

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Aventura at Terrace View		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Terrace Drive Peckville, PA 18452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>41581</p> <p>Based on a review of select facility policy, facility grievance forms, and resident and staff interviews, it was determined the facility failed to make ongoing efforts to resolve grievances and the provision of timely follow up with residents regarding the status update on the resolution process of the grievance for one out of 24 residents interviewed (Resident 27).</p> <p>A review facility policy entitled Complaints and Grievances, Filing and Investigating Resident/Family last reviewed by the facility on January 22, 2025, indicated that upon receipt of an oral, written, or anonymous grievance submitted by a resident, the grievance official will take immediate action to prevent further potential violations of any resident rights while the alleged violation is being investigated. If the grievance committee/grievance official determines that the resident rights violation has occurred, then the violation must be corrected within 5 working days. Upon completion of the review, the grievance official will complete a written grievance decision. The grievance official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved within 10 working days. The facility will keep evidence of the resolution of all grievances for a period of three years from the date the grievance decision is issued.</p> <p>A review of resident council notes from a meeting held on March 18, 2025, revealed a complaint from the residents in relation to call bell response times. The notes reveal the activities director would assist with submitting a grievance about the call bell response times.</p> <p>An interview with the Activities Director on March 27, 2025, at 9:00 AM revealed the employee submitted a verbal grievance to the grievance official on March 19, 2025 in regard to the call bell response time.</p> <p>An interview with the grievance official (Employee 11) conducted on March 28, 2025, at 10:00 AM revealed the call bell response times were added to an unresolved grievance from November 22, 2024. Further the employee stated that call bell response times continued to be an issue brought up in resident council and instead of starting a new grievance he just continues with the old one. The employee indicated call bell response time continues to be a concern and has not yet been resolved.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the uploaded grievance about the call bell response time initially submitted on November 22, 2024, revealed during resident council meeting the residents' indicated concerns with staff response to call bells. Further it was indicated on that grievance on February 18, 2025, the residents continued to complain of call bell response times. The grievance remains unresolved as of the date of the survey ending on March 28, 2025.</p> <p>A review of paper grievances submitted between January 2025 and March 2025 revealed Resident 27 submitted a grievance on February 25, 2025, in reference to missing clothing and blankets.</p> <p>A review of the facility's grievance report submitted electronically for the grievance, revealed the resident's grievance was not filed and reviewed until March 4, 2025 six days after the resident filed his grievance about his missing items.</p> <p>On March 7, 2025, facility staff conducted an interview with the resident and confirmed his clothes were missing. Follow up information revealed as of March 13, 2025, the items were still being searched for and no resolution has been obtained.</p> <p>An interview with Resident 27 on March 28, 2025, at 8:43 AM revealed the facility could not find his pants nor his two blankets. The resident stated he had to buy more pants out of his own money because he could not go without pants. As of the time of the interview no resolution had been provided to the resident. The resident stated he was not satisfied with how the facility was handling his missing items.</p> <p>An interview on March 28, 2025, at 11:30 AM the Nursing Home Administrator confirmed the facility failed to resolve grievances as per their policy.</p> <p>28 Pa Code 201.18 (e)(1) Management</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on interview, and record review of clinical records and resident trust account records, it was determined the facility failed to ensure residents' personal funds held by the facility were refunded within 30 days of discharge or death for forty-two of 42 residents sampled (Residents CR1, CR2, CR3, CR4, CR5, CR6, CR7, CR8, CR9, CR10, CR11, CR12, CR13, CR14, CR15, CR16, CR17, CR18, CR19, CR20, CR21, CR22, CR23, CR24, CR25, CR26, CR27, CR28, CR29, CR30, CR31, CR32, CR33, CR34, CR35, CR36, CR37, CR38, CR39, CR40, CR41 and CR42).</p> <p>Findings include:</p> <p>Review of clinical and financial records revealed that the following residents had remaining balances in their resident trust accounts at the time of discharge, and that those funds had not been refunded within 30 days.</p> <p>Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1642.00 remaining in his resident trust account (personal bank account facilitated by the facility) at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR2 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$894.83 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR3 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$83.98 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR4 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$824.55 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR5 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1978.40 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident CR6 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2487.72 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR7 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$18.87 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR8 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$898.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR9 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1203.80 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR10 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$9.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR11 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2616.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR12 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$3933.37 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR13 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$809.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident CR22 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1749.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR23 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2238.69 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR24 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1143.17 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR25 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2175.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR26 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1764.32 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR27 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$524.05 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR28 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1359.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR29 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2510.00 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident CR30 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$792.63 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR31 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$3523.01 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR32 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$1496.20 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR33 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2789.71 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR34 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2032.40 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR35 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$127.35 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR36 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$5632.79 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR37 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$398.10 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>(continued on next page)</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident CR38 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$20.25 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR39 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$511.26 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR40 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$621.15 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR41 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$2368.60 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Clinical record review revealed that Resident CR42 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>A review of a document provided by the Nursing Home Administrator on March 26, 2025; the resident had \$291.28 remaining in his resident trust account at the time of his discharge from the facility.