a.m., revealed that Resident 27 had a new skin issue identified. According to the report, the resident had an intact blister to the lower right back by upper buttock crack which measured 2cm x 2cm and another intact blister to the lower left back by the inner buttock crack which measured 1cm x 1cm. Physician orders were received to apply skin prep to the blisters every shift and cover with a dry dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Wound Consultant documentation dated September 3, 2024, indicated that Resident 27 had a stage 2 partial thickness pressure wound (an open wound or blister that occurs when the skin's epidermis or dermis is partially damaged) to the sacrum that measured 3.7 cm x 3.8 cm x 0. 1cm, exudate was light serous (clear to yellow fluid that's a little bit thicker than water), and the dermis was exposed recommendations included to off-load wound, reposition per facility protocol, turn side to side in bed every 1-2 hours if able, cleanse with soap and water, and apply zinc ointment every shift. A review of Wound Consultant documentation dated October 1, 2024, indicated that the resident's stage 2 sacral pressure wound measured 0.8 cm x 1cm x 0. 2cm and required debridement (a procedure that removes dead or unhealthy tissue from a wound to help it heal), and change the treatment to the wound from zinc ointment to Santyl (an ointment used to remove damaged tissue from skin ulcers) daily and cover with a gauze dressing. Interview with the Director of Nursing on October 4, 2024, at approximately 11:00 a.m. confirmed that there was no evidence that the facility had implemented adequate interventions to prevent the development of Resident 27's sacral pressure ulcer. 28 Pa. Code 211.5(f)(ii)(iii)(iv)(viii)([NAME]) Medical records 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services

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	395414	A. Building B. Wing	10/13/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 21738 Based on clinical record review, review of select facility policy, and resident and staff interview, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility for one resident (Resident 57) and to maintain range of motion to the extent possible for one resident (Resident 5) out of three residents sampled. Findings include: Review of the facility Restorative Nursing Services Policy last reviewed 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 57 was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), unsteadiness on feet, and muscle weakness. A Quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated July 12, 2024, revealed the Brief Interview for Mental Status (BIMS 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 equates to being cognitively intact) indicated the resident scored a 14, which indicated that he was cognitively intact. During an interview with Resident 57 on October 2, 2024, at 8:50 AM, the resident voiced concerns that he was not provided with a restorative nursing program since being discharged from physical therapy (PT). Resident 57 stated that the only time anyone walks with me is when I'm in therapy. Review of Resident 57's Physical Therapy Discharge Summary dated May 13, 2024, revealed the resident had reached his maximum potential with skilled services and the resident's prognosis to maintain his current level of functioning was excellent with consistent staff support. Resident 57 was referred for a restorative nursing program (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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	395414	A. Building B. Wing	10/13/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 57's care plan, in effect at the time of the survey ending October 4, 2024, 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 (acid reflux), 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 (medication-induced movement disorder) with the goal for the resident to ambulate 50-100 feet using a rolling walker (walker with wheels on the front) with assistance of one staff member for 5-7 days per week. Interventions included: document the distance the resident ambulates on the restorative nursing flow record; explain the ambulation task to the resident and provide a walker, verbal cueing and encouragement as needed; notify the charge nurse of any changes in his 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. Review of the facility Tasks for Resident 57's revealed a task for Nursing Rehab: ambulate 50-100 feet using a rolling walker with assistance of one staff member for 5-7 days per week. Review of the Documentation Survey Report v2 dated September 2024 , revealed the restorative program for ambulation was not provided to the resident on 18 times out of the ordered 30 times, with staff documenting NA (not applicable) as a response. Interview with the Director of Rehab (DOR) on October 3, 2024, at 2:00 PM, verified that NA was not an appropriate response to document in the Documentation Survey Report v2. The DOR and confirmed the facility failed to consistently implement the planned restorative nursing program for Resident 57 to maintain his functional abilities and deter declines. A review of the clinical record revealed Resident 5 was admitted to the facility on [DATE], with diagnoses to include chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), osteoarthritis (a chronic disease that causes the breakdown of cartilage and other tissues in the joints, leading to pain, stiffness, and swelling), muscle weakness, and diabetes. A Quarterly Minimum Data Set assessment dated [DATE], revealed Resident 5 was cognitively intact with a BIMS score of 13, required extensive staff assistance for mobility and transfers, and had impairment of both lower extremities (part of the body that includes the hip, thigh, knee, leg, ankle, and foot). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's Physical Therapy Discharge Summary dated July 29, 2024, revealed the highest practical level was achieved for the resident. Discharge recommendations noted the prognosis to maintain current level of function good with consistent staff follow-through. Interventions provided included passive stretches (staff assistance provided to complete a stretch) to the bilateral lower extremities, prolonged static stretches (staff assistance provided to hold joint in lengthened position for period of time) to improve range of motion and decrease muscle tightness and reports of pain. The resident was also noted to have improved bilateral lower extremity knee flexion (bending the knee) and ankle dorsiflexion (the movement of the foot towards the shin) allowing for decrease in reports of pain with movement. Instructed resident and primary caregivers in positioning maneuvers in order to facilitate improved functional abilities and preserve current level of function with 100% carryover demonstrated by primary caregivers. A restorative nursing program was not recommended upon discharge. Interview with the Director of Rehab (DOR) on October 3, 2024, at 10:45 AM confirmed that Resident 5 was not referred for a restorative nursing passive range of motion program upon conclusion of therapy. The DOR stated that therapy evaluates the resident every two to three months. The DOR confirmed that Resident 5 does require staff assistance to move her lower extremities. The DOR indicated that although Resident 5 was not recommended for a formal restorative nursing program staff were educated and that PROM (passive range of motion movement to a joint by an external force) exercises were to be provided during care to the resident to maintain the resident's range of motion of the lower extremities. Review of Resident 5's current care plan initially dated April 2, 2024, indicated the resident has chronic pain related to neuropathy (nerve disorder that causes pain, numbness, tingling, swelling, or muscle weakness in various parts of the body) and lower extremity contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues that cause the joints to shorten and become very stiff). The goal included to not have an interruption in normal activities due to pain. Review of planned interventions failed to include passive range of motion restorative exercises which were to be provided to the resident to maintain the resident's current level of function and prevent worsening of contractures when the resident was discharged from physical therapy on July 29, 2024. Review of Resident 5's August through October 2024 Survey Documentation Report failed to provide documented evidence of any passive range of motion exercises to Resident 5. Interview with Resident 5 on October 3, 2024, at approximately 11:45 AM confirmed she no longer goes to therapy. Resident 5 confirmed she requires staff assistance for movement of her lower extremities. Resident 5 stated since therapy stopped, she is no longer receiving range of motion exercises. Resident 5 stated she would like staff to provide stretching and range of motion exercises. Interview with the director of nursing on October 3, 2024, at approximately 2:00 PM failed to provide documented evidence that Resident 5 was receiving appropriate treatment and services to prevent a decrease in range of motion 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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	395414	A. Building B. Wing	10/13/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and facility investigative reports and staff interview, it was determined the facility failed to implement necessary individualized safety measures and staff supervision of resident identified with poor safety awareness and a history of falls to prevent a fall with serious injury, laceration to the head and traumatic subarachnoid bifrontal hemorrhage, for one of 26 sampled residents (Resident 89). Findings include: A review of Resident 89's quarterly Minimum Data Set (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], indicated