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	07/31/2025

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 - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 of a private pay rate increase for 1 of 2 residents reviewed for billing notification of charges (Resident 18).Findings include: Resident 18 was admitted to the facility on [DATE], with diagnoses including frequent falls and pneumonia (a lung infection caused by various germs such as bacteria, viruses, or fungi). A quarterly Minimum Data Set (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 21, 2025, indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 (a tool used to assess a resident's attention, orientation, and ability to register and recall information; a score of 13-15 indicates intact cognition). Documentation further indicated the resident was his own responsible party, with his daughter listed as the emergency contact and Health Insurance Portability and Accountability Act (HIPAA) contact (HIPAA is a federal law that protects patient health information). A review of the facility's admission Agreement revealed that the facility is responsible for providing at least 60 days' written notice to the resident or the resident's representative before any financial rate increase takes effect. Review of Resident 18's billing statements revealed that on April 1, 2025, the monthly charge was $1,200. The billing statements for May 1, June 1, and July 1, 2025, reflected a monthly charge of $1,567.18. There was no documented evidence that the resident or his representative had been provided advance written notice of this rate increase prior to the increased charges being applied. A review of facility documentation showed that on July 2, 2025, the resident's daughter emailed Employee 5, the Business Office Manager, inquiring about the increased billing amount and requesting clarification on the charges. In the facility's email response, it was stated that the higher bill reflected the balance in the event the resident was not approved for Medicaid, and that the lower bill reflected the resident's Social Security amount due to the facility. During an interview on July 31, 2025, at approximately 10:00 a.m., Employee 5 confirmed that written notification of the private pay rate increase had not been provided to Resident 18 or his representative prior to the implementation of the increased charges. 28 Pa Code 201.29(c)(1) Resident rights.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports and interviews with staff and residents it was determined the facility failed to ensure that one resident (Resident 49) out of 19 residents sampled was free from physical abuse perpetrated by a facility staff member This failure to prevent, identify, and respond appropriately to physical abuse placed Resident 49 and all other residents in the facility at risk for further harm, resulting in Immediate Jeopardy.Findings include: A review of a facility policy entitled Abuse Policy, last reviewed July 8, 2024, revealed it is the policy of the facility that acts of physical, verbal, phycological and financial abuse directed against residents are absolutely prohibited. Eash 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. Further under the section titled Protection, stated that residents will be protected from harm during the investigation of allegations of abuse. A review of Resident 49's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life). A Quarterly Minimum Data Set Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 20, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 2 (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 equates to being severely cognitively impaired). A review of facility investigative documentation dated July 4, 2025, at 7:45 PM documented that Employee 1 (Nurse Aide) reported to Employee 2 (Registered Nurse Supervisor) that Employee 3 (Nurse Aide) had physically abused Resident 49 while providing care. Employee 1 alleged that Employee 3 roughly pushed the resident's head back while the resident was in a mechanical lift (Hoyer lift) during a transfer. After the transfer, Employee 3 allegedly grabbed the resident's hands and pinned them to her chest to prevent the resident from pulling at her own clothing. The resident was assessed and found to have two areas of discoloration on her left hand. Employee 3 was removed from the unit, escorted out of the facility and placed on administrative leave. A written witness statement from Employee 1 dated July 4, 2025, confirmed Employee 1 and Employee 3 were providing care to Resident 49. According to Employee 1, while the resident was in the Hoyer lift her head was close to the bar on the lift, and Employee 3 pushed the residents head back roughly to keep her head from hitting the bar. Further stating that Employee 3 pinned the resident's hands to her chest to keep the resident from grabbing her clothing while yelling in the resident's face. A review of a written witness statement from Employee 4 NA also dated July 4, 2025, revealed she entered Resident 49's room to retrieve the Hoyer lift and observed Employee 3 push the resident's head roughly. She stated that Employee 3 appeared frustrated, grabbed a brief from the resident's hand, and threw it across the room. She also witnessed Employee 3 pin the resident's hands to her chest to prevent her from grabbing her clothing. Further investigation