

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Creekside		STREET ADDRESS, CITY, STATE, ZIP CODE 45 North Scott Street Carbondale, PA 18407	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>43944</p> <p>Based on a review of grievances filed with the facility and the minutes from Residents' Council meetings and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by three out of the 10 residents sampled (Residents 11, 17, and 50).</p> <p>Findings include:</p> <p>A review of resident council meeting minutes dated February 22, 2024, revealed that residents voiced concerns of waiting 35 - 40 minutes for staff to answer their call bells. The meeting minutes indicated that residents in attendance also indicated that there are not enough nurse aides on the floor to provide timely care to residents.</p> <p>A grievance form filed on behalf of a resident dated March 22, 2024, revealed that the resident had been waiting for nursing staff to assist him to the restroom, but staff did not respond timely. After waiting for a response, the resident's family member went to find staff assistance and observed nursing staff on their cell phones. The grievance indicated that nursing staff were educated about answering call bells in a timely manner.</p> <p>A review of resident council meeting minutes dated April 23, 2024, revealed that residents in attendance indicated that nurse aides at night are not answering residents' calls for assistance.</p> <p>A grievance filed following the Resident Council meeting dated April 23, 2024 indicated that nursing staff are not answering the call bells in a timely manner, there are not enough nurses to do a medication administration pass in the evening, and showers are not being offered in the evenings due to staffing issues. The grievance indicated that staff were educated regarding answering call bells in a timely manner, medication passes, and showering residents. There was no documented evidence at the time of the survey ending May 16, 2024, that the facility had reviewed the adequacy of nurse staffing or nurse staff assignments to ensure that sufficient nursing staff was available to provide timely care based on the needs of the residents.</p> <p>A grievance dated May 15, 2024, revealed that Resident 17 complained that she rang her call bell at 11:30 AM but staff told her that they could not provide her care until lunch was done being served in the dining room.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on May 16, 2024, at 11:25 AM, Resident 17 stated that she waits on average 20 minutes for staff to respond to her call bell rings for assistance. She explained that two days ago she waited two hours for staff assistance and filed a grievance with the facility. Resident 17 stated that she was very upset because she had feces in her brief and needed staff to help with care. Resident 17 explained that long wait times for staff to provide care are an ongoing problem at the facility. She expressed anger and frustration about the wait times for care. Resident 17 stated that there are very few staff on duty and when they take a break, there is no one left to assist the residents with care on the unit.</p> <p>During an interview on May 16, 2024, at 1:15 PM, Resident 50 indicated that she waits about 20 minutes for staff to respond to her call bell rings when she needs care or assistance. She explained that the wait times seem to be the worst during the night shift. Resident 50 indicated that the long wait times have been an issue for herself and other residents for the last two to three months.</p> <p>During an interview on May 16, 2024, at 1:45 PM, Resident 11 indicated that it takes staff about 15 minutes to respond to his call bell rings for care or assistance. He explained that when the facility is short on staff, he waits about 30 minutes for assistance. Resident 11 indicated that in the morning, during breakfast, the wait times are the longest.</p> <p>During an interview on May 16, 2024, at approximately 5:30 PM, the Nursing Home Administrator (NHA) verified that all residents at the facility should be treated with dignity and respect. The NHA was unable to explain why residents are reporting untimely staff responses to residents' requests for assistance, which is negatively affecting their quality of life in the facility.</p> <p>28 Pa. Code 201.18 (e)(1)(4) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p>		