the resident was cognitively impaired with a BIMS of 4 (brief interview for mental status a tool to assess cognitive status. A score of 00 - 07 indicates severe cognitive impairment.) and was always incontinent of bladder and bowel and was not on a bladder or bowel retraining program. Clinical record review revealed that Resident 89 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (decline in brain function which causes memory loss and causes brain tissue to breakdown), abnormalities of gait and mobility, and muscle weakness and was severely cognitively impaired. The resident's care plan, initiated December 16, 2023, indicated Resident 89 is at risk for falls related to Alzheimer's disease. Interventions planned were to encourage resident to lie down on her own bed when she appears tired, the resident's name sign placed on the door of her room, non-skid footwear (sneakers or non-skid socks) to be worn at all times, offer to go to bed around 10 p.m., place call bell within reach and answer promptly. As of a care plan initiation date of April 15, 2024 the resident prefers late bedtime and prefers to get back to bed late, scoop mattress, wheelchair prn (as needed) for fatigue, and wheelchair with anti-roll backs and gel cushion. Further review of Resident 89's care plan revealed a focus area which was initiated January 8, 2024, that identified the resident as an elopement risk and has the potential to wander. Interventions planned were for all staff to be aware of the resident's tendency to wander, staff are to attempt to redirect wandering behavior by initiating conversation with the resident, code alert bracelet (bracelet that alarms to alert staff if resident laves the unit) ensure safe environment which enables free movement around the unit, involve resident in exercise program to help with excess energy, take on walks whenever possible, and observe behavior, redirect to activity of choice/interest when wandering, and observe resident's whereabouts throughout the day. A review of a Morse Fall Scale (a method of assessing a patient's likelihood of falling) dated August 1, 2024, indicated Resident 89 was at high risk for falling. According to the assessment, the resident had a history of falls, and overestimates or forgets her limits. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 89's Documentation Survey Report v2 (document that records the completion of activities of daily living by a certified nursing assistant) dated September 2024, revealed Resident 89 required the assistance of two staff members for transfers, and assistance of two staff members with a rollator walker for ambulation. According to information documented by nurse aide staff, Resident 89's need for staff assistance with ambulation and/or transfers fluctuated each day and each shift. There was no evidence that facility staff consistently provided the required assistance with ambulation as indicated on the Documentation Survey Report. A review of a facility investigative documentation dated September 14, 2024, at 9:20 p.m., completed by Employee 6, registered nurse (RN), revealed Resident 89 was on the floor in the hallway laying on her left side. Resident 89 was assessed by Employee 6, RN and found to have a large open laceration to the center of her forehead that measured 3 cm x 3 cm x 0.5cm with moderate amount of bleeding. According to the investigative statement, the fall was not witnessed by staff, but staff heard a bang and another resident yelled that someone was on the floor. The staff applied pressure and ice to the wound and staff remained with the resident on floor in hallway until the ambulance arrived. Further review of the investigative statement completed by Employee 6 indicated that Resident 89 had rubber soled sneakers on at the time of the incident, is independent for transfers and resident is non-compliant with use of wheelchair. A review of hospital encounter dated September 15, 2024 at 1:46 a.m. revealed Resident 89 presented to the emergency room after an unwitnessed fall with a large forehead laceration. A repeat CT of the head/brain was completed which indicated the resident had a traumatic subarachnoid bifrontal hemorrhage (bleeding between the space between the brain and the surrounding tissue). According to the report, the resident was safe for discharge back to the facility at 10:14 a.m. with final diagnostic impression of Traumatic subarachnoid bifrontal hemorrhage which was resolving,forehead laceration, severe dementia, and acute delirium, requiring sedation. A review of documentation dated September 15, 2024, at 1:04 p.m., revealed Resident 89 returned from the hospital with sutures to her forehead laceration and was combative with any attempts to render care. Despite the initial investigative statement completed by Employee 6, the facility's investigation conclusion indicated Resident 89's socks were rotated to the side, not allowing the grippy part of the socks to grip the floor properly. The resident fell , hitting her head off the door between the D and C1 units. The intervention to be implemented upon return from hospital is for staff to ensure the resident's grippy socks are on properly throughout the day. When possible and when the resident allows, and the resident should have shoes on when out of bed. There were no additional staff witness statements obtained and/or provided related to Resident 89's unwitnessed fall with injury. Interview with the interim Director of Nursing on October 3, 2024, at approximately 2:30 p.m. failed to provide evidence that Resident 89's fall with head laceration was adequately investigated and confirmed that individualized fall prevention interventions had were not implemented to prevent the resident's fall with serious injury. 28 Pa. Code 211.12(a)(c)(d)(3)(5) Nursing services (continued on next page)

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	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.11 (d) Resident care plan

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and select facility policy, and resident and staff interview it was determined the facility failed to monitor weight and evaluate nutritional and hydration requirements to ensure acceptable parameters of nutritional status are maintained to the extent possible for three residents (Resident 324, 70, and 103), resulting in harm when Resident 324 suffered a significant weight loss in one month, and failed to ensure a physician ordered fluid restriction was maintained for one of 26 sampled residents (Resident 78). Findings include: Review of the facility Weight Assessment and Intervention Policy dated June 19, 2024, indicated resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each unit's weight record chart and in the resident's medical record. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian, The physician and power of attorney (resident representative) will also be notified. Unless notified of significant weight change the dietitian will review the unit weight record monthly to follow individual weight trends over time. Interview with the Director of Nursing (DON) on October 4, 2024, at 10:00 AM verified the intervals established by the interdisciplinary team for weighing a resident are as follows: Upon admission, the resident will be weighed each day for two days. After the admission weights are obtained, the resident will be weighed weekly for four weeks. After the first 4 weeks, the interdisciplinary team will determine the need for continuation of weekly weights or a change to monthly weights. A review of the clinical record revealed that Resident 324 was admitted to the facility on [DATE], with diagnoses to include immunodeficiency infection, and Hepatitis B (serious liver infection) and Hepatitis C (infection caused by a virus that attacks the liver and leads to inflammation). An admission Minimum Data Set Assessment (MDS- standardized assessment process conducted at periodic intervals to plan resident care) dated September 9, 2024, revealed the resident had a BIMS (brief interview to aid in detecting cognitive impairment, a score of 13-15 equates to being cognitively intact) score of 15, indicating that his cognition was intact. Review of a physician order dated September 3, 2024, revealed an order to weigh resident as needed. A review of Resident 324's weights revealed the resident was weighed upon admission and the day after admission. Weights were as follows: September 3, 2024 133 lbs. September 4, 2024 133.8 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Admission Nursing Evaluation dated September 3, 2024, revealed the resident had a fair appetite, had a swallowing problem and was receiving a mechanically altered diet (foods that are easy to swallow because they are blended, chopped, grounded or mashed so that they are easy to chew and swallow). Review of Resident 324's Nutritional Risk Assessment completed by the Registered Dietician, dated September 10, 2024, indicated the resident's height was 72 inches, and weight was 133 pounds with a BMI of 18.1 (a BMI, or body mass index, of 18 or lower is considered underweight, a BMI of 18.5 to 24.9 is considered a normal, healthy weight). Resident 324's usual body weight was reported as 160 pounds. Further review of the clinical record revealed no documented evidence that weekly weights were obtained (weeks of September 10, September 17, September 24 and October 1, 2024) as per facility policy and confirmed by the DON. During an interview with Resident 324 on October 2, 2024, at 12:33 PM, he reported during his oncology appointment on September 30, 2024, his weight was 120 pounds. He stated he knew he lost weight even before the oncology appointment because he was not eating much of the food because the food isn't appetizing. Interview with the Registered Dietician on October 3, 2024, at 9:00 AM confirmed that Resident 324's weights were not obtained as per facility policy. At the