conducted onsite on July 29, 2025, revealed that an earlier incident involving potential staff-to-resident abuse occurred on July 4, 2025, prior to the confirmed physical abuse of Resident 49. During an interview conducted with Employee 1 (Nurse Aide) at approximately 12:30 p.m., Employee 1 disclosed to the survey team that prior to providing care to Resident 49, on July 4, 2025, she and Employee 3 (Nurse Aide) had also provided care to another resident (Resident 8). Employee 1 stated that Resident 8 had been attempting to pull up her pants during care and that Employee 3 had responded by roughly grabbing Resident 8's hand. Employee 1 described Employee 3's actions as aggressive and concerning. Employee 1 further stated that immediately after completing care for Resident 8 and just prior to beginning care for Resident 49, she approached Employee 2 (the RN Supervisor on duty at the time) to express concern about Employee 3's conduct. Employee 1 stated that because other staff were present at the time, she and Employee 2 were unable to complete their discussion about the incident involving Resident 8. However, she stated she asked Employee 2 to come observe the care being provided to Resident 49 due to her concerns about the way Employee 3 had treated Resident 8. Employee 1 stated that Employee 2 responded by saying she needed a minute, and did not accompany them. Employee 1 then proceeded to assist Employee 3 with providing care to Resident 49 without any supervisory oversight. An in-person interview with Employee 2, conducted at approximately 12:45 p.m. the same day, revealed that she denied receiving any report or concern from Employee 1 regarding Employee 3's treatment of Resident

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of the facility's abuse prohibition policy, it was determined that the facility failed to ensure allegations of abuse were reported to the State Survey Agency within 24 hours of the incident and failed to submit completed investigation findings within five (5) working days, for two of four abuse allegations reviewed (Residents 8 and 9).Findings include: A review of the facility policy entitled Abuse Policy, last reviewed July 17, 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. Under the section titled Investigation and Reporting, the policy states the Administrator, Director of Nursing (DON), or designee shall notify the Department of Health Event Reporting System and will notify the Adult Protective Services Area Agency on Aging within 24 hours of an alleged incident. A report of abuse will be submitted within five (5) working days to the Department of Health. The Administrator/designee is responsible for operationalizing all policies and procedures that prohibit abuse and neglect and is required to report instances of suspected or actual abuse or neglect occurring within the facility. Abuse coordinators are the Administrator and the DON/designee of the facility, who shall coordinate all investigations ensuring resident safety and report findings to regulatory agencies as required. Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/DON immediately and initiate gathering requested information. An investigation must be conducted by the Administrator or designee immediately and no later than twenty-four (24) hours after the knowledge of the alleged incident. The Administrator, DON, or designee shall notify the Department of Health via the Event Reporting System electronically, or by phone in the event the electronic system is unavailable. Upon receiving an incident or suspected incident of resident abuse, the Administrator/DON/designee will conduct an investigation and report all alleged violations timely, thoroughly, and objectively, with corresponding reports submitted within five (5) working days to the appropriate agency. A review of Resident 8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change). A review of a Quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 6, 2025, revealed the resident was severely cognitively impaired with a BIMs score of 2 (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 equates to being severely cognitively impaired). During an interview with Employee 1 nurse aide (NA) on July 29, 2025, at approximately 12:30 p.m., she disclosed an incident involving Employee 3 (NA) and Resident 8 that had occurred on July 4, 2025. Employee 1(NA) reported that while assisting Resident 8 with care, Employee 3 (NA) roughly grabbed the resident's hand to stop her from pulling at her pants. Employee 1(NA) stated she immediately shared her concerns with Employee 2 Registered Nurse (RN) that the act was aggressive and inappropriate. This disclosure during the survey interview was the first time surveyors became aware of the alleged incident. Upon follow-up with the DON at 1:00 p.m. on July 29, 2025, it was confirmed that the facility had not reported this allegation of physical abuse to the State Survey Agency within 24 hours of the event. A review of a written witness statement completed by Employee 1(NA) on July 4, 2025, documented that Employee 3 (NA) had roughly grabbed Resident 8's hand during care, and that Employee 1(NA) felt uncomfortable with the interaction, describing it as aggressive. Further review determined that the facility did not submit a complete investigation to the State Survey Agency within five (5) working days of the incident, as required by policy. The DON confirmed during an interview on July 29, 2025, at 11:25 a.m., that neither the timely reporting requirement nor the investigation submission requirement had been met. Resident 9 was admitted [DATE], with diagnoses including Parkinson's disease (a progressive neurological disorder affecting movement), aphasia (difficulty communicating), and epilepsy (a seizure disorder). An annual MDS dated [DATE], documented a BIMS score of 3, indicating severe cognitive impairment. A review of Resident CR1's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included stage 3 chronic kidney disease (CKD) refers to permanent damage to the kidneys that occurs gradually over time) and [NAME] Syndrome (is a rare genetic disorder caused by a loss

