STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395984	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Creekside	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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on resident billing record review, clinical record review, facility document review, and staff interview, it was determined the facility failed to provide advance written notice of a per diem (daily) room rate increase for 1 of 2 residents reviewed for billing notification of charges (Resident 1). Findings include: Clinical record review revealed that Resident was admitted to the facility June 15, 2022, with diagnosis including, but not limited to, diabetes. An admission Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 5, 2025 revealed the resident was cognitively intact with a BIMS score of 13 (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 indicates intact cognition). Documentation indicated the resident was his own responsible party, with his sister listed as an emergency and HIPAA contact (Health Insurance Portability and Accountability Act federal standards to protect protected patient healthcare information). Review of the resident's billing statement on April 3, 2025, revealed that as of December 1, 2024, the resident was charged a daily per diem room rate of $350.00. Review of the billing statement for February 1, 2025, and March 1, 2025, revealed the per diem room rate increased to $550.00. Review of facility documentation provided during the survey revealed that on March 4, 2025, the resident's sister contacted the Nursing Home Administrator (NHA) via email. The email stated: NHA, thank you for providing me with the letter regarding the increase of daily room and board dated January 6, 2025, the increase from $350.00 to $550.00. Prior to you providing me this letter, today March 4, 2025, neither I nor my brother (Resident 1) saw this letter. A review of documentation provided by the facility at the time of the survey dated March 4, 2025, the resident's sister contacted the Nursing Home Administrator (NHA). The e-mail stated, NHA, thank you for providing me with the letter regarding the increase of daily room and board dated January 6, 2025, the increase from $350.00 to $550.00. Prior to you providing me this letter, today March 4, 2025, neither I nor my brother (Resident 4) saw this letter. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence provided by the facility that Resident 1 and/or his representative were notified in writing of the per diem room rate increase prior to the effective date of February 1, 2025. During an interview on April 3, 2025, at 2:00 PM, the NHA confirmed that the notice of the private pay per diem room rate increase was not sent timely to Resident 1 and/or his representative. 28 Pa Code 201.29(c)(1) Resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, investigative reports, staff interviews, and facility documentation, it was determined the facility failed to consistently ensure adequate supervision, staff training, and implementation of appropriate individualized interventions to prevent accidents for three residents (Residents 1, 2, and 3) out of 10 sampled resulting in harm including skin ters, lacerations and a head injury requiring staples. Findings include: A review of clinical records revealed that Resident 1 was admitted to the facility on [DATE] with diagnosis to include Picks Disease (condition that affects the brain leading to inappropriate behavior and language difficulties), psychotic disorder with hallucinations (a mental health condition that may include hearing things, false beliefs based on reality, and difficulty sustaining activities), and muscle atrophy (loss of muscle tissue, resulting in decreased strength) and a history of falling. A Quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 3, 2025, revealed that the resident was cognitively impaired with a BIMS score of 0 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 0-7 indicates severe cognitive impairment) and required assistance for activities of daily living. A review of a Morse Fall Score (MFS is a rapid and simple method of assessing a patient ' s likelihood of falling) dated February 10, 2025, indicated Resident 1 was at high risk for falls. A review of the resident's plan of care initially dated June 6, 2024, last revised March 6, 2025, revealed that the resident was at risk for falls related to agitation, instability, and muscle weakness. Further it was indicated the resident required assistance of 1 with transfers, bed bolsters to define the edge of the bed and staff to keep the resident's environment clutter free. Despite these documented risks and interventions, the resident experienced multiple falls with injuries. Nursing documentation dated December 9, 2024, at 4:30 AM revealed the resident had fallen from the bed and was found on the floor. The resident was noted to be restless and incontinent of a large amount of urine. The bed alarm was in place but failed to sound. Nursing documentation dated February 10, 2025, at 9:34 PM revealed the resident had another fall from bed with no injury noted. The resident was placed on 15-minute checks as an intervention to prevent future falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility investigation report dated March 16, 2025, at 12:52 AM documented that Employee 1 (Nurse Aide) approached the doorway of Resident 1's room and observed the resident to be restless and climbing out of bed. The employee reported leaving the room to request assistance