time of the survey ending October 4, 2024, the facility had not obtained the resident's weight and only did so after repeated requests were made by the surveyor. Review of Resident 324's weight on October 4, 2024, was 119.8 pounds. Resident 324 lost 14 pounds or a 10% loss in one month, since admission to the facility on [DATE]. Interview with the Director of Nursing (DON) on October 4, 2024, at 10:00 AM confirmed that Resident 324's weight was not obtained as per facility policy to provide the necessary information to accurately assess the resident's nutritional status and needs and evaluate the adequacy of the resident's nutritional intake and plan nutritional support as necessary to prevent weight loss. A review of the clinical record revealed that Resident 70 was admitted to the facility on [DATE], with diagnoses which included cardiovascular accident (stroke- damage to the brain from interruption of its blood supply) with left hemiplegia (paralysis of one side of the body) and dysphagia (difficult swallowing). Resident 70's weight record revealed: July 25, 2024 169.6 pounds August 15, 2024 169.1 pounds pounds September 2024 No weight recorded October 2, 2024 167.4 pounds (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The clinical record revealed that Resident 70 was discharged to the hospital on August 19, 2024, and readmitted to the facility on [DATE]. There was no documented evidence of a weight upon Resident 70's readmission to the facility. Review of current monthly physician orders noted an order initially dated August 22, 2024, to weigh resident as needed. Further review of the clinical record revealed no documented evidence to justify the order to weigh resident as needed. There was no documented evidence that the order to weigh the resident as needed was a decision made by the interdisciplinary team as per facility policy. Interview with the registered dietitian (RD) on October 3, 2024, at approximately 11:00 AM confirmed the order to weigh the resident as needed was a mistake. The RD confirmed that Resident 70 should have been weighed upon readmission from the hospital on August 22, 2024, and that a monthly weight should have been obtained in September. A review of the clinical record revealed that Resident 103 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (disorder of the central nervous system that affects movements, often including tremors) and dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired thinking). A physician order dated August 8, 2024, noted an order for weekly weights. Resident 103's weight record revealed: August 6, 2024 120.5 pounds August 15, 2024 120 pounds August 22, 2024 119.6 pounds Week of August 29, 2024 weekly weight not completed September 5, 2024 113.4 pounds (no reweights completed per policy; 5.1% weight loss in 14 days) September 12, 2024 111.6 pounds Week of September 19, 2024 weekly weight not completed Week of September 26, 2024 weekly weight not completed October 2, 2024 112.5 pounds Further review of the clinical record revealed no evidence that the physician was notified of the resident's significant weight loss on September 5, 2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A dietary note dated September 14, 2024, noted the significant weight change which occurred on September 5, 2024 (9 days prior). The weight loss was noted to be undesirable. Etiology related to variable intake. BMI (body mass index- estimates body fat based on person's weight and height) 16.2 (underweight). The resident is ordered a regular diet with dietary intakes of 25 to 75%. Decline and inconsistent intakes noted. Receives super pudding (pudding with extra calories and protein) twice daily and Ensure (nutritional beverage supplement) three times daily. Mashed potatoes and ham and cheese sandwich with lunch and dinner. Weekly weights. Goals of weight stability with a gradual gain towards ideal body weight, intakes greater than 50%, diet tolerance, and maintain good skin integrity. Interview with the registered dietitian (RD) on October 3, 2024, at approximately 11:00 AM confirmed that Resident 103's weekly weights were not completed as ordered. Interview with the Director of Nursing on October 3, 2024, at approximately 1:00 PM failed to provide documented evidence that Resident 103's significant weight loss which occurred on September 5, 2024, was promptly addressed by the facility. Review of the facility policy titled Fluid Restriction Policy last reviewed by the facility on June 19, 2024, indicated the facility will provide an appropriate amount of fluid to residents who have a prescribed physician order for fluid restriction. Fluid restrictions will be based upon individual needs and will be effectively monitored. Residents with fluid restriction orders will be reviewed for compliance by the dietician, with clinical follow up to the physician for exceeding intakes. If the resident is receiving dialysis, the clinical nutrition staff will communicate excessive intakes to the dialysis unit. Clinical record review revealed that Resident 78 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease (kidneys lose the ability to remove waste and balance fluids in the blood), and dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A quarterly Minimum Data Assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 6, 2024, indicated the resident is cognitively intact with a BIMS (brief interview for mental status) score of 13 (13-15 indicates cognitively intact responses), has impairments on both sides of her upper extremities (arms), required substantial/maximal assistance from staff for eating, and received dialysis treatments. A physician order dated June 4, 2024, noted an order for 1000 cc per 24 hour fluid restriction with the breakdown as follows: 7 AM - 3 PM: Breakfast: 240 cc Lunch 240 cc Snack 40 cc Medications 80 cc 3 PM- 11 PM: Dinner 240 cc (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Snack 40 cc Medications 80 cc 11 PM - 7 AM:Medications 40 cc A review of Resident 78's Medication Administration Record (MAR) from August 1 through September 30, 2024, revealed Resident 78 exceeded the physician ordered fluid restriction on the following days: August 7, 2024 1320 cc daily total August 8, 2024 1800 cc daily total August 9, 2024 1240 cc daily total August 11, 2024 1240 cc daily total August 13, 2024 1200 cc daily total August 15, 2024 1440 cc daily total August 16, 2024 1320 cc daily total August 18, 2024 1320 cc daily total August 19, 2024 1320 cc daily total August 20, 2024 1320 cc daily total August 21, 2024 1240 cc daily total August 25, 2024 1150 cc daily total August 26, 2024 1320 cc daily total August 29, 2024 1800 cc daily total August 30, 2024 1240 cc daily total September 1, 2024 1560 cc daily total September 2, 2024 1240 cc daily total September 3, 2024 1320 cc daily total September 4, 2024 1800 cc daily total September 5, 2024 1560 cc daily total (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	September 6, 2024 1240 cc daily total September 8, 2024 1320 cc daily total September 10, 2024 1320 cc daily total September 12, 2024 1200 cc daily total September 17, 2024 1320 cc daily total September 19, 2024 1320 cc daily total September 21, 2024 1320 cc daily total September 23, 2024 1240 cc daily total September 24, 2024 1560 cc daily total September 26, 2024 1320 cc daily total September 28, 2024 1240 cc daily total September 29, 2024 1560 cc daily total September 30, 2024 1240 cc daily total Further review of the clinical record revealed no documented evidence the physician was notified of the resident exceeding the fluid restriction as per facility policy. There was no documented evidence the nutrition staff communicated the excessive intakes to the dialysis center as per facility policy. There was no documented evidence the fluid restriction was evaluated for reasons to explain how the resident, who is dependent on staff to provide fluids was exceeding the fluid restriction. Interview with the Nurse Consultant and Assistant Director of Nursing (ADON) on October 3, 2024, at 1:15 PM failed to provide documented evidence that Resident 78's fluid restriction was maintained as per physician order. The ADON failed to provide documented evidence the physician and dialysis center was notified of the resident exceeding the fluid restriction as per facility policy. 28 Pa. Code 211.5 (f)(iii) Medical Records. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, select facility review and staff and resident interview, it was determined that the failed to reassess a resident's pain and daily use of an opioid pain medication to ensure effective individualized pain management plans are developed and implemented for one of 26 residents sampled (Resident 108). Findings include: A review of a facility for Pain-Clinical Protocol reviewed July 2024, revealed, the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition and when there is an onset of new pain or worsening of existing pain. If pain is stable, and the underlying cause is resolved or it is unclear whether a source of pain remains, the physician will consider a trial reduction or elimination of analgesic medication. Clinical record revealed that Resident 108 was admitted to the facility on [DATE] with diagnosis to include dementia and chronic pain syndrome. Resident 1 had a current physician orders dated March 25, 2024 Tramadol (an opioid pain medication and a Serotonin-norepinephrine Reuptake inhibitor used to treat moderately severe pain) 50 MG give one by mouth every 8 related to chronic pain syndrome. A review of medication administration records dated April, May, June, July, August and September 2024 revealed that Resident 108 received the Tramadol three times a day. A review of an annual Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 1, 2024, revealed Resident 1 was severly, cognitively impaired, with a BIMS score (BIMS Brief Interview for Mental Status a quick