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<p>F 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on observations, review of clinical records and staff interviews, it was determined that the facility failed to conduct meal service in a manner respectful of each resident's personal dignity for two residents observed during meals (Residents 61 and 68), failed to maintain a respectful environment as evidenced by observation of staff conduct and behaviors and as reported by two residents (Resident 50 and 17) and failed to ensure that resident maintained a dignified personal appearance for two of the 10 residents sampled (Residents 29 and 66).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 29 was admitted to the facility on [DATE]. A review of an initial Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 18, 2024 revealed that Resident 29 is moderately cognitively impaired with a BIMS score of 12 (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 8-12 indicates cognition is moderately impaired).</p> <p>Clinical record review revealed that Resident 61 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE], revealed that the resident was dependent on staff assistance to eat.</p> <p>Resident 66 was admitted to the facility on [DATE]. An initial MDS assessment dated [DATE], revealed that the resident is moderately cognitively impaired with a BIMS score of 10.</p> <p>A clinical record review revealed that Resident 68 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE], revealed that the resident was dependent on staff assistance to eat.</p> <p>An observation in the facility dining room on May 16, 2024, at 12:05 PM revealed Resident 29 wearing a brown t-shirt. Small white dandruff-like flakes were observed on the front and shoulders of the shirt and there was a hole in the left arm of the shirt. Resident 29 was also wearing a bright yellow bracelet that indicated the resident was a fall risk in black letters.</p> <p>An observation in the facility dining room on May 16, 2024, at 12:07 PM revealed Resident 66 was wearing a bright yellow bracelet that indicated the resident was a fall risk in black letters.</p> <p>An observation in the facility dining room on May 16, 2024, at 12:12 PM revealed Resident 68, seated in a wheelchair, while Resident 61 was fed by a staff member. Resident 68's meal tray was on the table in front of her, but she was not able to feed herself and watched while Resident 61 was being fed. After 12 minutes, Resident 68 staff fed Resident 61 and provided an opportunity to eat her meal.</p> <p>An observation in the facility dining room on May 16, 2024, at 5:01 PM revealed Resident 29 in the same brown shirt. [NAME] dandruff-like flakes remained visible on his shoulders and chest.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation in the facility dining room on May 16, 2024, at 5:24 PM revealed that meal trays were placed on a table in front of Residents 61 and 68. At the same table, a third tray was placed in front of another resident, who began eating. Residents 61 and 86 were observed waiting with their food trays in front of them. Approximately 10 minutes passed before they were assisted by staff to eat their meal.</p> <p>During an interview on May 16, 2024, at 1:15 PM, Resident 50 stated that she regularly hears staff swearing. She explained that she doesn't know who they are talking to, but it makes her upset when she hears it outside of her bedroom. Resident 50 state that she hears staff say f*ck you and go f*ck yourself.</p> <p>An observation on May 16, 2024, at 4:52 PM in the resident dining room revealed residents seated and waiting for their evening meal. Staff were observed talking to each other near the entrance to the facility kitchen. This surveyor overheard a staff member saying, 'I'll f*cking leave right now, loud enough to be heard across the dining room by the residents and others present in the dining room.</p> <p>During an interview on May 16, 2024, at 11:25 AM, Resident 17 stated that the nurse aides will curse when they are talking to people, and it bothers her to hear that language. Resident 17 stated that she hears them say f*ck and shit, and she does not like to hear those curse words.</p> <p>During an interview on May 16, 2024, at approximately 6:00 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) indicated that Residents 29 and 66 were wearing yellow fall risk bracelets since admission from the hospital, which the facility staff should have removed. The NHA and DON confirmed that residents should not have to watch other residents consume their meals while they wait for assistance and staff should not be using foul language in the presence of residents.</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services</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** 43944</p> <p>Based on observation and resident and staff interviews it was determined that the facility failed to provide housekeeping services to maintain a clean and orderly environment in three of the three nursing halls.</p> <p>Findings include:</p> <p>During a facility tour on May 16, 2024, an observation of the resident activity room at 11:11 AM revealed crumbs, food, and paper debris on the floor.