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 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)

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

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 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

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 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)

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 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

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

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 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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and interviews with staff, it was determined the facility the facility did not identify and respond to significant unplanned weight loss for one of 20 sampled residents . (Resident 9).Findings include: A clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease (a progressive neurodegenerative disorder that primarily affects movement often causing tremors, muscle stiffness and balance problems) A clinical record review revealed Resident 9 weighed 133.5lbs on March 12, 2025. The clinical record revealed the resident weighed 111lbs on April 18, 2025, indicating a significant weight loss of 16.9% over 37 days. Meal intake records documented the resident's consumption was variable, ranging from 25% to 100% of meals offered. Review of a dietary note dated April 20, 2025, at 09:18AM (two days after the weight loss was documented), indicated the resident had an unplanned significant weight loss confirmed by re-weight for one month. The progress note further revealed the resident previously received nutritious dessert cups with meals. The note further revealed the resident was to receive nutritious dessert cup twice daily to promote weight gain. A review of the clinical record revealed no documentation indicating that the nutritious dessert cups were offered or consumed with meals as recommended. The record also lacked documented evidence that the resident's physician and resident representative were notified of the significant weight loss, as required by professional standards and regulatory guidance. An interview with Employee 6 (Registered Dietician) conducted on July 31, 2025, at 10:08AM, revealed that when a resident experiences a significant weight loss, the resident is to be placed on weekly weights and have monthly nutritional assessments to ensure proper nutrition status. The interview further revealed that Resident 9's significant weight loss was not addressed timely. a weekly weight was not obtained following the weight loss on April 20, 2025, and the facility failed to provide documented evidence the resident's physician and resident representative were notified of the significant weight loss. Further review of the clinical record revealed the resident did not receive a nutritional assessment between April 20, 2025, and June 5, 2025. No weekly weights were documented during that period. An interview with the Director of Nursing (DON) on July 31, 2025, at 12:00PM revealed the facility could not provide a written policy addressing the monitoring and management of residents' nutritional status. The DON confirmed the facility could not provide documentation of any interventions implemented to address the weight loss identified on April 20, 2025. 28 Pa Code 211.5 (f)(ii)(iii)(x) Medical records. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered in accordance with physician's orders for three of 20 residents reviewed (Residents 13, 79, and 85).Findings include: A review of the facility policy titled Oxygen Administration, last reviewed by the facility on July 17, 2025, revealed it is the facility's policy to provide oxygen therapy to residents upon order of the physician. The policy indicated it is the responsibility of the licensed nurse to initiate and monitor the administration of oxygen per physician's orders. Oxygen therapy is a medical treatment in which supplemental oxygen is administered to a resident to maintain adequate oxygen levels in the blood. Oxygen is typically delivered by a nasal cannula, which is a lightweight tube that splits into two prongs placed into the nostrils. The flow rate, measured in liters per minute (LPM), is determined by the physician based on the resident's medical needs. Deviations from prescribed flow rates can result in insufficient oxygen delivery or, in some cases, excessive oxygen administration, both of which can adversely affect health. A clinical record review revealed Resident 13 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure with hypoxia (a condition in which the lungs are unable to adequately exchange oxygen, leading to persistently low blood oxygen levels). Further clinical record review revealed Resident 13 had a physician's order placed on May 22, 2025, for supplemental oxygen via nasal cannula at 4 liters per minute (LPM). An observation on July 29, 2025, at 8:15AM revealed Resident 13 was awake and sitting upright in her chair with nasal cannula tubing connected to an oxygen concentrator via an oxygen concentrator with the liter flow set at 0 liters per minute (LPM). During an interview on July 29, 2025, at 8:18 AM, the Director of Nursing (DON) confirmed that Resident 13 should have been receiving continuous oxygen at 4 LPM as ordered and stated she would immediately adjust the concentrator and check the resident's vital signs. A clinical record review revealed Resident 85 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD a progressive lung disease that causes airflow blockage and breathing-related problems). A physician's order dated July 19, 2025, directed supplemental oxygen via nasal cannula at 3 LPM continuously.An observation on July 30, 2025, at 8:30 AM revealed Resident 85 was awake and lying in bed with nasal cannula tubing connected to an oxygen concentrator; however, the flowmeter was set at 2.5 liters per minute (LPM). During an interview at 8:35 AM, Employee 8 Licensed Practical nurse (LPN) confirmed the setting was incorrect and stated it would be adjusted to the prescribed 3 LPM immediately.A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with a diagnosis to include chronic obstructive pulmonary disease. A physician's order dated November 30,2023 revealed the resident was prescribed supplemental oxygen via nasal cannula to be applied at 3 liters per minute (LPM) continuously. An observation on July 29, 2025, at 09:00AM revealed resident 79 was awake and sitting upright in her chair with supplemental oxygen in place via nasal cannula tubing connected to an oxygen concentrator with the liter flow set at 2 liters per minute (LPM). An interview with the resident at this time revealed the resident did not feel oxygen coming from the cannula but denied experiencing distress. An interview on July 29, 2025, at 9:05 AM, the DON confirmed Resident 79 should have been receiving 3 LPM and stated she would adjust the concentrator and check the resident's vital signs. The facility failed to follow their policy in accordance with physician orders for three resident's receiving supplemental oxygen. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of facility policies, medication count records, and staff interviews, it was determined that the facility failed to ensure nursing staff consistently follow established procedures for verifying and documenting the count of controlled substances at shift change on two of two medication carts observed. Findings include: A review of the facility policy entitled Controlled Substances last reviewed July 17, 2025, revealed it is the expectation of nursing staff to count controlled medication inventory at the end of each shift. The policy further revealed the nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. A review of the facility Narcotic Card Count from the green nursing unit medication cart revealed the following: July 22, 2025, the night shift on coming nurse failed to sign that the narcotic count was completed and correct. July 25, 2025, the day shift on coming nurse failed to sign that the narcotic count was completed and correct. July 26, 2025, the day shift on coming nurse failed to sign that the narcotic count was completed and correct. July 28, 2025, the day shift on coming nurse failed to sign that the narcotic count was completed and correct. A review of the facility Narcotic Card Count from the lilac nursing unit medication cart revealed the following: July 27, 2025, the night shift on coming nurse failed to sign that the narcotic count was completed and correct. July 28, 2025, the night shift on coming nurse failed to sign the narcotic count was completed and correct. An interview with Employee 7 LPN (licensed practical nurse) on July 30,2025, at 8:15 AM revealed it is the expectation of nursing staff to review and sign off on narcotic count sheets with each shift change. An interview on July 30, 2025, at approximately 1:45 PM, the Nursing Home Administrator confirmed the facility failed to demonstrate consistent implementation of procedures for promoting accurate controlled drug records. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of two medication carts observed (Lilac Hall).Findings include: Review of the facility policy titled Medication Labeling and Storage last reviewed by the facility July 17,2025, indicated that multi-use medication vials/bottles that have been opened or accessed (e.g. seal broken) are to be labeled with the date they were opened to ensure proper tracking for expiration purposes. An observation of the medication cart located on Lilac hall unit on July 30, 2025, at 8:22 AM, in the presence of Employee 8 (Licensed Practical Nurse) of the medication stored in the medication cart, revealed one (1) multi-dose insulin pen of Insulin Degludec (a long acting insulin medication used to lower blood sugar) and one (1) multi-dose pens of Insulin Glargine (a long acting insulin medication used to lower blood sugar) that had been opened and available for resident use, but not dated when initially opened. Further observation revealed one (1) multi-dose insulin pen of Insulin Aspart (a rapid acting insulin used to lower blood sugar) with a date on the sticker of the pen indicating the pen was opened July 1, 2025. Review of manufacturer safety information revealed the multi-dose pen of Insulin Aspart is to be discarded 28 days after opening indicating the dated pen should have been discarded on July 28, 2025. An interview with Employee 8 (LPN) on July 30,2025, at 8:24 AM, confirmed all three (3) multi dose insulin pens one (1) Insulin Aspart, one (1) Insulin Glargine and one (1) Insulin Degludec were opened, available for resident use, currently being used for administration, and not dated when initially opened with one pen of insulin Aspart being used past the expiration date. Interview with the Director of Nursing (DON) on July 31, 2025, at approximately 11:00 AM, confirmed the facility policy reflects it is the expectation of the staff to adhere to acceptable storage and labeling practice for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of select facility policies, and staff interviews, it was determined that the facility failed to store, prepare, and serve food under sanitary conditions to prevent potential contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department.Findings included: 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). A review of facility policies entitled Environment and Food Storage last reviewed by the facility on July 17, 2025, indicated all preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. All foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) Food Code (a model that assists food control jurisdictions at all levels of government by providing them with a scientifically sound technical and legal basis for regulating the retail and food service segment of the industry (restaurants and grocery stores and institutions such as nursing homes). All food items will be stored 6-inches above the floor and 18-inches below the sprinkler units. An initial tour of the dietary department, conducted on July 29, 2025, at 9:03 AM with the facility's consultant Certified Dietary Manager (CDM), revealed unsanitary conditions with the potential to contaminate food and increase the risk of foodborne illness. Upon entry into the dietary department, dirty breakfast meal carts containing soiled resident trays were stored in close proximity to food preparation areas, clean utensils, and clean cooking equipment. Observations of the ceiling tiles and light fixtures above the dishwashing machine revealed brown discoloration, splattered residue, and visible dirt and debris within the light covers throughout the kitchen area. Observations of the juice station revealed the thickened juice dispenser contained a gelatinous substance inside the nozzle and was sticky to the touch. The consultant CDM reported that the juice station equipment cleaning was done weekly. Further observations of the dietary department revealed that the inside of the dry storage area revealed wire racks stored directly on the floor, debris under shelving, and an accumulation of dirt and debris behind the door. During an interview with the Nursing Home Administrator (NHA) on July 30, 2025, at 2:30 PM, the above observations were reviewed. The NHA acknowledged that the facility's dietary department is required to be maintained in a clean and sanitary condition. 28 Pa. Code 201.18 (e) (2.1) Management. 28 Pa. Code 211.6 (f) Dietary Services. 28 Pa. Code 211.10 (d) Resident care policies.