snapshot of how well you are functioning cognitively at the moment) of 6 (a score of 0 to 7 indicated severe, cognitive impairment), required staff assistance for activities of daily living and had no pain and a pain assessment should be be conducted. A review the resident's initial care plan for, pain related to age related health conditions, indicated the resident was a boxer and complained of various pain areas, ex; neck, date Initiated: March 07, 2024 with interventions to include; Administer pain medication as per MD orders and note the effectiveness; Acknowledge presence of pains and discomfort; Listen to resident's concerns; Document/Report complaints & non-verbal signs of pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility pain tool dated May 28, 2024, April 21,2024 and September 14, 2024 revealed that Resident 108 had no pain'. During an interview August 3, 2024 at 1 P.M., the Director of Nursing (DON) stated that resident pain assessments are conducted with MDS assessments. She further confirmed that Resident 108 received three times a day doses of the Tramadol, daily with no further assessment for the resident's continued daily use of the opioid pain medication. There was no evidence at the time of the survey that a comprehensive evaluation of the resident's pain had been conducted in response to the resident's daily use of the opioid drug to include evaluating the existing pain and the causes and developing and implementing a pain management regimen to prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, and a facility investigative report and staff interviews it was determined the facility failed to provide nursing staff with the appropriate competencies and skills sets to provide nursing services to maintain safety, determined by the resident's assessments and care plan, during the provision of nursing care, and medication administration for two of 26 residents sampled. (Resident 324 and 101). Findings include: A review of the clinical record revealed that Resident 324 was admitted to the facility on [DATE], with diagnoses to include Hepatitis B (serious liver infection) and Hepatitis C (infection caused by a virus that attacks the liver and leads to inflammation) along with being immunocompromised. Resident 324 had a physician order dated September 5, 2024, for Midodrine HCl (medication used to treat low blood pressure) Oral Tablet 5 MG. Give one tablet by mouth before meals for Hypotension (low blood pressure). Hold for SBP greater 120 (systolic blood pressure) and DBP greater 90 (diastolic blood pressure). A review of the Medication Administration Record (MAR) for September 2024, revealed Resident 324's Midodrine was scheduled for 8:00 AM. The resident's blood pressure was 89/60. Nursing staff failed to administer the medication to the resident on September 21, 2024, as the medication was not signed out but instead, the code 16 was entered in the MAR for September 21, 2024. Code 16 on the MAR indicated hold/see nurse notes. Review of nursing documentation on September 21, 2024, at 8:01 AM revealed the nurse documented BP (blood pressure) 89/60. Held as per parameters. Review of the facility incident report dated September 21, 2024, at 5:30 PM indicated that Employee 9 (registered nurse supervisor) was called to nursing care by Employee 7 (licensed practical nurse) to discuss a possible medication error that occurred on September 21, 2024, at 8:00 AM. Resident 324's Midodrine 5 MG dose scheduled for 8:00 AM was held with a BP noted to be 89/60. Employee 9 was made aware at approximately 5:30 PM and advised Employee 7 to follow policy and procedure and to complete an incident report. The physician and resident were made aware of the omission. Assistant Director of Nursing notified at 7:11 PM. Review of a witness statement from Employee 8 (licensed practical nurse) dated September 22, 2024, (no time indicated) revealed Employee 8 stayed over to 7-3 shift due to no nurse arriving until later in the AM. Misread parameter directions for Midodrine and held medication due at 8AM Interview with the Director of Nursing on October 1, 2024, at 1:30 PM confirmed that Resident 324 missed a dose of his prescribed Midodrine 5 MG on September 21, 2024, and revealed that Employee 8 misread the dosing parameters, resulting in a significant medication error. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses to included NEUROCOGNITIVE DISORDER WITH LEWY BODIES (A progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior). A quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE] revealed the resident was severly cognitively impaired, unable to complete the BIMS testing and required staff assistance for activities of daily living. A review of Physicians orders dated August 14, 2024 revealed Lamotrigine ER, extended release (Lamotrigine ER is used alone or with other medications to prevent and control seizures. It may also be used to help prevent the extreme mood swings of bipolar disorder in adults, currently used to treat patients with Lewy Body Dementia) in increasing dosage; -August 15 2024, - Lamotrigine ER 25 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 50 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 100 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 200 mg, oral tablet one every day for 7 days then, - Lamotrigine ER 250 mg, oral tablet one every day. A review of a facility investigation report dated August 19, 2024 at 8 A.M, revealed that on August Employee 13 LPN transcribed the above Physicians orders into the electronic clinical record (PCC). The LPN entered the order incorrectly and attempted to correct the error. On August 14, 2024 the pharmacy dispensed Lamotrigine ER 250 mg, 15 tabs. A review of an August 2024 medication administration record (MAR) indicated that a dose of Lamotrigine ER 25 mg was given to Resident 101 on August 15, 16, 17 and 18, 2024. However, 250 mg tabs were given to the resident on those dates. Nursing documentation dated August 16, 2024 at 5:27 P.M. revealed, the RN supervisor received a phone call from pharmacy related to the resident's new Lamotrigine order. Pharmacy reports the medication is currently out of stock but should be available in 2-3 days. Contacted the RN nurse practioner and she stated it would be ok to put the medication on hold until it came in. Medication was placed on hold and the responsible party was contacted. There was no evidence of a call from the pharmacy, notification of the nurse practioner or that the medication was on hold until received from the pharmacy. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a witness statement dated August 20, 2024 at 1:30 P.M., Employee 14 (RN Supervisor) stated that she received a call from the pharmacy on August 16, 2024 stating that Resident 101's Lamotrigine 25 mg tabs are out of stock and they would send them when they became available. The Physician and responsible party were notified. A note was put into the resident's clinical record and clicked the button to hold the medication. Again, there was no evidence at the time of the survey the pharmacy had contacted the facility, the Physician was notified or the medication had been put on hold. At the time of this witness statement, the wrong dosage of the medication was given to this resident on two days, August 15 and 16, 2024 at 9 AM each day. A review of witness statements dated August 19, 2024 indicated that Employee's 15, 16, 17 anf 18 (all LPN's) admitted they all gave the incorrect dose of the medication to Resident 101 despite the dose on the medication card reading 250 mg instead of 25 mg. During an interview October 2, 2024 at 1:00 PM the Director of Nursing confirmed the incorrect dose of the Lamotrigine was given to Resident 101 on 4 consecutive days. She stated that Employee 13 (LPN) transcribed the initial Physicians order into the electronic record incorrectly and instead of discontinuing the order, as the pharmacy policy states, he attempted to correct the order. The DON further confirmed the facility was unable to demonstrate that Employee 13, 15, 16, 17 and 18's competencies and skill sets were evaluated when the employee began working in the facility to prevent this adverse event. The facility failed to ensure that Employee 13 demonstrated knowledge of the techniques and skills to maintain resident safety regarding Physician order transcription and that Employee's 15, 16, 17 and 18 demonstrated safe medication administration. At the time of the survey the facility failed to demonstrate that this agency/contract and facility staff members were evaluated to ensure competencies and skills to care for the resident population. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services.

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	10/13/2024

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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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 26142 Based on interview with administrative staff and a review of employee personnel records and facility provided documentation, it was determined the facility failed to show that annual performance evaluation of nurse aides were conducted at least once every 12 months for those nurse aides employed by the facility for longer than one year. Findings include: On October 1, 2024, at 11:00 AM the surveyors requested the facility provide evidence of the completed performance evaluations for nurse aides who have been employed by the facility for longer than one year. As of the conclusion of the survey ending October 1, 2024, the facility was unable to locate any performance evaluations for nurse aides employed by the facility for longer than one year. During an interview on October 1, 2024 at 1:00 p.m. the Director of Nursing confirmed the facility failed to complete annual performance evaluations for nurse aides at least once every 12 months 28 Pa. Code 201.19 (2) Personnel records.