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse prohibition policy and information provided by the facility it was determined the facility failed to promptly conduct a thorough investigation to rule out abuse and implement corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by two of 4 residents reviewed (Resident 9 and 8).Findings include: A review of the facility's Abuse Policy that was last reviewed by the facility on July 17, 2025, indicated the Administrator/designee was responsible for operationalizing all policies and procedures that prohibit abuse and neglect and are required to report instances of suspected or actual abuse or neglect occurring within the facility. Abuse coordinators are the Administrator and the Director of Nursing (DON)/designee of the facility. They shall coordinate all investigations ensuring resident safety, and report the findings to the regulatory agencies, as required. Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/DON immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately and no later than twenty-four (24) hours of knowledge of the alleged incident The Administrator, DON, or designee shall notify the Department of Health, via the Event Reporting System electronically, or by phone in the event of the electronic system being unavailable. Further review of the facility's abuse policy indicated that upon receiving an incident or suspected incident of resident abuse, the Administrator/DON/designee will conduct an investigation to include, but not limited to the following: complete designated report form for investigation or abuse, interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident; interview the resident's attending physician and review the resident's clinical record; interview staff members (on all shifts) having contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, or visitors; interview other residents to which the accused employee provided care or services; and review all circumstances surrounding the incident. The Administrator/DON is responsible to receive and investigate all alleged violations timely, thoroughly, and objectively. A review of Resident 8's clinical record revealed admission on [DATE], with diagnoses including unspecified dementia (a progressive loss of intellectual function affecting memory, reasoning, and behavior). A review of a Quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 6, 2025, revealed the resident was severely cognitively impaired with a BIMs score of 2 (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 equates to being severely cognitively impaired). During an interview with Employee 1, a Nurse Aide (NA), on July 29, 2025, at approximately 12:30 p.m., stated there was an incident with Employee 3, NA, and Resident 8 on July 4, 2025. Employee 1 stated that Employee 3 had grabbed Resident 8's hand roughly to stop her from grabbing her pants while they were providing care to the resident. Employee 1 stated she went to Employee 2, the Registered Nurse (RN), with concerns that Employee 3, NA, had roughly grabbed Resident 8's hand while they were providing care. A review of a written witness statement completed by Employee 1, NA, on July 4, 2025, indicated that while providing care to Resident 8 with Employee 3, NA, she had roughly grabbed the resident's hand to stop her from grabbing her own pants. Employee 1 NA stated that she felt uncomfortable with the way Employee 3 NA had treated the resident indicating it was aggressive. There was no documented evidence of a complete investigation as required by the facility's abuse policy. Missing elements included completion of the investigation form, interviews with all staff on the shift having contact with the resident, notification to the physician and responsible party, and interviews with other residents cared for by the alleged perpetrator. During an interview on July 31, 2025, at approximately 12:00 p.m., the DON confirmed no documentation existed showing the facility had conducted an investigation consistent with the abuse policy. A review of Resident CR1's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included stage 3 chronic kidney disease (CKD) refers to permanent damage to the kidneys that occurs gradually over time) and [NAME] Syndrome (a rare genetic disorder caused by a loss of function of specific genes and begins in childhood. Individuals affected become constantly hungry, which often leads to obesity and type 2 diabetes and may cause mild to moderate intellectual impairment and behavioral problems). Review of Resident CR1's admission MDS (Minimum Data Set a federally mandated standardized assessment process