</p> <p>An observation in the hallway outside the activity room at 11:12 AM revealed two three-inch clumps of hair on the floor. During another observation at 5:06 PM, the clumps of hair were still in the hallway outside the activity room.</p> <p>An observation of the nursing station at 11:14 AM revealed a brown substance splattered on the handrail and on the wall above the handrail. A buildup of dirt and debris was observed on the surface of the handrail extending along the nursing station. Multiple dried tan liquid stains were observed on the wall across from the nursing station.</p> <p>An observation of resident room [ROOM NUMBER] at 11:18 AM revealed used tissues and food debris on the floor, under the window side bed, and near the exit.</p> <p>An observation of the resident day room at 11:20 AM revealed three dead black winged insects on the floor. Dirt and debris was observed on the floor next to the exit to the day room, and along the threshold to the room. A gap was visible in the corner of the door, allowing light to be seen through the bottom of the back door.</p> <p>An observation of resident room [ROOM NUMBER] at 11:22 AM revealed pink droplet stains on the floor and dirt and debris on the floor along the wall to the right of the entrance. Tiles in the resident's bathroom were stained with multiple brown, black, and tan discolorations.</p> <p>During an interview on May 16, 2024, at 11:25 AM, Resident 17 stated that the facility staff only lightly clean, but not thoroughly. She explained that there is still dirt on her room floor after staff cleaned the area. Resident 17 stated that she hates looking at her bathroom floor because it is very stained and discolored.</p> <p>An observation of resident room [ROOM NUMBER] at 11:40 AM revealed a three-foot-by-one inch gash in the wall, exposing white drywall.</p> <p>An observation of resident room [ROOM NUMBER] at 11:45 AM revealed brown and tan stains or discoloration on the molding strip measuring 3 feet along the bottom of the floor. A small red stain was visible on the floor, with drops of the red substance around the stain.</p> <p>(continued on next page)</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>During an interview on May 16, 2024, at approximately 5:30 PM, the Nursing Home Administrator (NHA) confirmed that the facility is to be maintained in a clean and orderly manner.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>43944</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on a review of clinical records and select incident reports, and staff interviews, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to demonstrate that a registered nurse promptly assessed a resident displaying possible signs and symptoms of a potential change in condition for one resident (Resident 38) out of 15 sampled residents sampled.</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>An incident report completed by Employee 2, a Registered Nurse (RN), dated May 10, 2024, at 2:17 p.m., revealed that Resident 38 had an unwitnessed fall and was found face down on the floor. The resident was assessed and had sustained a small bump to his right forehead. Resident was placed back into bed and neuro-checks initiated. Ambulance called due to medical condition. Resident was confused and appeared jaundice [is a condition where your skin, the whites of your eyes and mucous membranes (like the inside of your nose and mouth) turn yellow. Many medical conditions can cause jaundice, like hepatitis, gallstones, and tumors].</p> <p>A nurses' progress note completed by Employee 2, dated May 10, 2024, at 2:19 p.m., revealed that the resident was found face down on the floor in his room on the right side of his bed. Bed was in the lowest position; wheelchair was on the left side of the bed near the window. Resident was wearing a nonskid sock. Continent of bowel and bladder and call bell was within reach. A small bump noted on his right forehead, cold compress applied. Neuro-checks started, and the resident was confused, not following commands, pupils pinpoint, sluggish, BUE (bilateral upper extremity) weakness noted. Nurse aide stated that before this happened that resident wasn't acting right and went back to his bed after lunch. Resident self-transfers and was moaning, and color was brownish yellow. Temperature at 98 degrees Fahrenheit, pulse 70, respirations 26, blood pressure 148/100, pulse OX 95 % room air. Physician was notified with new orders were obtained to transfer to the emergency department for evaluation due to changes in condition.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement completed by Employee 3, a Nurse Aide (NA), dated May 10, 2024, no time noted, indicated that at around 1:30 p.m., Resident 38's color wasn't right and that the resident wasn't acting like himself and seemed more confused than normal and reported it to the RN Supervisor.