in getting the resident into her chair. While the resident was left unsupervised, she rolled out of bed and struck her head on the corner of the nightstand located at the head of the bed. The resident sustained a laceration to the left side of her head above the temple (the flattened area on either side of the head, situated between the forehead and ear, and behind the eye), measuring 2 cm x 2 cm x 1 cm, and was actively bleeding. Resident 1 was documented as requiring extensive assistance with both transfers and bed mobility. Following the fall, neuro checks and vital signs were initiated, the physician was notified, and the resident was transferred to the hospital for evaluation and treatment. A witness statement from Employee 1, dated March 15, 2025, corroborated the above events, stating that she had passed by Resident 1's room and observed the resident slightly moving in bed. She acknowledged the resident was restless and that she turned away to get help. When she returned, the resident was found on the floor with the bed alarm sounding, and blood was visible on the corner of the dresser. A review of a witness statement dated March 15, 2025, no time indicated, revealed Employee 5 agency LPN (licensed practical nurse) revealed that Employee 1 had come out of Resident 1's room to ask for assistance because the resident was attempting to crawl out of bed. Employee 5 stated that before assistance could be rendered, a bang was heard, and the resident was found on the floor. A review of hospital documentation dated March 16, 2025, revealed that Resident 1 was evaluated in the emergency department following the fall. The resident was diagnosed with a 2 cm x 2 cm x 1 cm laceration to her left eyebrow area, which required closure with five sutures. A CT scan (computed tomography head scan uses X-rays to develop a 3D image of the skull, brain, and other related areas) of the head was performed, revealing a thin subdural hematoma (brain bleed). A nursing progress note dated March 16, 2025, at 9:03 AM documented that Resident 1 returned to the facility with five sutures and bruising to the left temple. In response to family concerns, a sign was placed on the wall where the nightstand had been located, stating that no furniture should be placed at the head of the bed. A review of the resident's plan of care for fall risk revealed that a new intervention was added on March 18, 2025, which included the removal of the nightstand from the resident's room per family request. In an interview conducted on April 3, 2025, at 1:30 PM, the Director of Nursing (DON) confirmed that prior to the fall on March 16, 2025, the nightstand had been moved to the foot of the bed at the family's request. However, during a routine deep cleaning, the nightstand was inadvertently returned to the head of the bed. During the fall, Resident 1 struck her head on the nightstand, resulting in a laceration and subdural hematoma. The DON also acknowledged that Employee 1 should not have left the resident unattended, especially given the resident's restlessness, history of falls, and need for extensive assistance. The facility failed to provide appropriate supervision by leaving the room when Resident 1 was agitated and trying to climb out of bed resulting in the resident failing from bed causing the resident to sustain a laceration requiring sutures and a brain bleed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of manufacturer's instructions for the use of a Broda chair, dated February 2022, included, chair assessments, positioning adjustments, and mobilization handling must be performed by professionals who have been trained for this purpose. Before using the chair, caregivers must have received adequate training from the chair manufacturing company or a trained third party. Recommended instructions for the use of the chair to include, to tilt the chair forward for the resident to stand and transfer out of the chair and for a more upright position while eating. Improper uses of the chair to include, transferring/transporting the resident without using the tilt function. A review of a facility investigation report dated March 21, 2025, at 9:26 AM revealed that Resident 1 fell from her Broda chair (reclining wheelchairs that offers tilt, recline and leg rest adjustments) while being transported from the dining room to the activity room by Employee 2 (Activity Aide). At the time of transport, the Broda chair was in the upright position, which is intended for eating and not for safe transport, a reclined position is utilized for transport. During the incident, the resident sustained two lacerations, measuring 3 cm x 1 cm and 2 cm x 1 cm, along with a raised area and a hematoma (a localized collection of blood) to the right side of her forehead. The attending physician, who was on site, assessed the resident, and the responsible party declined hospital transfer. A witness statement dated March 21, 2025, at 9:00 AM, from Employee 2, documented that while she was pushing Resident 1 in the Broda chair, the resident began rocking forward. As the employee attempted to stop the chair, the resident leaned forward and fell out, resulting in injury. During an interview conducted on April 3, 2025, at approximately 2:30 PM, Employee 2 stated she had recently started working at the facility and had not received training on the use or adjustment of the Broda wheelchair. She explained that she was responsible for transporting residents from the dining room to the activity room but did not adjust the chair into the