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	395414	A. Building B. Wing	10/13/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reports, observations, and staff interviews, it was determined that the facility failed to fully develop and consistently implement an individualized person-centered plans to address residents' dementia-related behavioral symptoms and provide the necessary care to manage dementia related behaviors for two residents out of 26 sampled residents (Resident 63 and Resident 72). Findings include: During an interview September 28, 2024 at 11 A.M, the Nursing Home Administrator (NHA)confirmed that two of the four resident units were designated as Dementia units with the D unit all female and the C1 unit, all male units. The NHA confirmed there was no dementia program in use at the facility for either the male or female designated dementia units. A review of the facility facility assessment (nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The assessment is used to make decisions about direct care staff needs, as well as capabilities to provide services to the residents in the facility, at least annually) updated July 15, 2024 included a section entitled Locked Units. The locked units were described as, Units C1(an all female dementia unit) and D (an all male dementia unit) units to provide a safe, homelike environment for male/female residents with a dementia diagnosis. These units are staffed with individuals who are utilizing their training to appropriately direct staff to care for them in a positive direction. Dining and activities in these units are curtailed and directed to meet their specific needs. There was no policy or procedure regarding either dementia care unit available at the time of the survey. In addition, there was no dementia related activities provided on either dementia unit. A review of activities posted daily at 9 A.M. October 1 through 4, 2024, noted that at 9 A.M., individual resident room visits was noted as the only daily activity provided on the units. During an interview October 2, 2024 at 11 A.M., the activity director confirmed that there were no specific dementia related activities provided for either the D or the C1 dementia units. She stated that there was one morning and one afternoon activity for all residents held off unit in the first floor common area. She stated that all residents were invited to attend, however few residents on the dementia units attend. Clinical record review revealed that Resident 72 was admitted to the facility on [DATE] with diagnosis to include, Alzheimers disease, anxiety and psychotic disorder. She resided on the D (locked dementia unit). (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 72's annual Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE], revealed that she had severe cognitive impairment, unable to complete the BIMS testing and frequently had physical and verbal behavioral symptoms towards other residents, and exhibited wandering behavior. She required limited assistance of staff for activities of daily living and ambulated independently. A review of a care plan for Cognitive Impairment: Disorganized thinking, Alzheimer's Disease date Initiated October 20, 2020 and Revised on March 28, 2023, withinterventions to include, the resident will make daily decisions & choices as able, orient to person, place and time as needed, provide cues and reminders as needed, provide cues and reminders as needed, provide reassurance during periods of confusion, speak slowly & clearly & repeat if needed. A review of a care plan for, elopement risk and the potential to wander, date Initiated, October 20, 2020 and revised on May 22, 2024 revealed interventions to include, all staff be aware of the resident's tendency to wander, attempt to redirect wandering behavior by initiating conversation, ensure safe environment which enables free movement around unit, involve the resident in an exercise program to help with excess energy. Take on walks whenever possible, observe behavior and redirect to activity of choice/interest when wandering There was no evidence provided at the time of the survey that Resident 72's care plan included interventions regarding specific dementia behavior interventions or activities specific for this resident. A review of a a facility incident investigation dated August 10, 2024 at 9:50 PM revealed the resident was sitting in a chair in the hallway, stood up and tripped and fell to the ground. A witness statement dated August 10, 2024 at 10:00 PM Employee 11 stated, Resident 72 was unsteady on her feet. I assisted her to a chair (in the hallway). I turned around. I saw her fall out of the chair. A review of a facility incident investigation date September 2, 2024 at 8:45 PM revealed, Resident 72 was sitting in a chair in the hallway. The resident fell out of her chair, hitting her head on the cart next to her. She received a laceration to her left outer eyebrow measuring 2cm x 1 cm x 0.1 cm, with bleeding noted. A review of a nurses note dated September 8,2024 1:38 AM revealed the resident was found with a hematoma (a collection of blood under the skin) on her left forehead. The doctor aware and neuro checks (a series of checks preformed after hitting the head to monitor neurological status) were in place. A review of a facility incident report dated September 8, 2024 at 3 PM revealed Resident 72 had a fall in her room. The investigation conclusion (no date noted) indicated after further investigation Resident 72 was noted to have bumped her head on the bedside table in her room when attempting to return back to bed. It could not be determined by the investigation report what time the fall occurred. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a witness statement dated September 8, 2024, no time indicated, Employee 12 stated, noticed a bump on Resident 72's head at 3:00 PM, I notified the nurse. A review of resident 72's nurses notes dated from August 1, 2024 through the date of the survey October 4, 2024 revealed the resident wandered in the hallways of the D unit. Multiple observations October 1 through 4, 2024, Resident 72 was noted to be wandering on the D unit. There was no evidence the facility had implemented an individualized person-centered plan to address, modify, and manage Resident 72's dementia-related behaviors. Interview with the Nursing Home Administrator (NHA) on October 3, 2024, at 1:30 PM, confirmed the facility failed to fully develop and implement a dementia-care plan that included specific interventions to manage Resident 62's behaviors. A review of Resident 63's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include unspecified dementia (cognitive communication deficit is a difficulty with communication that is caused by a cognitive impairment) and anxiety. The resident resided on the C1 locked dementia unit. A review of the resident's annual MDS assessment dated [DATE], revealed the resident had severe cognitive impairment, and was unable to participate in BIMS testing, required limited assistance with activities of daily living and independently ambulated. A review of nursing documentation indicated this resident exhibited wandering behaviors daily, often wandering into other residents rooms. The notes also noted that this resident exhibited physical aggression towards staff and other residents. A review of Resident 63's plan of care initiated September 16, 2021 revealed that Resident 63 has the potential to wander. Interventions to include: All staff be aware of the resident's tendency to wander, attempt to redirect wandering behavior by initiating conversation with the resident. Ensure safe environment which enables free movement around unit. If wandering must place in close supervision until behavior de-escalates. Involve the resident in exercise program to help with excess energy. Take on walks whenever possible. Observe behavior and redirect to activity of choice/interest when wandering. Observe the resident's whereabouts throughout day. Allow ample time for the resident to absorb & respond to information. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow and encourage the resident to make needs known, decisions and choices as able. A review of Resident 63's plan of care initiated on September 17,2021 Resident 63 has potential to exhibit distressed mood & behavioral symptoms as evidenced by tearfulness, territorial, anxiety, repetitive speech\questions, resistance of care, swearing & swinging at staff, agitation and uncooperative, pacing related to diagnosis of Major Depressive Disorder and anxiety. Resident 63 does pack up his belongings several times a week in a clear plastic bag. The resident had potential to be verbally and physically aggressive towards staff and other residents. Interventions to include, 15 minute checks, Approach from the front in a calm and unhurried manner, encourage activities of choice/interest (ie: Music, watching sports, reading the newspaper,discussions, encourage and allow time for expression of feelings, medicate per physician order and observe for effectiveness, offer newspaper and snacks). A review of Resident 63's clinical record through survey ending October 4, 2024, revealed that he was the aggressor in verbal and physical incidents with other cognitively impaired residents and staff members. Additionally, the clinical record revealed that the resident exhibited aggressive, threatening, and abusive behaviors towards other residents and staff members. Observations during survey that began on October 1, 2024, and ended on October 4, 2024, revealed that Resident 63 was observed wandering about the unit and displaying intrusive behaviors with other cognitively impaired residents. A review of a nurses note dated October 1, 2024 at 9:34 PM revealed yelling was heard from Resident 39's room (which is noted to be in a different hallway from Resident 63). Upon entering the room, Resident 63 was laying in Resident 39's bed. Resident 39 physically assaulted Resident 63. A bruised area was noted to Resident 39's right middle knuckle and small abrasion noted to Resident 63's forehead. Resident 63 was removed from the room. The Physician and Responsible party were notified. The facility failed to develop and implement an individualized person-centered plan to address, modify, and manage Resident 63's dementia-related behaviors. The resident's care plan for behavioral symptoms failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in effort to manage the resident's dementia-related behavioral symptoms to promote the resident's psychosocial well-being. The facility failed to demonstrate the use of qualified staff that demonstrate the competencies and skills to support residents through the implementation of individualized approaches to care, including direct care and activities, that are directed toward understanding, preventing, relieving, and/or accommodating the residents' distress or loss of abilities. Interview with the Nursing Home Administrator (NHA) and Director of Nursing on October 3, 2024, at 1:30 PM, confirmed that the facility failed to fully develop and consistently implement care and services to treat the resident's dementia related behaviors. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.12 (d)(3)(5) Nursing services.