</p> <p>A review of a witness statement completed by Employee 4, a Nurse Aide (NA), dated May 10, 2024, at 3:30 p.m., indicated that he walked into the room to tend to Resident 38's roommate and heard a groan and then a thud coming from Resident 38's side of the room. I yelled over to ask the resident if he was okay, and he did not answer but groaned. Employee 4 indicated that he looked behind the curtain and saw the resident on the floor and quickly yelled to the LPN (licensed practical nurse). The RN Supervisor, LPN, and NA arrived and put the resident back into bed to be assessed. Employee 4 recalled that Resident 38 was very yellow-skinned more than usual and wasn't acting himself.</p> <p>There was no documented evidence that prior to the resident's fall on May 10, 2024, and in response to Employee 3's report to the RN Supervisor that Resident 38 appeared to show signs and symptoms of a change in condition, that the RN supervisor had promptly assessed the resident's status and condition.</p> <p>An interview with the Director of Nursing (DON) on May 16, 2024, at 5:20 p.m., confirmed that there was no evidence of a prompt assessment of Resident 38 by professional nursing staff of signs and symptoms of a change in resident condition.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on a review of clinical records and select facility policy and staff interviews it was determined that the facility failed to consistently and accurately monitor resident weights to timely identify changes in nutritional parameters for two residents out of 15 sampled (Residents 51 and 47).</p> <p>Findings included:</p> <p>Review of facility policy entitled Weight Policy and Procedure Facility Guidelines, provided by the facility on May 16, 2024, indicated that monthly weights would be documented in the resident's electronic medical record and that nursing needs to ensure completion of weekly weights. Discontinuation of weekly weights should occur once stabilization has been determined by the Dietitian and Interdisciplinary Team. A progress note by the Dietitian needs to reflect the stabilization and return to monthly weights. Weekly weights should not go on for months at a time unless truly clinically indicated. Weight accuracy issues require problem solving. Dietitians need to drive the re-weight process and re-weights are to be completed by the following day and documented in the electronic medical record the same day. The threshold for significant unplanned and undesired weight loss will be based on the following criteria as follows; 1 month (30 days) - 5% weight loss, 3 months (90 days) - 7.5% weight loss, and 6 months (180 days) - 10% weight loss. The Dietitian should be contacting the Physician and Responsible Party to discuss significant weight changes and completed in a timely manner and documented in the clinical record.</p> <p>A review of the clinical record revealed that Resident 51 was admitted to the facility on [DATE], with diagnoses that included aphasia [a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain], diabetes, and muscle weakness.</p> <p>Resident 51's current recorded weights revealed the following:</p> <p>12/12/2023 2:12 p.m. - 137.4 -pounds</p> <p>1/22/2024 9:22 a.m. - 133.4-pounds</p> <p>2/7/2024 2:25 p.m. - 122.2 - pounds</p> <p>2/8/2024 10:32 a.m. - 123.0 - pounds</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note in the clinical record completed by the facility's remote (completes work off-site) Registered Dietitian (RD) on February 8, 2024, at 2:13 p.m., revealed that the resident's new monthly weight was 123-pounds and on 1/22/2024 the resident's weight was 133.4-pounds (loss of 10.4-pounds or 7.8% in 17-days), 11/14/2023 weight was 139.8-pounds, and 8/4/2023 weight was 143.4-pounds that indicated a (-10.4-pound or 7.8%) loss x 1 month, a (-16.8-pound -12%) loss x 3 months, and a (-20.4-pound, -14.2%) loss x 6 months. The RD noted that the resident's weight loss was significant, undesirable, and unplanned. The RD noted that the Weight loss could likely be related to previous positive COVID-19 on 1/1/2024 and slight decrease in oral intakes noted in one month. Consumes mainly 50-100% most meals. Resident also noted to be on diuretic therapy Lasix [a medication used to remove extra fluid from the body to prevent fluid overload and cardiac distress] 20 mg daily related to history of edema (swelling) and weight fluctuations may occur. Spoke to resident and she really enjoys and has good acceptance of ensure plus supplement; will increase ensure plus (high calorie nutrition supplement) to three times per day (350kcal, 16g pro) per 8oz shake for added nutrition support. Food preferences obtained and on file. Advanced directives: long term tube feeding/hydration indicated. Will also add resident to weekly weights so close monitoring can continue. RP/IDT/MD aware of weight loss. Will continue to make new recommendations PRN (as needed) and follow up with nutrition POC (plan of care).