reclined position prior to transport on March 21, 2025. Employee 2 was unaware the upright position was not appropriate for transport. In an interview with Employee 3 (Activities Director) on April 3, 2025, at approximately 10:00 AM, it was confirmed that Employee 2 was new and on orientation at the time of the incident. Employee 3 further stated that Employee #2 had not been trained on the proper positioning and handling of the Broda chair during transport. In a separate interview with Employee #4 (Activities Aide) on April 3, 2025, at approximately 12:30 PM, the staff member explained that activity aides were expected to assist with transporting residents but were not permitted to adjust or reposition specialized chairs such as the Broda chair, either before or after transport. In an interview with the Nursing Home Administrator (NHA) conducted on April 3, 2025, at approximately 1:00 PM, the NHA acknowledged the facility had not provided training to staff on the proper use and positioning of the Broda chair. A clinical record review revealed Resident 3 was admitted to the facility on [DATE] with diagnosis to include dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and atrial fibrillation (an irregular heartbeat). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A quarterly MDS assessment dated [DATE], revealed the resident was severely cognitively impaired with a BIMS score of 4. A review of the resident's care plan, initiated on April 10, 2024, identified the resident as being at risk for falls related to declining functional status. Interventions included assistance of one staff member for transfers. However, the care plan did not define the level of assistance required for bed mobility or toileting, despite the resident's increasing physical and cognitive decline. The resident was also noted to be resistive to care, with the only documented intervention being to leave and re-approach after five to ten minutes if care was refused. There was no care card or [NAME] (a list of instructions for nurse aide staff to ensure the provision of care provided is accurate) in use January 29, 2025, to guide nurse aide staff on the number of staff required or the method of assistance needed for bed mobility or toileting tasks. The following incidents involving Resident 3 were identified. January 29, 2025, at 8:37 AM: A facility investigative report and nursing documentation indicated the resident was found on the floor with a 2 cm x 2 cm abrasion to the center of his lower back. The physician was notified, and a treatment plan was obtained. There was no indication of a witnessed fall, or documented interventions reviewed or revised following this incident. February 6, 2025, at 7:15 PM: facility investigative documentation and nursing documentation noted the resident fell from the bed during provision of care. A 0.3 cm x 0.4 cm skin tear was observed on his left heel. A review of Employee 9's NA witness statement dated February 6, 2025, at 7:15 PM, indicated the employee was in the middle of changing Resident 3 in bed when he became agitated and rolled out of the bed onto the floor. Employee 9 stated she yelled out for help. A review of a witness statement from Employee 8 (LPN) dated February 6, 2025, at 7: 15 PM stated that Employee 9 had informed her the resident had fallen while being changed. It was indicated that the resident rolled over too far and fell onto the floor. There was no documentation indicating that two staff were present, nor was there evidence the care plan had been updated to address agitation during care or to require additional staff during bed mobility. A review of a facility investigative documentation and nursing documentation dated March 8, 2025, at 8:00 PM, indicated the resident was again found on the floor after having previously been in bed. No injuries were noted, and the physician was contacted. A new intervention to apply nonskid strips on the floor to the right side of the bed was implemented. A review of a facility investigative documentation and nursing documentation dated April 2, 2025, at 1:45 AM revealed Resident 3 was found in bed with active bleeding. Assessment revealed a 1.5 cm x 1.5 cm V-shaped laceration on the back of his head and a 10 cm laceration to his lower right arm. The resident reported he had fallen out of bed and then put himself back in bed. Given the resident's use of anticoagulation medication, the physician was notified, and the resident was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility investigation determined the resident had turned off the bed alarm, contributing to the fall. A new intervention to add a magnetic alarm box was implemented after this event to alert staff of unsafe transfers or falls. A review of nursing documentation dated April 2, 2025, at 2:04 AM revealed the resident was transported to the hospital for evaluation and treatment. Nursing documentation dated April 2, 2025, at 6:11 AM revealed hospital staff reported a CT of the head showed negative results, but the resident required two staples to the back of the head and treatment for the arm laceration. The resident returned to the facility at approximately 10:40AM. Despite multiple incidents and injuries, there was no documented evidence that the facility implemented effective and individualized interventions to prevent the recurrence of falls. The care plan was not updated to reflect changes in the resident's fall patterns, behavioral triggers, or the need for increased staff assistance during personal care tasks. In an interview with