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	395414	A. Building B. Wing	10/13/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41460 Based on review of controlled drug records, pharmacy receipts and select facility policy and staff interview, it was determined the facility failed to implement procedures to assure accurate administration and maintain records of controlled drug administration for two of 26 residents sampled (Residents 6 and 121). Finding include: A review of the clinical record revealed that Resident 6 had a physician order dated [DATE], for Norco (narcotic pain medication) ,d+[DATE]mg by mouth three times a day related to a displaced fracture (a displaced or unstable fracture happens when the broken bone ends are out of alignment) of the right wrist. A review of a pharmacy provided packing slip revealed the pharmacy dispensed 89 Norco ,d+[DATE] tablets (29 days' worth of medication provided in 3 cards with a maximum of 30 tablets per card) to the facility for administration to Resident 6 as ordered by the physician. The medication was received by the facility on [DATE], and signed as received by Employee 13, registered nurse. The medication received from the pharmacy should have lasted from [DATE], through [DATE]. A review of Individual Patient Controlled Substance Administration Record provided by the pharmacy for use by the facility, revealed that 29 of the 89 tablets were administered as of [DATE], at 2:45 p.m., and a new Individual Patient Controlled Substance Administration Record was initiated for an additional 30 of the 89 tablets on [DATE], at 9:00 p.m. A review of the Individual Patient Controlled Substance Administration Record initiated [DATE], at 9:00 p.m. through [DATE], at 1:15 p.m. revealed the medication was available and administered according to the physician's order. A total of 59 of the 89 tablets received from pharmacy on [DATE], had been administered to Resident 6 as of [DATE], at 1:15 p.m. and 30 tablets should have been remaining. A review of the Controlled Substance Count sheet for medication cart D low, indicated that on [DATE]. 2024, Resident 6 had completed a card of Norco medication and the Individual Administration Record was removed from the cart. According to instructions on the count sheet, removal of a completed controlled substance card is to include the resident's first initial and last name, medication name and strength, signature of nurse and witness. Further review of the count sheet revealed there was no signature of a witnessing nurse when Resident 6's medication card was completed and removed on [DATE]. A review of the Individual Patient Controlled Substance Administration Records for Resident 6's Norco, the form that should have accounted for doses administered from [DATE], at 10 :00 p.m., through [DATE], at 2:00 p.m. was not available for review. (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of documentation dated [DATE], at 8:00 a.m. completed by the Nurse Practitioner, indicated that a script was needed for Resident 6's Norco and one was completed as requested. A review of the pharmacy emergency supply log dated [DATE], revealed that Norco ,d+[DATE]mg was removed from the supply on [DATE], at 8:52 p.m., [DATE], at 5:23 a.m., [DATE], at 1:05 p.m., [DATE], at 5:49 p.m., [DATE], at 6:08 a.m., [DATE], at 1:45 a.m., [DATE], at 7:09 p.m., [DATE], at 4:40 a.m., and [DATE], at 12:57 p.m. On [DATE], a facility investigation was initiated for the 30 tablets of Norco not accounted for. There was no evidence the facility nursing staff and/or pharmacy identified a discrepancy in Resident 6's Norco pain medication prior to [DATE], when an investigation was initiated. A review of facility policy entitled Medication Disposal/Destruction, provided by the facility on [DATE], indicated the facility will adhere to all federal, state, and local regulations related to medication destruction/disposal when discarding any medication and medical waste. Schedule II Controlled Substances are to be disposed of in accordance with federal regulations. Review of Resident 121's clinical record revealed admission to the facility on [DATE], and expired at the facility on [DATE]. Review of clinical record revealed that Resident 121 had a physician order dated [DATE], for Morphine Sulfate oral solution 20mg/5mL give 4mg by mouth every four hours as needed for discomfort. A review of Resident 121's Medication Administration Record dated [DATE], revealed that Morphine Sulfate was administered on [DATE], at 10:19 p.m. Interview with the Director of Nursing on [DATE], at approximately 9:30 a.m. revealed the resident's ordered Morphine Sulfate had not been received from the pharmacy. The nursing staff used the emergency supply of medication for administration on [DATE]. Review of pharmacy report dated [DATE], revealed that on [DATE], at 9:32 p.m., Morphine sulfate solution 10mg/0.5mL was removed from the emergency supply for administration to Resident 121. The resident required administration of 0.2mL to equal the physician ordered 4mg. Interview with the Director of Nursing on [DATE], at 10:00 a.m. confirmed there was no accountability for the remaining medication that would have had to be wasted (0.3mL) after administration. Review of Resident 121's clinical record failed to provide evidence of receipt and/or disposition of the narcotic medication. During an interview, [DATE], at approximately 2 PM the Director of Nursing confirmed the facility failed to implement effective procedures to prevent diversion of controlled substance medications and inaccurate administration of the antianxiety medication for the above resident. At time of survey ending on [DATE], the facility investigation into the missing narcotic pain medication remained ongoing to identify a perpetrator (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9(a)(1)(k)Pharmacy services. 28 Pa Code 211.5(f)(x) Medical records

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	10/13/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the presence of physician documentation of the clinical rationale for the continued administration of an antipsychotic medication for one resident out of five sampled residents for unnecessary medication use (Resident 108). Findings included: A review of Resident 108's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include unspecified Alzheimers disease and dementia. A review of current Physicians orders dated January 8, 2024 revealed, Ativan (an antianxiety medication) Oral Tablet 0.5 mg, Give 0.5 mg by mouth every 8 hours for Agitation;anxiety and Depakote Sprinkles (an antiseizure medication used for mood stabilization) Oral Capsule Delayed Release Sprinkle 125 MG, give 250 mg by mouth every 8 hours related to dementia with behavioral disturbance. A review of a pharmacist's recommendation to the physician/prescriber dated May 20, 2024 revealed psychotropic medication management, a request to the Physician for a gradual dose reduction(GDR) for Resident 108's Ativan and Depakote. The form stated, please consider an attempted dose reduction or trial discontinuation as you deem appropriate. If this cannot be accomplished, please document risk vs benefit of continued therapy with current regimen'. The Physician's response dated May 30, 2024 revealed, A GDR of the above medications (Ativan and Depakote) is not warranted at this time, will put resident at risk for psych instability. Benefits vs. risks discussed and documented. The facility certified registered nurse practioner disagreed with the Pharmacist request for a GDR. There was no documented evidence of any additional documentation regarding the GDR request in the resident's clinical record. A review of the attending physician's response dated May 30, 2024, failed to include a resident specific rationale to justify the continued use of the antianxiety medication Ativan and the mood stabilization medication Depakote In an interview with the Director of Nursing (DON), on September 30, 2024, at approximately 1 PM, confirmed the facility failed to ensure that Resident 108's attending physician provided clinical justification/rationale for the continued administration of antianxiety and mood stabilizer medication. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (5) Nursing services. (continued on next page)

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	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.2 (d)(3) Medical Director

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	10/13/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records, facility investigation, select policy review and staff interview it was determined the facility failed to assure that two residents out of 26 sampled were free of a significant medication errors. (Resident 324 and 101). Findings include: A review of the clinical record revealed that Resident 324 was admitted to the facility on [DATE], with diagnoses to include, Hepatitis B (serious liver infection) and Hepatitis C (infection caused by a virus that attacks the liver and leads to inflammation) the resident was also immunocompromised. Resident 324 had a physician order dated September 5, 2024, for Midodrine HCl (medication used to treat low blood pressure) Oral Tablet 5 MG. Give one tablet by mouth before meals for Hypotension (low blood pressure). Hold for SBP > 120 (systolic blood pressure) and DBP > 90 (diastolic blood pressure). A review of the Medication Administration Record (MAR) for September 2024, revealed Resident 324's Midodrine was scheduled for 8:00 AM. The resident's blood pressure was 89/60. Nursing staff failed to administer the medication to the resident on September 21, 2024, as the medication was not signed out but instead, the code 16 was entered in the MAR for September 21, 2024. Code 16 on the MAR indicated hold/see nurse notes. Review of nursing documentation on September 21, 2024, at 8:01 AM revealed the nurse documented BP (blood pressure) 89/60. Held as per parameters. Review of the facility incident report dated September 21, 2024, at 5:30 PM indicated that Employee 9 (registered nurse supervisor) was called to nursing care by Employee 7 (licensed practical nurse) to discuss a possible medication error that occurred on September 21, 2024, at 8:00 AM. Resident 324's Midodrine 5 MG dose scheduled for 8:00 AM was held with a BP noted to be 89/60. Employee 9 was made aware at approximately 5:30 PM and advised Employee 7 to follow policy and procedure and to complete an incident report. The physician and resident were made aware of the omission. Assistant Director of Nursing notified at 7:11 PM. Review of a witness statement from Employee 8 (licensed practical nurse) dated September 22, 2024, (no time indicated) revealed that Employee 8 stayed over to 7-3 shift due to no nurse arriving until later in the AM. Misread parameter directions for Midodrine and held medication due at 8AM Interview with the Director of Nursing on October 1, 2024, at 1:30 PM confirmed that Resident 324 missed a dose of his prescribed Midodrine 5 MG on September 21, 2024, and revealed that Employee 8 misread the dosing parameters, resulting in a significant medication error. A review of a facility, pharmacy policy for Physicians ordering system, last reviewed July 2024, revealed, (continued on next page)