</p> <p>Review of a document provided by the Nursing Home Administrator (NHA) on March 26, 2025, revealed that each of these residents had remaining balances in their resident trust accounts (facility-managed personal funds) at the time of discharge. Individual resident account balances ranged from \$9.00 to \$10,949.30, and the total amount not refunded to the residents, or their representatives was \$72,312.54.</p> <p>During an interview on March 26, 2025, at 11:00 AM, the Temporary Manager confirmed the above-listed residents had not received refunds of their trust account balances within 30 days of discharge.</p> <p>In a follow-up interview on March 26, 2025 at 11:15 AM, the Nursing Home Administrator verified the facility had not issued required refunds within 30 days of death or discharge to any of the 42 residents or their estate representatives.</p> <p>28 Pa. Code: 201.18 (b)(2)(e)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>26142</p> <p>Based on review of the residents' personal funds account and facility surety bond, and staff interview, it was determined the facility failed to ensure the surety bond coverage met or exceeded the balance for the total residents' personal funds account for four months (October 2024, November 2024, December 2024 and January 2025) and failed to assure that the obligee (the bond's beneficiary) of the surety bond was in favor of the residents of the facility.</p> <p>Findings include:</p> <p>Review of the facility's surety bond dated January 21, 2024, indicated the amount of surety was \$150,000 on this date. The obligee was noted as The Pennsylvania Department of Health.</p> <p>A review of the balance of the resident fund accounts deposited with the facility from October 1, 2024 through January 16, 2025 the total amount in the resident account exceeded \$150,000 on the following dates:</p> <p>October 1, 2024--162,970.68</p> <p>October 2, 2024--160,054.03</p> <p>October 3, 2024--207,236.26</p> <p>October 7, 2024--167,168.26</p> <p>October 8, 2024--161,681.02</p> <p>October 9, 2024--170,357.23</p> <p>October 10, 2024-175,054.13</p> <p>October 11, 2024-162,750.93</p> <p>October 15, 2024-162,869.86</p> <p>October 16, 2024-168,440.35</p> <p>October 21, 2024-162,548.35</p> <p>October 23, 2024-164,082.35</p> <p>October 24, 2024-160,136.12</p> <p>October 28, 2024-160,097.12</p> <p>October 30, 2024-162,893.36</p> <p>(continued on next page)</p>

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<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>December 26, 2024-168,941.02</p> <p>December 27, 2024-166,557.78</p> <p>December 30, 2024-157,565.56</p> <p>December 31, 2024-163,759.01</p> <p>January 2, 2025-163,976.24</p> <p>January 3, 2025-199,988.23</p> <p>January 6, 2025-162,516.03</p> <p>January 7, 2025-165,100.14</p> <p>January 8, 2025-173,301.04</p> <p>January 10, 2025-165,302.43</p> <p>January 13, 2025-163,094.03</p> <p>January 14, 2025-162,781.03</p> <p>January 15, 2025-168,841.03</p> <p>January 16, 2025-163,311.03</p> <p>Interview with the business office manager on March 25, 2025, at approximately 10 a.m., confirmed the facility administrative staff failed to acquire a surety bond with coverage that met or exceeded the balance in the residents' personal funds account for that time period.</p> <p>A review of the facility surety bond also confirmed the obligee of the bond, who would collect in case of loss, was The Pennsylvania Department of Health. Upon interview with the nursing home administrator on March 25, 2025, it was confirmed the facility failed to assure the residents of the facility would be compensated in case of loss.</p> <p>28 Pa. Code 201.18 (b)(2)Management</p> <p>28 Pa Code 201.14(a) Responsibility of licensee.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Aventura at Terrace View		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Terrace Drive Peckville, PA 18452	
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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>43944</p> <p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation and resident interview, it was determined the facility failed to ensure the Department of Health's most recent survey results were readily accessible to residents and visitors on two units out of 5 units observed.</p> <p>Findings Include:</p> <p>During a resident council interview on March 26, 2025, at 10:00 AM, 6 alert and oriented residents (Residents 49, 25, 3, 80, 47 and 81) in attendance indicated they did not know where the facility posted the Department of Health survey results.</p> <p>During an observation on March 27, 2025, at 10:00AM on the C2 Unit, the survey results binder was located behind the nurses' station where residents were prohibited to enter.</p> <p>An observation on March 27, 2025, on the B2 Unit Nursing Station revealed the survey results were not posted or accessible to residents and visitors. Residents and visitors were not able to access the survey results without asking staff for assistance.</p> <p>During an interview on March 28, 2025, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure the most recent Department of Health survey results were posted in a manner that was readily accessible to residents, family members, and legal representatives of residents.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of select facility policy, observations, and staff interview, it was determined the facility failed to provide housekeeping services necessary to maintain a clean and sanitary environment and resident care equipment for one resident out of 24 sampled (Resident 114).</p> <p>Findings include:</p> <p>A review of a facility policy entitled Tube Feeding Management last reviewed January 22, 2025, indicated staff should maintain and clean the feeding pump and equipment.</p> <p>Review of Resident 114's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing) and unspecified severe protein calorie malnutrition (a condition characterized by a severe deficiency of both protein and calories resulting in significant wasting of muscle and fat, and potentially leading to life-threatening complications).</p> <p>Resident 114 required a PEG tube (Percutaneous endoscopic gastrostomy an endoscopic medical procedure in which a tube is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) for enteral feeding (enteral nutrition generally refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements).</p> <p>An observation on March 25, 2025, at 9:45 AM revealed dried tube feed solution was noted on the pump, pole, stand, wall, and floor.</p> <p>An observation on March 26, 2025, at 10:06 AM revealed a large amount of dried tube feed noted on the floor . The dried tube feeding solution was still noted on the pump, pole, stand, and wall.</p> <p>An observation on March 27, 2025, at 10:05 AM revealed dried tube feed solution was noted on the pump, pole, stand, wall, and floor.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on March 28, 2025, at approximately 1:45 PM, confirmed resident equipment and the environment was to be maintained in a clean and sanitary manner.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.14(b)(1) Management</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>41581</p> <p>Based on observations, a review of a select facility policy, and resident and staff interviews, it was determined the facility failed to provide and/or make information regarding the facility's grievance policy and the residents' rights to file a grievance readily available in prominent locations on the nursing units for two of five units as reported by five of six residents interviewed. (Residents 25, 47, 49, 80, 81)</p> <p>Findings include:</p> <p>A review of select facility policy entitled Complaints and Grievances, Filing and Investigating Resident/Family last reviewed January 22, 2025, indicated a copy of the facility's grievance forms and grievance procedures are posted on the B1, C1, C2, and D unit across from the nurse's station on the bulletin boards. On the B2 unit the grievance forms and grievance procedures are located in the meditation room.</p> <p>During a group interview conducted on March 26, 2025, at approximately 11:00 AM, six alert and oriented residents participated. Of those six residents, five (Residents 25, 47, 49, 80, and 81) reported that they did not know how to file a grievance without assistance from the Resident Council President.</p> <p>An observation of the B2 nursing unit on March 26, 2025, at approximately 1:20 PM revealed there were no posted grievance procedures or instructions on how to file a grievance in the meditation room.</p> <p>An observation of the C1 nursing unit on March 26, 2025, at approximately 1:45 PM revealed there were no posted grievance procedures or instructions on how to file a grievance in the area across from the nursing station.</p> <p>During an interview conducted on March 28, 2025, at approximately 1:45 PM, the Nursing Home Administrator and Director of Nursing confirmed the facility had failed to post and provide residents with the procedures for filing a grievance.