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	05/15/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to ensure that the discharge process honored the resident's preferences and goals and failed to demonstrate that the discharge was appropriate and necessary, for one of six sampled residents (Resident 1). Findings include: Clinical record review revealed the resident was admitted to the facility on [DATE] with diagnosis to include, Wernicke's Encephalopathy (an acute inflammatory hemorrhagic encephalopathy caused by thiamine deficiency, often associated with chronic alcoholism or malnutrition, characterized by loss of muscle coordination, visual disturbances such as diplopia, and confusion), alcohol-induced psychotic disorder, alcoholic cirrhosis of the liver without ascites, and nicotine dependence. Documentation indicated the resident was cognitively intact. While it was noted that the resident had a legal guardian, the facility was unable to produce documentation confirming guardianship status during the survey. A review of a social services note dated May 6, 2025, at 5:49 P.M. revealed, I allowed time for Resident 1 to vent his feelings related to his admission. The resident voiced his desire to move to a different facility located in a neighboring city. The social worker documented that she would contact the guardian the following day to discuss the resident's wishes. A review of a social services note dated May 8, 2025, at 11:14 A.M. revealed, Social Services received a visit from Resident 1's Guardian today. This worker informed the Guardian that the resident would like to move to a facility in a local city. The guardian gave permission for the resident's records to be sent to two local skilled nursing facilities. However, a social services note dated May 15, 2025, at 8:14 A.M., indicated the resident was being transferred to a facility located several hours away from the current facility, contradicting the resident's stated desire to remain in a local setting. A nurses note dated May 15, 2025, at 9:39 A.M. revealed the resident was discharged from the facility to facility identified as located several hours distance away. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on May 15, 2025, at 2:00 P.M., the facility social services worker stated that Resident 1 had clearly expressed his desire to be transferred to a local skilled nursing facility that permitted smoking. The social worker could not explain why the discharge did not align with the resident's expressed preferences, nor was there documentation justifying why an appropriate local discharge option could not be pursued or why the facility was no longer able to meet the resident's needs. The facility failed to demonstrate that the discharge was based on the resident's goals or that it was necessary and appropriate. Furthermore, there was no evidence the resident was involved in the discharge decision-making process in a meaningful way that honored his preferences, nor was there documentation to show that alternative local placement options had been exhausted or deemed unsuitable. Cross refer F 926 28 Pa. Code 201.29(h) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, observation, and resident and staff interviews, it was determined that the facility failed to implement its established smoking policy to ensure resident safety and regulatory compliance. Specifically, the facility failed to post smoking policies in a conspicuous and legible manner, ensure required smoking safety equipment was available in the designated smoking area for 12 residents who smoke, and assess one cognitively intact resident (Resident 1) who requested to smoke for safe smoking practices out of 6 residents sampled. These failures created a potential for fire hazards and compromised resident safety. Findings include: Review of the facility policy titled Resident smoking policy and procedure, no review date available revealed, to ensure compliance with regulatory guidelines and safety protocols, the facility prohibits smoking except for in specifically designed areas. Review of the facility's undated policy titled Resident Smoking Policy and Procedure revealed that smoking is prohibited except in specifically designated areas and outlined the following requirements: The smoking policy must be posted in a conspicuous and legible format for residents, so that they may be easily read by residents, visitors and staff. Each resident must be individually assessed to determine if they can safely smoke with or without supervision. The assessment must include whether a smoking apron is needed, and findings should be documented in both the resident's care plan. Reassessments should occur as necessary. The smoking determination should be noted in the resident's care plan and in a smoking log to be kept on each residential floor. Residents who have been determined to require supervision must be actively supervised by a staff member while in the designed smoking area. Designated areas must be public spaces and may not include bedrooms. Designated smoking areas must include: Signage indicating that smoking is allowed, Easy access to fire extinguishers, Design features that limit secondhand smoke exposure, Noncombustible ashtrays in sufficient number, (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Outside ventilation, Metal containers with self-closing covers for ash disposal During the entrance conference on May 15, 2025, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the facility permits smoking in designated areas. An observation conducted on May 15, 2025, at approximately 1:00 PM revealed nine residents smoking on the patio outside the activity/dining room. Although all were wearing smoking aprons and were being supervised by a staff member, no fire extinguisher or fire blanket was present in the smoking area. No signage indicating this was a designated smoking area or posting of the facility's smoking policy was observed. A locked cabinet inside the facility contained a small fire extinguisher, as reported by the activity director. An observation conducted on May 15, 2025, at approximately 1:00 PM revealed nine residents smoking on the patio outside the activity/dining room. Although all were wearing smoking aprons and were being supervised by a staff member, no fire extinguisher or fire blanket was present in the smoking area. No signage indicating this was a designated smoking area or posting of the facility's smoking policy was observed. A locked cabinet inside the facility contained a small fire extinguisher, as reported by the activity director. Further facility-wide observations, including resident areas and lobby spaces, also failed to identify any postings of the smoking policy. An interview with the Activity Director on May 15, 2025, at 1:15 PM, confirmed that the smoking policy was not posted in the designated patio area, and that no fire safety equipment (e.g., fire extinguisher or fire blanket) was located outside where residents smoked. She stated that there was a small fire extinguisher located in the locked activity cabinet in the dining room She confirmed that 12 residents regularly participate in smoking multiple times of day, and the patio is used frequently. Clinical record review for Resident 1, admitted [DATE], with diagnoses including Wernicke's encephalopathy (a neurological disorder characterized by confusion, lack of coordination, and memory loss caused by thiamine deficiency), and nicotine dependence, revealed that the resident was cognitively intact. A Social Services note dated May 8, 2025, at 2:03 PM, documented that Resident 1 was observed on the smoking patio with peers and grabbed a cigarette butt from the ashtray and a lighter from a staff member's hand to light the cigarette. Social Services intervened and explained the smoking policy. The resident complied and extinguished the cigarette. Subsequent documentation from the Activity Department (May 8, 2025, 4:32 PM) and Social Services (May 8, 2025, 4:45 PM) recorded that Resident 1 became agitated when denied access to the smoking patio and was told he could not participate until assessed by nursing. A nursing progress note dated May 10, 2025, at 3:31 PM, documented Resident 1 became verbally aggressive, banged on the door, and had to be redirected after being denied access to smoke. Another staff member was able to calm the resident and escort him back to his room. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON and NHA on May 15, 2025, at approximately 1:30 PM, confirmed the facility failed to implement its smoking policy as written. Specifically, the DON acknowledged that Resident 1 had not been assessed for safe smoking and confirmed that required safety postings and equipment were not in place in the designated smoking area. The facility failed to assess residents for safe smoking, ensure required fire safety equipment was present in the smoking area, and post smoking policies in accordance with its established procedures. Cross refer F 627 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 209.3 (a) Smoking.