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of clinical records, select investigative reports, and employee job descriptions and staff interview it was determined the facility's administration failed to effectively use its resources to promote resident safety and maintain the highest practicable physical and mental functioning of residents in the facility by failing to prevent the physical abuse of one resident (Resident 49) out of 5 sampled residents. Findings include: A review of the clinical record for Resident 49 revealed that the facility failed to immediately remove Employee 3,Nurse Aide (NA), an employee alleged to have physically abused a resident, from resident contact. Despite the allegation, Employee 3 (NA) remained in the facility with access to residents while the allegation was unresolved. This failure to implement immediate protective measures placed Resident 49 and all residents in danger and resulted in the Immediate Jeopardy cited at F600. Further review revealed the facility failed to fulfill mandatory reporting obligations for additional abuse allegations:The facility did not report an allegation that Employee 3 (NA) abused Resident 8 to the State Survey Agency and other officials as required.The facility did not report an allegation that Employee 10 (NA) abused Resident 9 to the State Survey Agency and other officials as required. The facility also failed to conduct thorough investigations into these additional allegations:No investigation was completed into the allegation involving Resident 8 and Employee 3 (NA).No investigation was completed into the allegation involving Resident 9 and Employee 10 (NA). The absence of timely reporting and investigation prevented the facility from determining whether abuse had occurred, identifying and removing potential perpetrators from resident contact, and implementing protective measures to prevent further harm. A review of the undated job description for the Administrator revealed the Administrator is responsible for directing day-to-day operations of the facility in accordance with federal, state, and local standards governing long-term care facilities; ensuring all personnel comply with facility policies and applicable laws; ensuring each resident receives necessary nursing, medical, and psychological services to attain and maintain the highest practicable well-being; and ensuring compliance with all facility policies and procedures by staff, residents, families, visitors, and governing agencies. The undated job description for the DON revealed the DON is responsible for assisting the Administrator in achieving nursing department goals, directing the operations and staff of the nursing department, ensuring strict compliance with regulatory requirements, maintaining resident care plans per guidelines, and promoting high standards of professional nursing care. These failures demonstrate a systemic failure in administrative oversight and an inability of facility leadership to ensure resident safety, enforce abuse prevention policies, and maintain compliance with federal regulation which contributed to the Immediate Jeopardy cited at F600 and placed all residents at continued risk for abuse, neglect, and exploitation.Cross refer F600, F609, F610. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (e)(1) Management. 28 Pa. Code 211.12 (c) Nursing services.