</p> <p>28 Pa. Code 201.29 (a)(c.1) Resident rights.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on interview, record review, and review of facility policy and investigative reports, the facility failed to ensure that one of 24 sampled residents (Resident 79) was free from misappropriation of property, monetary, by a facility staff member.</p> <p>Findings include:</p> <p>A review of the facility's Abuse policy, last revised January 2025, revealed it is the policy of the facility that acts of physical, verbal, psychological and financial abuse directed against residents are absolutely prohibited. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect exploitation and misappropriation of property. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, (temporary or permanent) use of a resident's belongings or money without the resident's consent.</p> <p>Clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses of multiple sclerosis (a progress neurological disorder).</p> <p>An annual Minimum Data Set assessment dated [DATE] (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) revealed the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact).</p> <p>A review of facility documentation dated March 26, 2025, at 3:35 PM, Resident 79 reported to the Director of Social Services that approximately two years prior, a facility nurse aide (Employee 11) transported him to a bank to cash a check totaling \$2,800.00 (from his employment prior to admission). He stated that Employee 11, whom he knew prior to his admission, advised him not to retain such a large sum of money at the facility and offered to hold \$2,000.00 for him. Resident 79 stated that the money was never returned.</p> <p>The Social Worker, Nursing Home Administrator (NHA), and Director of Nursing (DON) met with the resident to discuss the concern. When asked why he had not reported the incident sooner, the resident stated that he did not think to mention it until now and was planning to be discharged soon and needed the money. Employee 11 was suspended from duty on March 27, 2025, and the matter was referred to local law enforcement.</p> <p>A written statement dated March 27, 2025 (no time documented), provided by Employee 11, indicated that she denied ever having seen, handled, or taken possession of Resident 79's money. She stated that after a period of about seven months without contact, she began receiving text messages from the resident referencing money under my mattress. Employee 11 stated that other staff members told her the resident had made similar allegations to them. She reported informing the resident that she did not have his money and that making such accusations was inappropriate. Employee 11 stated that she notified nursing supervisors and the scheduler that she was uncomfortable with the accusations and requested not to work on the resident's unit. She denied taking any money from the resident.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A written statement dated March 26, 2025, provided by the Social Services Director (SSD), indicated that Resident 79 approached him on that date to report the alleged misappropriation. The resident stated that Employee 11 took him to the bank, assisted him in cashing a check from previous employment, and advised him that it was unsafe to keep a large amount of money at the facility. He reported that the aide offered to hold \$2,000.00 for him but never returned the funds. The resident stated that Employee 11 now denies the incident ever occurred.</p> <p>In another statement from March 26, 2025 (no time documented), Resident 79 reiterated that Employee 11 had taken him to a check cashing facility where he cashed a check for \$2,800.00. He stated that she offered to hold \$2,000.00 for him for a rainy day but now denies any knowledge of the transaction.</p> <p>A review of a local police incident report dated March 26, 2025, at 5:24 PM revealed that the DON contacted the police at approximately 5:20 PM to report the incident. According to the report, Employee 11 had taken Resident 79 to a bank to cash a \$2,800.00 check and advised him to give her \$2,000.00 for safekeeping, stating it was not safe to keep that amount of money at the facility. The aide reportedly told the resident she would keep it under her mattress.</p> <p>The DON informed the police that Employee 11 had resigned from the facility in February 2024 and was re-hired in February 2025. She further stated that the resident had recently confronted Employee 11, who denied any knowledge of the money, after which the resident began reporting to other staff that she had stolen money from him.</p> <p>On March 27, 2025, the police officer conducted interviews at the facility. Resident 79 confirmed the allegation that Employee 11 had taken \$2,000.00 after accompanying him to a check cashing facility. The officer contacted the local business, which confirmed that Resident 79 cashed a check on August 1, 2023, in the amount of \$3,925.77, issued from an investment company.</p> <p>Employee 11 was interviewed at the police station. She acknowledged taking Resident 79 from the facility on multiple occasions, including to cash the referenced check, but stated she did not seek formal approval from the facility. She indicated the incident occurred in the summer of 2023. After the resident cashed the check, she expressed concern about him having so much money and offered to hold \$2,000.00 for him. The resident agreed, and she accepted the money. She reported that several weeks later, the resident began sending text messages accusing her of stealing the money and requesting its return. Employee 11 admitted that she did not return the money because she was scared. She further stated that after facility staff became aware of the situation, the resident stopped asking for the money, and she did not attempt to return it.</p> <p>Employee 11 was taken into custody and charged with theft.</p> <p>Employee 11 was suspended on March 27, 2025, and later terminated. During interviews on March 28, 2025, the DON and Nursing Home Administrator (NHA) confirmed the incident constituted misappropriation of the resident's property.</p> <p>28 Pa. Code 201.29 (a)(b) Resident rights</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on observations, review of select facility policy, clinical record review, and staff interview, it was determined the facility failed to ensure that residents were free from physical restraints for one of 24 residents reviewed (Resident 74).</p> <p>Findings include:</p> <p>Review of facility policy entitled Right to be Free from Restraints last reviewed January 22, 2025, indicated the purpose is for each resident to attain and maintain his/her highest practical well-being in an environment that prohibits the use of physical restraints for discipline or convenience, prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity, and limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints. Further it is indicated when a physical restraint must be used, the facility will use the least restrictive restraint for the least amount of time and provide ongoing re-evaluation of the need for the physical restraint.</p> <p>A review of the clinical record revealed Resident 74 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (a condition where the kidneys can no longer adequately filter waste and excess fluid from the blood), bipolar disorder (a mental health condition characterized by extreme mood swings), and obsessive compulsive disorder (a disorder marked by uncontrollable and recurring thoughts and/or repetitive and excessive behaviors).</p> <p>A review of physician's orders initially dated March 15, 2024, revealed an order for protective mittens (a type of physical restraint) on at bedtime and during times of agitation to prevent the resident from pulling at her dialysis catheter (a soft, flexible tube inserted into a large vein, typically in the neck or chest, that allows blood to be accessed for dialysis treatments). The mittens were to be removed every 2 hours for a skin assessment.</p> <p>An observation of the resident on March 25, 2025, at 9:45 AM revealed the resident was calm and no agitation was noted. The resident was in her Broda chair (tilt-in-space positioning chair) sleeping by the nursing station. Further observation revealed the resident's physical restraints (mittens) were in place despite the resident being calm and resting.</p> <p>An observation of the resident on March 25, 2025, at 1:20 PM revealed again the resident was calm and no agitation observed. The resident was in her Broda chair sleeping by the nursing station. Further observation revealed the resident's physical restraints (mittens) were in place despite the resident being calm and resting.</p> <p>An observation of the resident on March 26, 2025, at 12:45 PM revealed the resident was sitting calmly in the dining room being fed by staff. The resident did not appear to be agitated. Further observation revealed the resident's physical restraints were in place despite the resident being calm and resting.