</p> <p>However, the facility failed to obtain weekly weights as recommended by the RD on February 8, 2024. The resident's weights were noted on 2/19/2024 12:16 p.m. - 125.0 - pounds and the next weight approximately three weeks later on 3/15/2024 4:39 p.m. - 123.6 - pounds</p> <p>A weight change progress note completed by the remote RD dated March 19, 2024, at 12:20 p.m., revealed that the resident's weight loss was significant and would adjust supplement orders as per Resident 51's preference and to continue to monitor weekly weights.</p> <p>Resident 51's next record weights were noted 11 days later on 3/26/2024 11:08 a.m. as 106.6 - pounds (entry struck out on April 1, 2024, at 7:35 a.m., by the remote Registered Dietitian) and then on 3/29/2024 6:14 p.m. -122.8 - pounds</p> <p>The facility failed to ensure that weekly weights were completed to monitor Resident 51's weight status for further weight loss following a significant weight loss.</p> <p>A review of Resident 47's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included protein-calorie malnutrition, history of breast cancer, muscle weakness, and depression.</p> <p>Resident 47's recorded weights were as follows:</p> <p>1/19/2024 09:20 a.m. -145.6 - pounds</p> <p>2/5/2024 09:10 a.m. - 127.2 -pounds</p> <p>2/9/2024 11:08 a.m. - 126.2 - pounds</p> <p>2/19/2024 12:18 p.m. - 128.0 - pounds</p> <p>3/15/2024 4:39 p.m. - 131.0 - pounds</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/18/2024 2:29 p.m. - 128.8 -pounds</p> <p>3/26/2024 5:58 p.m. -127.6 - pounds</p> <p>4/9/2024 6:33 p.m. - 129.0 - pounds</p> <p>A review of the resident's weight record revealed that January 19, 2024, the resident weighed 145.6-pounds, and on February 5, 2024, the resident weighed 127.2-pounds, representing an 18.4-pound or 12.6% significant weight loss in seventeen days. No reweight completed to confirm the weight change.</p> <p>A nutrition weight change progress note completed by the remote RD dated February 9, 2024, revealed that the resident had an undesirable, and unplanned significant weight loss and was likely related to a slight decrease in oral intakes and previous antibiotic therapy. The remote RD noted Resident usually consumes 75-100%, now consuming 50-75% most meals over seven days. Tried calling the resident's phone number, but unavailable at this time and a message left for the resident's son. Physician and interdisciplinary team aware of weight loss and goal to deter further weight loss. Fortified foods (increased calorie and protein dietary meal plan) were added to meals and Ensure Plus (a high calorie supplement) was added daily for nutrition support. Food preferences on file and resident to be weighed weekly for close monitoring.</p> <p>Resident 47's weight record failed to reveal that the resident was weighed weekly as planned for close nutrition monitoring following the significant weight loss and that reweights were timely obtained to confirm weight changes.</p> <p>An interview with the DON on May 16, 2024, at 5:30 p.m., confirmed that the facility failed to ensure that weekly weights were obtained as planned for Residents 51 and 47 to monitoring their weight status following a significant weight loss.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Aventura at Creekside		STREET ADDRESS, CITY, STATE, ZIP CODE 45 North Scott Street Carbondale, PA 18407	
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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 and the resident unit food storage area.</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>During a tour of the unit resident pantry area in the presence of the food service manager on May 16, 2024, at 11:30 a.m., observation of the resident refrigerator revealed that the bottom of the unit was damaged and the vent was covered with dirt, debris, and rust.</p> <p>Food was splattered inside and debris/dust was observed behind the microwave.</p> <p>Observation revealed food splatter on the garbage can. There was no lid on the can and the trash was overflowing. The wall behind the garbage can was splattered with food. The pantry floor was stained with a reddish-brown substance.</p> <p>Observations of the dietary department during lunch tray line service on May 16, 2024, at 11:55 a.m., revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, was identified:</p> <p>Four, 4-ounce shakes were observed inside a stainless steel 1/4 pan that were not labeled with a thaw or discard date as indicated by the manufacturer's instructions (manufacturer notes a 14-day shelf life after thawing). The dietary manager reported that the shakes should be dated when staff pull them from the freezer and confirmed that the actual pull date/thaw date was unknown.