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	395414	A. Building B. Wing	10/13/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All new orders, discontinued orders or changes should be written on a telephone order or Physician interim sheet and sent to the pharmacy via fax or sent electronically on a daily basis. To change an order, the order as it is currently written should be discontinued and the entire order incorporating the change should be written as a new order. A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses to included Neurocognitive disorder with Lewy bodies(A progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior). A quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE] revealed the resident was severly cognitively impaired, unable to complete the BIMS testing and required staff assistance for activities of daily living. A review of Physicians orders dated August 14, 2024 revealed Lamotrigine ER, extended release (Lamotrigine ER is used alone or with other medications to prevent and control seizures. It may also be used to help prevent the extreme mood swings of bipolar disorder in adults, currently used to treat patients with Lewy Body Dementia) in increasing dosage; -August 15 2024, - Lamotrigine ER 25 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 50 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 100 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 200 mg, oral tablet one every day for 7 days then, - Lamotrigine ER 250 mg, oral tablet one every day. A review of a facility investigation report dated August 19, 2024 at 8 A.M, revealed that on August Employee 13 LPN transcribed the above Physicians orders into the electronic clinical record. The LPN entered the order incorrectly and attempted to correct the error. On August 14, 2024 the pharmacy dispensed Lamotrigine ER 250 mg, 15 tabs. A review of an August 2024 medication administration record (MAR) indicated that a dose of Lamotrigine ER 25 mg was given to Resident 101 on August 15, 16, 17 and 18, 2024. However, 250 mg tablets were administered to the resident on those dates. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation dated August 16, 2024 at 5:27 P.M. revealed, (the RN supervisor) received phone call from pharmacy related to the resident's new Lamotrigine order. Pharmacy reports med currently out of stock should be in in 2-3 days. Contacted the RN nurse practioner and she stated it would be ok to put med on hold until it came in. Med placed on hold and RP contacted. There was no evidence of a call from the pharmacy, notification of the nurse practioner or that the medication was on hold until received from the pharmacy. It could not be determined why the pharmacy dispensed Lamotrigine ER 250 mg instead of 25 mg tablets. A review of a witness statement dated August 20, 2024 at 1:30 P.M., Employee 14 (RN supervisor) stated that she received a call from the pharmacy on August 16, 2024 stating that Resident 101's Lamotrigine 25 mg tabs are out of stock and they would send them when they became available. The Physician and responsible party were notified. A note was put into the resident's clinical record and clicked the button to hold the medication. Again, there was no evidence at the time of the survey that the pharmacy had contacted the facility, the Physician was notified or the medication had been put on hold. At the time of this witness statement, a dose of the wrong doseage was given to the resident on two days, August 15 and 16, 2024 at 9 AM each day. A review of witness statements dated August 19, 2024 indicated that Employee's 15, 16, 17 anf 18 (all LPN's) admitted that they all gave the incorrect dose of the medication to Resident 101 despite the dose on the medication card reading 250 mg instead of 25 mg. During an interview October 2, 2024 at 1 PM the Director of Nursing confirmed that the incorrect dose of the Lamotrigine was given to Resident 101 on 4 consecutive days, resulting in significant medication error. She stated that Employee 13(LPN) transcribed the initial Physicians order into the electronic record incorrectly and instead of discontinuing the order, as the pharmacy policy states, he attempted to correct the order. The DON could not state why the pharmacy sent 25 doses of Lamotrigine 250mg as this dose would not have been given to the resident for 49 days (following the original Physicians increasing dosing) resulting in significant medication error. The facility was unable to provide any documentation from the pharmacy at the survey team's request at the time of the survey. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review clinical records, facility provided documents, the facility's plan of correction from the survey ending February 9, 2024, and the outcome of the activities of the facility's quality assurance committee it was determined that 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 pharmacy procedures to promote accurate medication administration, and the accuracy of physician orders and failed to identify quality issues related to increased resident falls and to ensure that plans were designed and implemented to improve the delivery of care and services and promote resident safety were in place to deter additional falls and future quality deficiencies (Resident 89). Findings include: A review of Resident 89's quarterly Minimum Data Set (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], indicated the resident was cognitively impaired with a BIMS of 4 (brief interview for mental status a tool to assess cognitive status. A score of 00 - 07 indicates severe cognitive impairment.) and was always incontinent of bladder and bowel and was not on a bladder or bowel retraining program. Clinical record review revealed that Resident 89 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (decline in brain function which causes memory loss and causes brain tissue to breakdown), abnormalities of gait and mobility, and muscle weakness and was severely cognitively impaired. The resident's care plan, initiated December 16, 2023, indicated Resident 89 is at risk for falls related to Alzheimer's disease. Interventions planned were to encourage resident to lie down on her own bed when she appears tired, the resident's name sign placed on the door of her room, non-skid footwear (sneakers or non-skid socks) to be worn at all times, offer to go to bed around 10 p.m., place call bell within reach and answer promptly. As of a care plan initiation date of April 15, 2024 the resident resident prefers late bedtime and prefers to get back to bed late, scoop mattress, wheelchair prn (as needed) for fatigue, and wheelchair with anti-roll backs and gel cushion. Further review of Resident 89's care plan revealed a focus area which was initiated January 8, 2024, that identified the resident as an elopement risk and has the potential to wander. Interventions planned were for all staff to be aware of the resident's tendency to wander, staff are to attempt to redirect wandering behavior by initiating conversation with the resident, code alert bracelet (bracelet that alarms to alert staff if resident laves the unit) ensure safe environment which enables free movement around the unit, involve resident in exercise program to help with excess energy, take on walks whenever possible, and observe behavior, redirect to activity of choice/interest when wandering, and observe resident's whereabouts throughout the day. A review of a Morse Fall Scale (a method of assessing a patient's likelihood of falling) dated August 1, 2024, indicated Resident 89 was at high risk for falling. According to the assessment, the resident had a history of falls, and overestimates or forgets her limits. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 89's Documentation Survey Report v2 (document that records the completion of activities of daily living by a certified nursing assistant) dated September 2024, revealed Resident 89 required the assistance of two staff members for transfers, and assistance of two staff members with a rollator walker for ambulation. According to information documented by nurse aide staff, Resident 89's need for staff assistance with ambulation and/or transfers fluctuated each day and each shift. There was no evidence that facility staff consistently provided the required assistance with ambulation as indicated on the Documentation Survey Report. A review of a facility investigative documentation dated September 14, 2024, at 9:20 p.m., completed by Employee 6, registered nurse (RN), revealed Resident 89 was on the floor in the hallway laying on her left side. Resident 89 was assessed by Employee 6, RN and found to have a large open laceration to the center of her forehead that measured 3 cm x 3 cm x 0.5cm with moderate amount of bleeding. According to the investigative statement, the fall was not witnessed by staff, but staff heard a bang and another resident yelled that someone was on the floor. The staff applied pressure and ice to the wound and staff remained with the resident on floor in hallway until the ambulance arrived. Further review of the investigative statement completed by Employee 6 indicated that Resident 89 had rubber soled sneakers on at the time of the incident, is independent for transfers and resident is non-compliant with use of wheelchair. A review of hospital encounter dated September 15, 2024 at 1:46 a.m. revealed Resident 89 presented to the emergency room after an unwitnessed fall with a large forehead laceration. A repeat CT of the head/brain was completed which indicated the resident had a traumatic subarachnoid infront hemorrhage (bleeding between the space between the brain and the surrounding tissue). According to the report, the resident was safe for discharge back to the facility at 10:14 a.m. with final diagnostic impression of Traumatic subarachnoid bifrontal hemorrhage which was resolving,forehead laceration, severe dementia, and acute delirium, requiring sedation. A review of documentation dated September 15, 2024, at 1:04 p.m.,revealed Resident 89 returned from the hospital with sutures to her forehead laceration and was combative with any attempts to render care. Despite the initial investigative statement completed by Employee 6, the facility's investigation conclusion indicated Resident 89's socks were rotated to the side, not allowing the grippy part of the socks to grip the floor properly. The resident fell , hitting her head off the door between the D and C1 units. The intervention to be implemented upon return from hospital is for staff to ensure the resident's grippy socks are on properly throughout the day. When possible and when the resident allows, and the resident should have shoes on when out of bed. There were no additional staff witness statements obtained and/or provided related to Resident 89's unwitnessed fall with injury. A review of the facility's monthly incident/accident logs and analysis dated April 2024 through September 2024 revealed that during April 2024, 48 resident falls had occurred. During May 2024, 33 resident falls had occurred. During June 2024, 46 resident falls had occurred. During July 2024, 44 resident falls had occurred. During August 2024, 23 resident falls had occurred. During September 2024, 32 resident falls had occurred. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no documented evidence at the time of the survey ending October 4, 2024, that the facility's quality assurance committee had identified the significant increase in resident falls occuring had not developed and implemented corrective action plans to address the quality deficiency and identify the care or service areas associated with this significant risk to the health or safety of residents Interview with the DON (director of nursing) and the Nursing Home Administrator, on October 4, 2024 at 1 PM confirmed that the number of resident falls had maintained at a high number From April through September 2024, and that this qualify deficiency was not identified and addressed by the facility's QAPI committee. The DON and NHA confirmed that no attempts were made to identify the root cause and any trends and to develop and implement plans to address the quality issue of multiple resident falls to promote resident safety and prevent quality deficiencies. The facility failed to explore the potential causes for the increased falls and show the actions taken to correct the issue. During the survey ending July 31, 2024, deficient facility practice was identified related to the facility's failure to prevent significant medication errors. The facility developed a plan of correction that was to be completed by August 14, 2024, that included a QA monitoring plan to ensure that solutions were sustained. Compliance was noted during the revisit survey of August 14, 2024 and continued quality assurance audits were maintained through the current survey ending October 4, 2024. Deficient practice was identified under this same requirement at the time of this survey ending October 4, 2024, whereas the facility failed to implement pharmacy procedures for the accurate ordering and administration of resident medications. A review of the clinical record revealed that Resident 324 was admitted to the facility on [DATE], with diagnoses to included, Hepatitis B (serious liver infection) and Hepatitis C (infection caused by a virus that attacks the liver and leads to inflammation). Resident 324 had a physician order dated September 5, 2024, for Midodrine HCl (medication used to treat low blood pressure) Oral Tablet 5 MG. Give one tablet by mouth before meals for Hypotension (low blood pressure). Hold for SBP > 120 (systolic blood pressure) and DBP > 90 (diastolic blood pressure). A review of the Medication Administration Record (MAR) for September 2024, revealed Resident 324's Midodrine was scheduled for 8:00 AM. The resident's blood pressure was 89/60. Nursing staff failed to administer the medication to the resident on September 21, 2024, as the medication was not signed out but instead, the code 16 was entered in the MAR for September 21, 2024. Code 16 on the MAR indicated hold/see nurse notes. Review of nursing documentation on September 21, 2024, at 8:01 AM revealed the nurse documented BP (blood pressure) 89/60. Held as per parameters. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility incident report dated September 21, 2024, at 5:30 PM indicated that Employee 9 (registered nurse supervisor) was called to nursing care by Employee 7 (licensed practical nurse) to discuss a possible medication error that occurred on September 21, 2024, at 8:00 AM. Resident 324's Midodrine 5 MG dose scheduled for 8:00 AM was held with a BP noted to be 89/60. Employee 9 was made aware at approximately 5:30 PM and advised Employee 7 to follow policy and procedure and to complete an incident report. The physician and resident were made aware of the omission. Assistant Director of Nursing notified at 7:11 PM. Review of a witness statement from Employee 8 (licensed practical nurse) dated September 22, 2024, (no time indicated) revealed that Employee 8 stayed over to 7-3 shift due to no nurse arriving until later in the AM. Misread parameter directions for Midodrine and held medication due at 8AM Interview with the Director of Nursing on October 1, 2024, at 1:30 PM confirmed that Resident 324 missed a dose of his prescribed Midodrine 5 MG on September 21, 2024, and revealed that Employee 8 misread the dosing parameters, resulting in a significant medication error. A review of a facility, pharmacy policy for Physicians ordering system, last reviewed July 2024, revealed, All new orders, discontinued orders or changes should be written on a telephone order or physician interim sheet and sent to the pharmacy via fax or sent electronically on a daily basis. To change an order, the order as it is currently written should be discontinued and the entire order incorporating the change should be written as a new order. A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses to included Neurocognitive disorder with Lewy bodies(A progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior). A quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE] revealed the resident was severly cognitively impaired, unable to complete the BIMS testing and required staff assistance for activities of daily living. A review of Physicians orders dated August 14, 2024 revealed Lamotrigine ER, extended release (Lamotrigine ER is used alone or with other medications to prevent and control seizures. It may also be used to help prevent the extreme mood swings of bipolar disorder in adults, currently used to treat patients with Lewy Body Dementia) in increasing dosage; -August 15 2024, - Lamotrigine ER 25 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 50 mg, oral tablet one every day for 14 days then, - Lamotrigine ER 100 mg, oral tablet one every day for 14 days then, (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Lamotrigine ER 200 mg, oral tablet one every day for 7 days then, - Lamotrigine ER 250 mg, oral tablet one every day. A review of a facility investigation report dated August 19, 2024 at 8 A.M, revealed that on August Employee 13 LPN transcribed the above Physicians orders into the electronic clinical record. The LPN entered the order incorrectly and attempted to correct the error. On August 14, 2024 the pharmacy dispensed Lamotrigine ER 250 mg, 15 tabs. A review of an August 2024 medication administration record (MAR) indicated that a dose of Lamotrigine ER 25 mg was given to Resident 101 on August 15, 16, 17 and 18, 2024. However, 250 mg tabs were given to the resident on those dates. Nursing documentation dated August 16, 2024 at 5:27 P.M. revealed, (the RN supervisor) Received phone call from pharmacy related to the resident's new lamotrigine order. Pharmacy reports med currently out of stock should be in in 2-3 days. Contacted the RN nurse practioner and she stated it would be ok to put med on hold until it came in. Med placed on hold and RP contacted. There was no evidence of a call from the pharmacy, notification of the nurse practioner or that the medication was on hold until received from the pharmacy. It could not be determined why the pharmacy dispensed Lamotrigine ER 250 mg instead of 25 mg tablets. A review of a witness statement dated August 20, 2024 at 1:30 P.M., Employee 14 (RN supervisor) stated that she received a call from the pharmacy on August 16, 2024 stating that Resident 101's Lamotrigine 25 mg tablets are out of stock and they would send them when they became available. The Physician and responsible party were notified. A note was put into the resident's clinical record and clicked the button to hold the medication. Again, there was no evidence at the time of the survey that the pharmacy had contacted the facility, the Physician was notified or the medication had been put on hold. At the time of this witness statement, a dose of the wrong doseage was given to the resident on two days, August 15 and 16, 2024 at 9 AM each day. A review of witness statements dated August 19, 2024 indicated that Employee's 15, 16, 17 anf 18 (all LPN's) admitted that they all gave the incorrect dose of the medication to Resident 101 despite the dose on the medication card reading 250 mg instead of 25 mg. During an interview October 2, 2024 at 1 PM the Director of Nursing confirmed that the incorrect dose of the Lamotrigine was given to Resident 101 on 4 consecutive days. She stated that Employee 13(LPN) transcribed the initial Physicians order into the electronic record incorrectly and instead of discontinuing the order, as the pharmacy policy states, he attempted to correct the order. The DON could not state why the pharmacy sent 25 doses of Lamotrigine 250mg as this dose would not have been given to the resident for 49 days (following the original Physicians increasing dosing). The facility was unable to provide any documentation from the pharmacy at the survey team's request at the time of the survey. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continued deficient practice was identified under this same requirement at the time of this survey ending October 4, 2024, whereas the facility failed to ensure residents were free from significant medication errors. During an interview October 4, 2024 the DON and NHA could not produce ongoing audits regarding the prior significant medication error deficiency. 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 July 31, 2024. Refer F689, F760 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(e)(1) Management