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation of the resident on March 27, 2025, at approximately 10:00 AM revealed the resident was calm and no agitation was noted. The resident was once again in her Broda chair sleeping by the nursing station. Further observation revealed the resident's physical restraints were in place despite the resident being calm and resting.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on March 28, 2025, at approximately 1:45 PM confirmed the facility failed to ensure that Residents 74 was free from physical restraints and the use of the mittens was limited to the least amount of time necessary.</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>28 Pa. Code 211.8(c.1) Use of Restraints</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>26142</p> <p>Based on a review of the facility's abuse prohibition policy and employee personnel files and staff interviews, it was determined the facility failed to implement abuse prohibition procedures to fully screen five out of five sampled employees (Employees 12, 13, 1, 15 and 16) to ensure they were eligible for employment in a long term care nursing facility.</p> <p>Findings include:</p> <p>A review of the facility's policy titled Resident Abuse (reviewed January 2025) indicated that all potential employees are to be screened prior to hire. This includes contacting references and obtaining pertinent information from former and current employers to assess for any past history of abuse, neglect, or professional misconduct.</p> <p>However, a review of personnel files revealed the following:</p> <p>Employee #12 (housekeeper), hired February 3, 2025, had previous employment listed in the application. There was no evidence that the facility attempted to contact prior employers.</p> <p>Employee #13 (nurse aide), hired February 21, 2025, lacked documentation of any reference checks or employment verification.</p> <p>Employee #1 (LPN), hired February 15, 2025, lacked evidence of attempts to contact former employers or verify prior employment.</p> <p>Employee #15 (RN), hired March 7, 2025, had no documentation indicating prior work references were contacted.</p> <p>Employee #16 (van driver), hired March 19, 2025, had no evidence of reference checks or employment history verification.</p> <p>In an interview conducted on March 27, 2025, at 11:15 a.m., the Human Resources Director confirmed the above findings. She acknowledged she had not contacted previous employers for the five employees and stated, I'm new to this job and didn't know that I had to call prior work references as part of the employment process.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.19 (1) Personnel records</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record reviews, resident interviews, and observations, the facility failed to ensure that dependent residents received the necessary services to maintain personal hygiene for 2 of 24 residents reviewed for activities of daily living (ADLs) (Residents #23 and #96).</p> <p>Findings include:</p> <p>A review of the facility's Activities of Daily Living Policy last reviewed January 22, 2025, revealed it is the facility's responsibility to provide the necessary services to maintain good grooming/personal hygiene to residents who are unable to carry out activities of daily living. The policy then goes on to state the facility is responsible to provide bathing, dressing, grooming, and oral care to residents who are unable to carry out these activities themselves.</p> <p>A review of the clinical record revealed that Resident 23 was admitted to the facility on [DATE], and had diagnoses, which included spastic quadriplegic cerebral palsy, (a type of cerebral palsy where arms and legs are affected by muscle stiffness making movement difficult) contractures (a condition of hardening muscles leading to deformities) of the right and left knees, and neuromuscular dysfunction of the bladder(loss of bladder control).</p> <p>A review of the resident's Annual Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2, 2025, revealed the resident was unable to shower/bathe self, further defining the resident was unable to wash, rinse, and dry self. The MDS revealed the resident is completely dependent on staff for transfers in and out of the tub or shower.</p> <p>The resident's care plan, revised on February 12, 2025, indicated a preference for bed baths due to her mobility limitations. Her scheduled bed baths were to occur every Monday and Thursday during the 3PM-11PM shift.</p> <p>A review of the resident's shower Documentation indicated the last recorded bed bath was provided on March 24, 2025. Observations on March 25, 2025, at 10:00AM showed the resident had dirt under her nails, unkempt, greasy hair with visible dandruff, and food stains on her hospital gown. The resident could not recall the last time her hair was washed and stated, they just wash me up in bed sometimes, but they do not wash my hair.</p> <p>A second observation conducted on March 25, 2025, at 1:00PM, revealed the resident to still have food particles on her hospital gown that were previously observed at 10:00AM, the resident's condition prevents the resident from removing the food particles herself.</p> <p>A clinical record review revealed documentation the resident was given a bed bath again on March 27, 2025, at 10:00AM.</p> <p>An interview with the resident conducted March 27, 2025, at 11:30AM revealed a statement from the resident stating that she was not given a bed bath, the resident's hair was still unwashed and greasy.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation conducted March 28, 2025, at 11:00AM revealed the resident to have food particles left on her hospital gown from the morning meal.</p> <p>An interview with the resident conducted March 28, 2025, at 11:00AM confirmed the staff frequently leaves food particles on her chest area after assisting her with eating, the resident stated she has not had her hair washed and that she would like to have her hair washed each time she receives a bed bath.</p> <p>There was no documented evidence in the resident's clinical record or care plan of any resident refusals or reasons for not washing the resident's hair as scheduled and as requested.</p> <p>Clinical record review revealed Resident 96 was admitted to the facility on [DATE], with diagnosis to include dementia (a condition that cause a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and judgment) and anxiety (a feeling of fear, dread, and uneasiness).</p> <p>A quarterly Minimum Data Set assessment dated [DATE], revealed he was moderately, cognitively impaired with a BIMS score of 8 (brief interview for mental status, a tool to assess the resident's attention, orientation and ability to register and recall new information, a score of 8-12, indicating moderately, cognitive impairment) and required staff assistance with activities of daily living (ADL).</p> <p>A review of the resident's care plan initiated: March 22, 2024, for potential for skin breakdown related to, decreased mobility, revealed interventions to include, skin checks to be completed bi-weekly with showers, shower days scheduled Mondays and Thursdays 3PM to 11PM shift. The care plan also included interventions for refusals, including re-education and reattempting care, as well as physician and social work notification.</p> <p>Shower documentation for March 2025 for Resident 96, showed only two recorded bed baths on March 20 and 24, 2025. There was no documentation of additional bathing or required skin assessments. Observation on March 26, 2025, at 12:00 PM, in the presence of the resident's sister, revealed the resident's feet were covered in white sloughing (shedding) skin, with thick, mycotic (fungal) toenails and debris between the toes. His fingernails were jagged, long, and dirty.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on March 28, 2025, at approximately 12:00 PM confirmed the facility failed to provide adequate services for personal hygiene to meet the residents' needs and preferences.</p> <p>28 Pa Code 211.12 (d)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Aventura at Terrace View		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Terrace Drive Peckville, PA 18452	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide an ongoing program of activities designed to meet the needs, interests, and preferences of residents as expressed by seven out of seven individuals interviewed during resident interviews. (Residents 3, 23, 27, 49, 80, 81).</p> <p>Findings include:</p> <p>A resident group interview was held March 27, 2025, at approximately 1:00PM, 6 out of 6 residents (3, 25, 47, 49, 80, 81) present reported that many activities they enjoyed such as trips to Walmart and gardening have been removed from the activities schedule. The residents reveal there is no change in activities and that the activities are the same each week.</p> <p>A review of the activity calendars for January, February, and March of 2025 revealed no change in activities each month. The activities specified on each unit revealed no variety in activities from week to week.</p> <p>A review of the clinical record revealed that Resident 23 was admitted to the facility on [DATE], and had diagnoses which included spastic quadriplegic cerebral palsy, (a type of cerebral palsy where arms and legs are affected by muscle stiffness making movement difficult) contractures (a condition of hardening muscles leading to deformities) of the right and left knees, and neuromuscular dysfunction of the bladder(loss of bladder control).