</p> <p>The cook was observed serving bacon, lettuce, and tomato (BLT) sandwiches that were the planned lunch and used his gloved hands to pick up the toast, then the lettuce, tomato, and bacon but then touched other kitchen surfaces without performing hand hygiene and changing his gloves. The cook/server did not change his gloves or perform hand hygiene during the lunch tray assembly and continued to use his gloved hands to pick up food for the residents' trays.</p> <p>Further observations of the tray line area revealed that the surfaces of the resident meal trays showed significant evidence of wear, such as deep scratches and non-slip surfaces worn away, which inhibit proper cleaning and sanitizing due to the surface breaks and deterioration.</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>An interview with the food service manager on May 16, 2024, at 12:11 p.m., confirmed sanitary conditions should be maintained in the kitchen and pantries to prevent 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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>43944</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice, by failing to ensure that a resident's clinical record included details related to injuries sustained post incidents with changes in medical status for one out of 15 sampled residents (Resident 38).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>A review of Resident 38's clinical record revealed that the resident was admitted to the facility September 28, 2026, with diagnoses to include muscle weakness, unsteadiness on feet, multiple rib fractures to the right side, and symbolic dysfunction [refers to the breakdown in communication caused by misinterpretation or misunderstanding of symbols that can significantly impact one's ability to effectively communicate and understand others].</p> <p>A review of Resident 38's comprehensive person-centered plan of care that was initiated on September 28, 2016, identified that the resident required extensive assistance with activities of daily living (ADLs) and was a potential risk for falls related to non-compliance with safety interventions. Planned interventions included extensive assistance with personal hygiene and dressing, assist of one-person with transfers, assist with tasks as needed, and observe and report any changes in cognitive status.</p> <p>An annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 1, 2024, revealed that the resident was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and ability to register and recall new information).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a nurse's progress note completed by Employee 1, a Registered Nurse (RN), dated April 15, 2024, at 6:22 a.m., indicated that the resident was assessed and an abrasion to left shin and a small laceration above left eyebrow. Blood already clotting when found by staff. Resident not on blood thinners. No LOC suspected. Resident sitting with back against right side of bed with drops of blood toward HOB (head of bed). Resident denied discomfort, pupils equal and reactive, hand grasps strong and equal, ROM (range of motion) of lower extremities at baseline with no pain/deformity noted on palpation of joints of lower extremities and upper extremities. Non-skid socks on and resident stated that he fell when he tried to go from his bed to his wheelchair. Stated that he did not ring his bell beforehand but did ring bell once he sat himself up from laying on the floor. Physician made aware of fall with new orders for Vaseline to laceration on forehead and xeroform to abrasions shins. Neuro-checks and every 15-minute checks initiated.</p> <p>Further review of nurses' progress notes dated April 15, 2024, at 1:37 p.m., revealed that Resident 38 was transferred to the emergency department (ED) for evaluation, resident congested with bilateral decreased breath sounds, nonproductive cough noted. Oxygen (O2) saturation at 88% on room air. O2 via nasal canula at 2 liters and 92% after O2 (oxygen) applied. Responsible party, daughter, notified of transfer and will meet the resident at the ED. Resident was awake and responsive to staff on transfer.