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Form Approved OMB
No. 0938-0391

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 07/22/2024
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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview it was determined that the facility failed to provide care consistent with a resident's advanced directive and honor the resident's requests for future treatment for one resident out of four sampled (Resident 1). Findings include: A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include dementia and hypertension. An admission minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 7, 2024 revealed the resident to be severly cognitively impaired with a BIMS (Brief Interview for Mental Status) is a tool to screen and identify the cognitive condition of residents in long-term care facilities) score of 00(0 to 7 indicates sever cognitive impairment) and required maximum assistance of staff for activities of daily living. An nursing admission assessment dated [DATE] at 6:20 PM did not indicate the resident's code status or wishes for future healthcare. Further review of the resident's clinical record revealed that the resident had a Healthcare Directive (a legal document indicating the residents health care wishes, signed prior to admission to the facility) dated February 7, 2022, which indicated that the resident was a DNR (resident did not wish to be resuscitated if the resident experienced cardiac arrest) and do not hospitalize. This document was not uploaded to the residents electronic record until April 4, 2024, three days after the resident's admission to the facility. A review of a nurse's note dated April 1, 2024, at 10:18 PM revealed that a nurse aide notified the licensed nurse that Resident 1 was in bed and unresponsive. The resident's vital signs were stable according to the entry. The nurse attempted a sternal rub (A sternal rub is a firm rub on someone's sternum is a method used when testing an unconscious person's responsiveness) on the resident and the resident responded. The physician was contacted and the resident was sent to the hospital later that night, on April 2, 2024. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on July 22, 2024, at 12 PM the Director of Nursing (DON) stated that the nurse on duty when Resident 1 was admitted to the facility was an agency nurse. This agency nurse failed to note the resident's code status when she was verifying the resident's admission physicians order. The DON confirmed that facility staff were unaware of Resident 1's advanced directive healthcare wishes, for no hospitalization , on the day of the resident's admission, and sent the resident to emergency room [DATE]. The resident's baseline care plan was dated April 3, 2024, noted that the resident's code status as DNR, do not resuscitate and do not hospitalize. The resident's baseline care was completed after the resident had been hospitalized on [DATE]. 28 Pa. Code 201.24 (e)(4) Admission policy 28 Pa. Code 201.29 (a) Resident rights

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and grievances lodged with the facility and staff interview it was determined that the facility failed to ensure that residents receive services to maintain hearing ability for one of four residents sampled (Resident 1). Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE] with diagnoses to include dementia and hypertension. An admission minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 7, 2024, revealed that the resident was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) is a tool to screen and identify the cognitive condition of residents in long-term care facilities) score of 00 (0 to 7 indicates severe cognitive impairment) and required maximum assistance of staff for activities of daily living. An admission nursing assessment dated [DATE], revealed that Resident 1 was admitted to the facility with bilateral hearing aids. A nurse's note dated May 16, 2024, at 12:03 PM indicated that nursing noted that Resident 1 had only one hearing aid at her bedside. A social services note dated May 21, 2024 at 12:55 PM, revealed that social services searched Resident 1's room and was unable to locate the resident's other hearing aid. The resident's belongs and laundry were also searched with no success in finding the resident's second hearing aid. A review of grievance dated May 21, 2024, that the resident's daughter filed with the facility on behalf of the resident revealed that one of the resident's hearing aids was missing. The resident's daughter stated that she purchased the new hearing aides for the resident, two weeks prior and was upset that the facility lost them. The facility's response to the resident's daughter's grievance regarding the loss of one of the new hearing aids, dated May 21, 2024 indicated that the resident's old pair of hearing aids (the hearing aids the resident had upon admission) were put into her ears. The facility's response noted that the resident's daughter stated that she had insurance on the hearing aids and would put a claim in. There was no evidence at the time of the survey ending July 22, 2024, that the facility assisted the resident in replacing the missing hearing aid, including assisting the resident and their representative in locating resources, as well as in making appointments, and arranging for transportation to replace the lost devices. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview July 22, 2024 at 12 P.M., the Director of Nursing and the Nursing Home Administrator (NHA) stated that hearing aids are kept at the resident's bedside and nursing staff assisted resident with application and removal. The NHA stated that the resident's daughter was going to put a claim into her insurance to replace the hearing aid, but the facility had made no plans to place to the device or assist the resident's daughter in securing its replacement. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 201.29 (a) Resident rights