</p> <p>A review of a yearly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2, 2025, revealed that Resident 23 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>An interview conducted with Resident #23 on March 27, 2025, at approximately 9:00 AM, revealed that her favorite leisure activity is coloring. However, she stated that she has not been given the opportunity to engage in this activity for some time.</p> <p>A subsequent review of Resident #23's activity participation records showed no documentation indicating that coloring had been offered as an option. Instead, the activity log noted her participation in physical, sport-like activities, including bowling, volleyball, bean bag toss, and an exercise club.</p> <p>However, a review of the resident's physical therapy evaluation, completed on January 31, 2025, indicated that Resident #23 has physical limitations that prevent her from participating in any sport-like activities. This suggests a disconnect between the activities recorded and the resident's actual physical capabilities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Activity Director on March 28, 2025, at 9:00 AM, it was clarified that Resident #23 did not actively participate in the sports activities listed in the records, but rather observed while other residents took part in activities such as bowling, volleyball, and bean bag toss.</p> <p>The Activity Director further explained that the facility currently has no allocated budget for resident activities. Staff members are reportedly purchasing activity-related prizes using their own personal funds, without reimbursement. In response to these limitations, the Activity Director stated that she organizes fundraiser's to support the activity department and is doing her best to develop engaging programs within the constraints of the available resources.</p> <p>Observations conducted on the D Unit throughout the survey period, from March 25 through March 28, 2025, revealed groups of residents sitting in front of a television that was playing an old western movie. During these observations, residents were neither offered nor encouraged to participate in any structured activities.</p> <p>In a follow-up interview with the Nursing Home Administrator (NHA) on March 28, 2025, at 1:00 PM, the NHA confirmed that the facility does not currently maintain a budget for resident activities. The Administrator acknowledged the facility's obligation to provide an ongoing program of activities tailored to meet the individual needs, interests, and preferences of each resident.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on observations, select facility policy, facility investigative reports, a review of clinical records, and staff interviews it was determined the facility failed to consistently provide care and services to prevent the development and promote healing of a pressure sore resulting in harm for one resident (Resident 93) out of 24 sampled residents.</p> <p>Findings include:</p> <p>According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to the body) 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.</p> <p>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.</p> <p>A review of facility policy entitled Pressure Ulcer/Injury Care and Management last reviewed January 22, 2025, revealed residents will receive care consistent with professional standards of practice, to prevent pressure ulcer/injury unless the individual's clinical condition demonstrates they were unavoidable. Residents will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. Residents with a pressure ulcer will have wound measurements weekly by the physician or registered nurse. Observation of the wound should be completed with each dressing change and should include at a minimum:</p> <p>A. Location and staging</p> <p>B. Size, depth, the presence and location of any undermining or tunneling</p> <p>C. Exudate if present the type, color, odor, and amount</p> <p>D. If pain is present the nature and frequency</p> <p>E. Wound bed to include the color and type of tissue</p> <p>F. Description of the wound edges</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 93's clinical record revealed admission to the facility on [DATE], with diagnoses, which included radiculopathy (a condition where the nerve roots become compressed or irritated. This compression or irritation can lead to pain, numbness, tingling, weakness), hypotension (low blood pressure), and peripheral vascular disease (a group of conditions that affect the blood vessels outside the heart and brain, primarily in the legs).</p> <p>A review of a Quarterly Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed the resident was moderately cognitively impaired and was at risk for developing pressure ulcers.</p> <p>A review of a quarterly Braden scale for predicting pressure sore risk assessment dated [DATE], revealed the resident responds to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits the ability to feel pain or discomfort. The resident's ability to walk is severely limited or nonexistent and was at risk for pressure ulcers.</p> <p>A review of the resident's plan of care for potential for skin breakdown related to decreased mobility initially dated May 1, 2024, revealed a goal that the resident will have no additional skin breakdown. Planned interventions included assist with bed mobility to prevent shearing (rubbing friction) of skin, provided incontinence care (the management and treatment of involuntary loss of urine or stool) and apply barrier cream (a topical product that forms a protective layer on the skin, shielding it from irritation and damage caused by prolonged contact with urine or feces) as ordered, and a pressure reducing device to the bed and chair.</p> <p>A review of the Documentation Survey Report for February 2025 revealed that Resident 93 was incontinent daily, yet there was no documented evidence that incontinence care and barrier cream were provided with each episode of incontinence.</p> <p>On February 26, 2025, at 10:15 PM, a facility investigative report revealed that Resident 93 was found to have an open area on the coccyx (bottom of the spine) measuring 2.5 cm x 2 cm. It was noted the area was cleaned and a dressing was applied. Further it was indicated the resident will be checked for incontinence and changed every two hours and as needed to prevent any further skin alterations.</p> <p>A review of a Weekly Skin Observation completed on February 27, 2025, at 6:10 AM, Employee 1, a licensed practical nurse (LPN) documented that Resident 93 had moisture-associated skin damage (MASD) on the coccyx measuring 2.5cm x 2cm but failed to describe wound characteristics such as shape, color, and drainage.</p> <p>There was no evidence that a registered nurse (RN) assessed the wound and provided documentation to the type of wound, location, size, color, odor, or drainage.</p> <p>There was no documented evidence the resident had any treatment, or a dressing applied to the wound on the evening shift on February 26, 2025, after the wound was identified. Further there was no evidence that a treatment or dressing was applied or in place on the night shift on February 27, 2025, or the day shift on February 27, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an onsite note dated February 27, 2025, at 3:58 PM by Employee 2 CRNP (certified registered nurse practitioner) revealed the resident was seen for a new open area to the coccyx. Employee 2 indicated the resident had a pressure ulcer of the sacral region (base of spine). No further assessment was documented of the wound. The employee indicated she wrote a new order for Zinc Oxide paste 20% apply to the coccyx every shift for wound care.</p> <p>A review of the February 2025 Treatment Administration Record (TAR) revealed the first treatment to the resident's newly developed pressure ulcer wasn't completed until February 27, 2025, on the evening shift.</p> <p>There was no documented evidence the facility implemented the two-hour check and change for Resident 93 to prevent further skin alterations.</p> <p>A physician's order dated February 28, 2025 (two days after the wound was identified) directed that Resident 93 be turned and repositioned every two to three hours.</p> <p>A review of the clinical record revealed the nurse aides who are responsible to turn and reposition the resident failed to document they were turning and repositioning the resident as indicated in the physician's order.</p> <p>A review of the Medication Administration Audit Report for the month of February 2025 revealed the licensed staff were signing out once a shift that the resident was offered to be turned and repositioned. Further review indicted staff were signing off the turning and repositioning was completed for the entire shift prior to the task being completed.