the Nursing Home Administrator (NHA) on April 3, 2025, at 3:00 PM, the NHA confirmed the facility failed to implement effective interventions to address and prevent repeated falls for Resident 3. The NHA acknowledged that despite known behavioral risks and multiple incidents, the care plan and staff guidance had not been adequately revised or communicated. A review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnosis to include chronic obstructive pulmonary disease (COPD a progressive lung disease causing difficulty with breathing). A quarterly MDS assessment dated [DATE], revealed the resident to be cognitively intact with a BIMS score of 14 (13 to 15 indicates cognitively intact), required staff assistance for activities of daily living and utilized a wheelchair for mobility. A wander risk assessment dated [DATE], identified the resident to be at moderate risk for wandering, and the resident was provided a Wander guard (an electronic device that alerts staff when a resident approaches an exit). However, a subsequent assessment dated [DATE], indicated a low risk for wandering, and the physician's order documented that the Wander guard was discontinued the same day. The resident's care plan for potential elopement related to exit-seeking behavior, initiated on April 24, 2024, included interventions such as frequent location checks, reorientation as needed, providing diversionary activities, and use of a Wander guard. However, following the March 10 assessment, the Wander guard was removed, and other interventions remained in place. A facility investigation report and nursing documentation dated March 21, 2025, at 2:39 PM, documented that the facility received a telephone call at approximately 2:48 PM from an unidentified passerby reporting a resident outside the facility alone. Staff responded and found Resident 2 in the parking area at the edge of facility property near the parking lot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of surveillance footage revealed the resident had exited the resident care area into the lobby at 2:32 PM and left the building through two sets of front doors by 2:39 PM. The footage showed the resident wheeling himself through the parking lot and toward the sidewalk before the resident was safely returned inside at approximately 2:50 PM with no injury noted. A review of Employee 6's (NA) witness statement dated March 21, 2025, at 3:05 PM, revealed the employee stated she was coming back from an appointment when she saw Resident 2 rolling himself away from the building. The employee indicated she called the facility to notify someone he was outside and two staff came outside to get him. A review of Employee 7's NA witness statement dated March 21, 2025, at 2:45 PM, indicated she received a phone call from a man reporting that a resident was wheeling himself through the bushes. She and a nurse (identity unconfirmed) went outside and observed Resident #2. When asked, the resident reportedly stated he was going for a walk. The facility could not provide a witness statement from the second staff member who retrieved the resident, nor was the nurse identified by name. A review of facility documentation revealed the resident wanted to go outside for a walk and was looking for Ivette. Interventions put into place after the incident were to place a Wander guard (a wearable device used in healthcare settings, particularly for memory care or senior living facilities, to help prevent residents from wandering or eloping) on the resident and to initiate every 15-minute checks. In an interview conducted April 3, 2025, at approximately 1:00 PM, the Nursing Home Administrator (NHA) explained that at the time of the incident, the designated front desk receptionist was not on duty. Per facility protocol, the Activity Director (Employee 3) was assigned to monitor the front lobby when the receptionist is unavailable. The NHA confirmed that the lobby doors are typically locked between 4:00 PM and 8:00 AM, with keypad access, but they remain open during daytime hours. He further stated the receptionist normally remains at the desk during her meal breaks. In a follow-up interview with Employee 3 (Activity Director) on April 3, 2025, at 1:30 PM, the employee stated she had been assigned to cover the front desk that day, in addition to her regular duties. She noted that on March 21, 2025, she left the building at approximately 12:30 PM to purchase supplies for a special activity and returned around 1:30 PM. From 1:45 PM to 2:30 PM, she was in the activity room setting up and conducting the event. She then took her break from 2:30 PM to 2:50 PM, during which the front lobby was left unattended. Upon returning, she saw staff bringing Resident 2 back into the building. A review of facility records showed that following the incident, elopement/wander risk assessments were completed on all residents on March 21, 2025, as part of a facility-wide review. In an interview on April 3, 2025, at 3:00 PM, the Director of Nursing (DON) and the NHA confirmed the lobby had been unattended at the time of the incident and acknowledged this contributed to the resident's ability to exit the building. While they acknowledged the lapse in supervision, they emphasized the resident remained on facility property, did not enter the public roadway, and was returned safely without injury. They indicated although the resident was outside briefly, the facility responded promptly, and the resident experienced no physical harm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services