</p> <p>A review of the resident's hospital history and physical examination from trauma surgery dated April 15, 2024, at 2:21 p.m., revealed that Resident 38 present to the emergency department as a Level 2 trauma [(Potentially Life Threatening): A Level of Trauma evaluation for a patient who meets mechanism of injury criteria with stable vital signs pre-hospital and upon arrival], and resuscitation performed by trauma team after a fall that occurred sometime overnight at the nursing facility and was reported that they {facility staff} found him with a black eye at 5:30 a.m., but did not call the ambulance. They {facility staff} indicated that the resident was more lethargic than usual and indicated that he had a positive head strike. Resident was admitted with mild bibasilar atelectasis [A condition where lungs collapse partially or completely. Mild cases show no signs and symptoms, but might develop breathing difficulty when it spreads.].</p> <p>The facility failed to ensure that licensed nursing staff accurately documented the findings of injuries sustained post fall in Resident 38's clinical record, such as the resident's sustained head trauma to the left side of forehead and abrasion to the left lower leg.</p> <p>An interview with the Director of Nursing (DON) on May 16, 2024, at 6:25 p.m., confirmed that the facility failed to ensure that licensed nursing staff accurately recorded findings of injuries sustained post fall and event details in Resident 38's clinical record.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43944</p> <p>Based on a review clinical record, the facility's plan of correction from the survey ending May 16, 2024, observations and the outcome of the activities of the facility's quality assurance committee it was determined that the facility failed to develop and implement a quality assurance plan, which was able to identify, and correct ongoing quality deficiencies related to providing a safe, clean and homelike environment.</p> <p>Findings included:</p> <p>The facility developed a plan of correction that included that all areas identified were cleaned or repaired as needed and a walk thru was performed on the remaining areas to identify any similar concerns. Any area identified were cleaned/repared as appropriate. A new system would be placed into effect with the Department Heads. Each Department Head would be assigned areas to monitor on a weekly basis. The days and times of these Ambassador Rounds would be random, assuring the chances for compliance. Any issues identified during these rounds, would be discussed during stand-up or stand-down meetings. Housekeeping and Maintenance staff were educated by the Maintenance Director on proper cleaning methods. The Administrator would perform walk through to identify any similar concerns and would monitor tour times per week for four weeks. Results would be reviewed by the QA Committee for 2 months, then reevaluated.</p> <p>This corrective active plan was to be in place by June 11, 2024.</p> <p>However, continued deficient practice was identified under this same requirement at the time of this revisit survey conducted June 18, 2024, based on observations on the resident unit.</p> <p>Observations of resident rooms within Lilac Hall (rooms 101-106 and 108), [NAME] Hall (109- 116), and Peach/Blue Hall (rooms 118, 120, 122, 124, and 127 - 132, and 135 - 142) on June 18, 2024, at 9:30 a.m., revealed that the entryways of resident rooms had an approximate 1/4 inch height differences between the new hallway flooring and the old floor inside the resident rooms creating an uneven surface for ambulation and mobility.</p> <p>The floor molding was missing from the floor at the bottom of the nurse's station and the walls presented black scuff marks.</p> <p>Observation of the resident shower room on June 18, 2024, at 9:43 a.m., revealed that inside the last stall, on the left side of the room, were nursing supplies, red plastic bins, a mattress, and other equipment stored in the bathroom stall.</p> <p>Interviews with three cognitively intact residents, Residents A8, A9, and A10 on June 18, 2024, at 12:10 p.m. , revealed the resident unit has been under construction for months, but there is no work going on from the construction crew for a few months. The construction crew left the areas unfinished, which does not create a homelike environment for residents.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the resident shower room area and in the presence of the facility's Assistant Director of Nursing (ADON) on June 18, 2024, at 2:45 p.m., revealed that between this handwashing sinks, on the left side of the room. there were two hand-held hair dryers hanging from their cords and were plugged into the electrical outlet creating a potential electrical accident hazard.</p> <p>The facility's quality assurance monitoring plans designed to ensure solutions were sustained, failed to identify the continuing deficient practice with these quality requirements and prevent recurrence of similar deficient practice as cited during the survey of May 16, 2024.</p> <p>Refer F584</p> <p>28 Pa. Code 201.18(e)(2.1) Management.</p>