</p> <p>A review of an Initial Wound Evaluation and Management Summary completed by the consultant wound practitioner dated March 3, 2025, noted it had deteriorated into an unstageable deep tissue injury (DTI) a pressure injury where the full depth of tissue damage is obscured by slough, layer of dead, yellow or gray tissue that separates from the underlying healthy skin, or eschar, thick, dry crust of dead tissue that forms over a wound, making it impossible to determine the underlying stage). The wound now measured 9 cm x 6.5cm and had a depth of 0.2cm. The wound was noted to have a moderate amount of serosanguineous drainage (a type of fluid that is discharged from a wound which is a mixture of clear, watery fluid and blood). Plan of care recommendations included offload the wound and turn side to side in bed every one to two hours.</p> <p>Despite recommendations to offload pressure and turn the resident side to side every 1-2 hours, facility documentation revealed that this intervention was never consistently implemented.</p> <p>A review of the Medication Administration Audit Report for the month of March 2025 revealed the licensed staff were signing out once a shift that the resident was offered to be turned and repositioned. Further review indicted staff were signing off that the turning and repositioning was completed for the entire shift prior to the task being completed.</p> <p>A review of a wound consultant note dated March 11, 2025, revealed an increased wound size to 9.5 cm x 7.5 cm x 0.6 cm, moderate serosanguineous drainage, and the wound bed was covered with thick necrotic tissue (dead, dry, black, leathery tissue that can cover a wound bed and hinders healing) all indications the wound had worsened rather than improved.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a progress note dated March 12, 2025, at 5:28 PM revealed the resident was transported out of the facility to the hospital for progressive wound deterioration, abnormal lab values and signs of systemic infection.</p> <p>A review of hospital documentation dated March 13, 2025, revealed Resident 93 was sent to the hospital for abnormal lab work and a progressive sacral wound. The resident stated at the hospital the wound was very painful. A CT scan (a medical imaging procedure that uses X-rays to create detailed, cross-sectional images of the body's internal structures, such as bones, organs, and blood vessels) was completed and confirmed a deep fissuring pressure ulcer penetrating the soft tissue. Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, causing widespread inflammation and damage to multiple organs) secondary to the wound infection and a surgical consult was recommended.</p> <p>Further Review of hospital paperwork revealed the resident had a surgical procedure on March 13, 2025. The resident's wound had a sharp excisional debridement (a method of wound care where a healthcare professional uses sharp instruments like scalpels, scissors, or curettes to remove dead or damaged tissue) down to the bone. On March 18, 2025, the resident required a diverting loop colostomy surgery (a surgical procedure that creates a temporary or permanent opening in the colon to divert fecal material away from a specific section). This procedure was only completed to divert fecal matter away from the wound on the resident's coccyx and promote healing.</p> <p>An observation of the resident on March 25, 2025, at 10:00 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound.</p> <p>An observation of the resident on March 25, 2025, at 1:45 PM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound.</p> <p>An observation of the resident on March 26, 2025, at 8:56 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound. The resident appeared to be uncomfortable in bed. The resident arms were flailing around. Resident was mumbling but unable to identify what he was saying.</p> <p>An observation of the resident on March 26, 2025, at 9:57 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound.</p> <p>An observation of the resident on March 26, 2025, at 11:30 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound.</p> <p>An observation of the resident on March 27, 2025, at 8:26 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound. The resident appeared to be uncomfortable in bed. The resident arms were flailing around. When asked if the resident was in pain he stated yes.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of the resident on March 27, 2025, at 10:14 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound.</p> <p>An observation of the resident on March 27, 2025, at 11:00 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound. Further observations revealed the incontinence pad underneath the resident was noted to be saturated with a yellow substance and the dressing was visibly wet. The resident's wound was observed with Employee 3 LPN and Employee 4 RN (registered nurse) and revealed a stage 4 pressure ulcer (the most severe, characterized by full-thickness tissue loss, exposing muscle, tendon, cartilage, or bone, and potentially leading to serious complications like infection) measuring 9.5cm x 7 cm x 2cm. The wound bed appeared large and deep with a red beefy wound base with some slough noted in the middle.</p> <p>An observation of the resident on March 28, 2025, at 8:36 AM revealed the resident was lying on his back and bottom in bed. The resident was not turned onto his side to offload the pressure on his wound. The resident appeared to be uncomfortable in bed. The resident arms were flailing around.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on March 28, 2025, at approximately 1:45 PM confirmed the facility failed to develop and implement planned measures to prevent the development and promote healing of a pressure ulcer.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.18(b)(1) Management</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on observation, review of clinical records, and staff and resident interview, it was determined the facility failed to consistently provide timely and necessary foot care for one of 24 residents sampled (Resident 23).</p> <p>Findings include:</p> <p>A review of the Facility's Foot Care Policy revealed that residents will be provided with foot care and treatment in accordance with professional standards of practice. The policy revealed residents with foot disorders or medical conditions associated with foot complication will be referred to qualified professionals.</p> <p>A review of the clinical record revealed that Resident 23 was admitted to the facility on [DATE], and had diagnoses, which included spastic quadriplegic cerebral palsy, (a type of cerebral palsy where arms and legs are affected by muscle stiffness making movement difficult) contractures (a condition of hardening muscles leading to deformities) of the right and left knees, and neuromuscular dysfunction of the bladder(loss of bladder control).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 17, 2025, revealed that Resident 23 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>On March 25, 2025, at 9:00 AM, an observation of Resident 23 revealed that the toenails on the left foot were excessively long, extending beyond the tips of the toes. There was evidence of dried blood beneath and along the cuticle line, and the toenails appeared yellow and encrusted with debris.</p> <p>During the observation on March 25, 2025, Resident 23 stated that she had not received podiatry services while at the facility.</p> <p>A review of Resident #23's clinical record showed no documented evidence indicating that podiatry services had been provided during her stay at the facility.</p> <p>An interview with the Director of Nursing (DON) on March 25, 2025, at approximately 1:00 PM, confirmed Resident 23 had not received routine podiatry care as of March 25, 2025.</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing Services</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on observations, select facility policy, a review of clinical records, and staff interviews, it was determined the facility failed to provide supplemental oxygen administration and care consistent with professional standards of practice for two of 24 residents reviewed (Resident 114 and 93).</p> <p>Findings include:</p> <p>A review of facility policy entitled Oxygen Management last reviewed January 22, 2025, indicated it is the policy of the facility to provide safe oxygen management. The facility will obtain physician orders for oxygen therapy to include prescribed flow rates, when to change the humidifier bottle, and when to change the tubing or mask. Further it is indicated that the maintenance and cleaning of oxygen equipment are consistent with federal, state, and local laws and regulations.</p> <p>Review of Resident 114's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included acute respiratory failure (a condition in which your blood doesn't have enough oxygen) with hypoxia (low levels of oxygen in your body tissues).</p> <p>An observation on March 25, 2025, at 9:45 AM and March 26, 2025, at 10:06 AM revealed the resident was receiving oxygen at 4.5 liters per minute.</p> <p>A review of the resident's physician's orders revealed no orders for the resident to receive oxygen on a continuous or as needed basis.</p> <p>A review of Resident 93's clinical record revealed admission to the facility on [DATE], with diagnoses, which included radiculopathy (a condition where the nerve roots become compressed or irritated). This compression or irritation can lead to pain, numbness, tingling, weakness), hypotension (low blood pressure), and peripheral vascular disease (a group of conditions that affect the blood vessels outside the heart and brain, primarily in the legs).</p> <p>A review of physician's orders initially dated March 20, 2025, revealed the resident was to receive oxygen at 2 liters per minute per nasal cannula every eight hours as needed for shortness of breath or an oxygen level below 94% initially dated March 8, 2023.</p> <p>Further review of Resident 93's physician's orders revealed no orders as to when or how often the tubing should be changed per the facility policy.</p> <p>An observation of Resident 93 on March 26, 2025, at 8:50 AM revealed the resident was lying in bed receiving 2 liters of oxygen. The oxygen tubing was not dated to indicate when the tubing was put into use to alert staff as to when the oxygen tubing should be changed.</p> <p>An observation of Resident 93 on March 27, 2025, at 10:14 AM revealed the resident was lying in bed. The resident's oxygen tubing was observed lying on the floor.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A subsequent observation of the resident on March 27, 2025, at 11:00 AM revealed the resident now had the oxygen tubing that was seen on the floor during the prior observation present and was receiving 2 liters of oxygen. The tubing remained undated at that time.</p> <p>An interview with Nursing Home Administrator and Director of Nursing on March 28, 2025, at approximately 1:45PM revealed oxygen tubing should be changed weekly and confirmed the facility failed to provide supplemental oxygen administration and care consistent with professional standards of practice.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of clinical records and staff interviews it was determined that the facility failed to develop and implement individualized pain management programs, consistent with professional standards of practice, to meet the pain management needs and attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of 24 reviewed (Resident 114).</p> <p>Findings include:</p> <p>According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Draft Final Report May 6, 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following:</p> <p>An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician.</p> <p>Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions.</p> <p>A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes.</p> <p>A review of Resident 114's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses, which included alcoholic cirrhosis of the liver (a chronic liver disease caused by long-term excessive alcohol consumption).</p> <p>A review of a physician order initially dated February 18, 2025, revealed the resident was ordered Oxycodone (narcotic pain medication) 5MG give one via G-Tube(a tube inserted into the stomach to administer nutrition and medication) every six hours as needed for increased pain.</p> <p>A review of the resident's February 2025 Medication Administration Record (MAR) revealed staff administered the as needed Oxycodone 23 times for the month of February. Of the 23 doses given, 18 were administered with no non-pharmacological interventions attempted prior to giving the pain medication.</p> <p>A review of the resident's March 2025 MAR revealed staff administered the as needed Oxycodone 74 times for the month of March. Of the 74 doses given, 60 were administered with no non-pharmacological interventions attempted prior to giving the pain medication.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator and Director of Nursing on March 28, 2025, at approximately 1:45 PM confirmed there was no evidence that non-pharmacological interventions were consistently attempted and proved ineffective prior to administration of a as needed pain medication.</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>41581</p> <p>Based on review of facility documentation and staff interview, it was determined the facility failed to ensure nurse aides received the required yearly 12 hours of in-service training and failed to ensure that nurse aides received an annual performance review for 5 out of 5 employees (Employee 6, 7, 8, 9, 10).</p> <p>The findings include:</p> <p>Review of the facility nurse aide training records revealed that Employees 6, 7, 8, 9, and 10 did not receive 12 hours of in-service training for the year 2024.</p> <p>The facility failed to provide any documentation the above-mentioned employees received a performance review in the last 12 months.</p> <p>An interview with the Director of Nursing and Nursing Home Administrator on March 28, 2025, at approximately 1:45 PM, confirmed the facility did not have documentation that Employee 6, 7, 8, 9, and 10 had received the required 12 hours of annual in-service training or a completed performance review for 2024.</p> <p>28 Pa. Code 201.19(2)(7) Personnel policies and procedures</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review, payor source data, and staff interview, it was determined the facility failed to provide timely and necessary dental services for one resident who is a Medicaid recipient (Resident 25) out of 24 residents reviewed.</p> <p>Findings included:</p> <p>Review of the clinical record indicated Resident 25 was admitted to the facility on [DATE], with diagnoses to include diabetes (high blood sugars).</p> <p>Review of a Quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated February 3, 2025, revealed Resident 25 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, 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).</p> <p>Review of a nurses note dated December 16, 2024, at 9:05 AM revealed, Resident 25 informed staff that her lower dentures had fallen out of her mouth and broken. The resident also stated she informed the dentist of the incident. Documentation indicated the social services worker was notified via voicemail, but no evidence of follow-up or action taken by the facility was found at that time.</p> <p>Further nursing documentation dated December 31, 2024, at 7:41 AM revealed, Resident 25 again reported her dentures were missing, and a search by staff was unsuccessful. Social services were notified again; however, there was no documentation of timely dental referral or follow-up action between this date and the eventual dental appointment on January 27, 2025.</p> <p>Nursing documentation dated January 27, 2025, at 2:35 PM 42 days after the initial report revealed the resident was seen by the dentist, who completed a full exam and noted that Resident 25 was fully edentulous and had lost her dentures. Impressions were taken for new upper and lower dentures.</p> <p>Continued dental documentation on March 3, 2025, indicated the denture fabrication process was ongoing, yet by March 28, 2025, during the survey, the resident remained without dentures.</p> <p>During an interview March 27, 2025, at 12:00 PM, Resident 25 stated that she had been without dentures since December 2024. She reported she coped by cutting food into smaller pieces and asked staff for assistance when needed.</p> <p>During an interview on March 28, 2025, at approximately 11:00 AM the Nursing Home Administrator (NHA) was unable to produce documentation to demonstrate that timely and appropriate dental services were provided following the resident's reports on December 16, 2024 and December 31, 2024. The NHA could not explain the delay in the dental referral or the prolonged timeline for denture replacement.</p> <p>28 Pa Code 211.12 (c)(d)(3)(5) Nursing services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>26142</p> <p>Based on observation, staff and resident interviews, and test tray temperature results, the facility failed to ensure that food was served at palatable and appetizing temperatures for one (1) of three (3) nursing units observed (First Floor D Unit).</p> <p>Findings include:</p> <p>According to the federal regulation 483.60(i)-(2) Food safety requirements - the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness.</p> <p>On March 25, 2025, at 12:00 PM, observation of the lunch tray line revealed the planned lunch meal included: baked chicken patty, roasted potatoes, corn, milk, lemon drink, ice cream, and coffee.</p> <p>A test tray was requested for the First Floor-D Unit. The tray included a regular diet chicken patty, roasted potatoes, corn, lemon drink, and coffee.</p> <p>Review of meal service revealed the trays were delivered in an enclosed cart to the First Floor D Unit at 11:25 AM. However, staff were still assisting residents to the dining area, and tray distribution did not begin until 11:50 AM. The last tray was served at 12:15 PM, approximately 45 minutes after the trays arrived on the unit.</p> <p>At 12:15 PM, a test tray revealed the following food temperatures:</p> <p>Chicken patty: 104.5 F</p> <p>Roasted potatoes: 107.5 F</p> <p>Corn: 106.7 F</p> <p>These items were observed to be cool and not palatable, falling within the Danger Zone as defined by regulation, and failing to meet the requirement for appetizing temperature.</p> <p>In addition, the ice cream on the test tray measured 35 F and was melted, rendering it not palatable at the time it was served.</p> <p>An interview with the Nursing Home Administrator on March 25, 2025, at 3:00 PM, confirmed the facility did not consistently serve food at acceptable and appetizing temperatures.</p> <p>28 Pa Code 201.18(1) Management</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43944</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>The initial tour of the dietary department was conducted with the facility's Certified Dietary Manager (CDM)/Food Service Manager on March 25, 2025, at 9:25 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified:</p> <p>Observations inside of the walk-in refrigerator revealed that there were three cooked meats that were each wrapped in clear plastic wrap with a bright green label that noted deli d/c (discard).</p> <p>Further observation revealed two brownish-pink colored cook meat that was sitting in a reddish liquid that was wrapped in plastic wrap, dated March 22, 2025, with a discard date of April 10, 2025, the CDM reported that it was cooked roast beef. Additionally, observed another whitish-tan colored meat wrapped in plastic wrap and dated March 22, 2025, with a discard date of April 10, 2025, the CDM reported that it was cooked ham. The CDM stated the items did not have the proper discard dates noted on the labels and the items should be discarded after seven days or March 29, 2025, and not April 10, 2025.</p> <p>A review of a facility policy entitled Food Storage and Retention Guide last reviewed by the facility on January 22, 2025, indicated that ready-to-eat/prepared foods, in a form that is edible without additional preparation to achieve food safety (examples: leftovers, deli salads, cut produce) and stored in a refrigerator at less than or equal to 41 degrees Fahrenheit for up to seven days. Day one is the day of preparation.</p> <p>Observations of the walk-in freezer, sections of the plastic strip air curtain were broken or missing, and ice buildup was observed on the floor. The damaged air curtain compromises temperature control and sanitation.</p> <p>A ceiling tile above the three-compartment sink had a hole approximately 4.25 inches in diameter. This structural deficiency poses a risk of dust or debris falling into the sink area used for cleaning and sanitizing dishware and equipment.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further observation of the dietary department revealed two doors, one leading into the dish room (used to bring in soiled meal carts) and another leading from the dish machine to the corridor (used for cleaned dishware), had peeling paint with rust underneath and failed to close properly. The disrepair impedes adequate separation of clean and dirty areas, increasing the risk of cross-contamination.</p> <p>The above findings were confirmed during the tour of the dietary department with the CDM on March 25, 2025, at 10:15 AM, who acknowledged the conditions and confirmed the dietary department should be maintained in a sanitary manner to prevent the potential for food contamination and foodborne illness.</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary Services</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>26142</p> <p>Based on staff interviews and a review of facility documentation, it was determined the facility failed to timely review and update its facility-wide assessment to identify the specific needs of residents, including those with dementia and behavioral health needs. The facility also failed to develop and maintain a plan to maximize recruitment and retention of direct care staff, which is necessary to ensure care for the current resident population.</p> <p>At the time of the survey ending March 28, 2025, the most recent documented facility-wide assessment was dated July 15, 2024. While the assessment included general population data, it failed to reflect changes in the resident population and staffing levels, including those required to care for the 39 residents on the locked D1 Dementia/Memory Care Unit and the 21 residents on the C1 Male Behavioral Health Unit.</p> <p>The assessment failed to describe the facility's specific strategies or resources needed to care for residents with dementia, Alzheimer's disease, and behavior-related diagnoses.</p> <p>The assessment tool provided to the survey team on March 25, 2025, did not include the activity needs or psychosocial needs of residents residing in the specialty units (D1 and C1).</p> <p>No documentation was found indicating a dedicated or tailored activities program or corresponding budget for these units. As a result, the facility failed to demonstrate it had the capacity to meet the unique needs of residents with cognitive and behavioral health diagnoses.</p> <p>A review of the January 23, 2025, state survey indicated previous citations related to inadequate services for residents with dementia and behavioral health needs. Despite this, the facility's assessment was not updated to reflect needed improvements or resource allocation to address these findings.</p> <p>The facility assessment did not include a documented plan to maximize the recruitment and retention of direct care staff.</p> <p>Facility documentation reviewed during the survey showed ongoing reliance on agency staff to meet basic staffing needs, with no evidence of initiatives or strategies to reduce agency dependency or enhance permanent staff retention.</p> <p>The assessment did not inform or guide budget decisions, staffing allocations, or operational adjustments necessary to ensure compliance with licensure and certification standards. There was no documented evidence the facility used the assessment to plan for or provide the necessary resources to safely care for its resident population.</p> <p>Refer F679</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>28 Pa. Code 201.18(b)(1)(e)(2) Management</p>

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on record review and staff interviews, the facility failed to implement an effective compliance and ethics program, including providing required training to 6 of 6 employees reviewed (Employees 11, 12, 13, 14, 15, and 16), and failed to uphold standards of ethical conduct, as evidenced by the lack of staff training and an incident of theft involving Employee 11 and Resident 79.</p> <p>Findings include:</p> <p>A review of the facility's Corporate Compliance and Ethics Plan, last updated July 2024, revealed the facility had established written policies intended to promote compliance with legal and ethical standards. The plan specified that employees must receive training on the facility's Code of Conduct, including expectations related to ethical behavior and reporting of misconduct.</p> <p>According to 42 CFR S483.85, the facility must develop, implement, and maintain an effective compliance and ethics program that includes:</p> <p>Standards, policies, and procedures to prevent and detect criminal, civil, and administrative violations, a designated compliance officer, effective training and education for all staff, and a Code of Conduct made available to all staff.</p> <p>However, during the survey the facility was unable to produce a copy of its Code of Conduct or policies related to the compliance and ethics program.</p> <p>The facility assessment, last reviewed July 15, 2024, did not identify the Compliance and Ethics Program or related staff training as a component of risk or operations.</p> <p>Employee files for Employees 12, 13, 14, 15, and 16, hired between February and March 2025, contained no evidence of ethics or compliance training.</p> <p>The personnel file for Employee 11, who was rehired in February 2025, also lacked documentation of any such training.</p> <p>Resident 79 was admitted on [DATE], with a diagnosis of multiple sclerosis. An annual MDS assessment dated [DATE], revealed the resident was cognitively intact (BIMS score of 15).</p> <p>On March 26, 2025, Resident 79 reported to the Director of Social Services that approximately two years earlier, Employee 11, nurse aide (NA) took him to a bank to cash a \$2,800 check and then offered to hold \$2,000 of the funds for him. The resident stated that Employee 11 NA never returned the money.</p> <p>A police report dated March 26, 2025, confirmed the incident had been reported. On March 27, 2025, law enforcement confirmed with a local financial institution that Resident 79 cashed a check in the amount of \$3,925.77 on August 1, 2023. Employee 11 NA later admitted during police questioning that she took the money for safekeeping but did not return it, stating she was scared and made no effort to correct the issue even after the resident confronted her.</p> <p>(continued on next page)</p>

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employee 11 NA was arrested and charged with theft.</p> <p>The facility failed to prevent this ethical violation through the implementation of a functioning compliance program and failed to detect or respond to unethical conduct in a timely manner. Interviews with facility leadership confirmed the compliance and ethics program was not part of orientation or ongoing training for staff, and documentation to support its implementation could not be produced.</p> <p>Refer F607, F 838</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(e)(2) Management</p>		