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	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Creekside	45 North Scott Street Carbondale, PA 18407

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure residents who lacked the ability to make medical decisions had an identified authorized representative and failed to ensure documentation of advance directives or evidence the resident was offered information regarding the right to formulate an advance directive. The facility failed to ensure medical treatment decisions were made by an appropriate legally authorized decision maker for three of 19 residents reviewed (Residents 13, 27, and 51).Findings included: A review of the clinical record revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (chronic autoimmune disorder where the immune system mistakenly attacks joint linings, causing pain, inflammation, swelling, and potential deformity) and bipolar disorder (chronic mental health condition characterized by alternating periods of depression and elevated mood). A review of Resident 13's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 20, 2023, revealed that Resident 13 was severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of the most recent quarterly MDS dated [DATE], revealed Resident 13 remained severely cognitively impaired with a BIMS score of 3. A review of the clinical record revealed medical decisions were documented as approved and signed by Resident 13, including consents for psychotropic medications (medications that affect mood, perception, or behavior), consent for nutritional supplements, and a vaccination refusal signed November 13, 2025, despite documentation indicating the resident lacked the ability to independently make medical decisions. Resident 13's clinical record revealed a Physician Orders for Life-Sustaining Treatment (POLST, a medical order indicating a person's preferences for life-sustaining treatment, it is not intended to replace an advance health care directive document or other medical orders. The POLST process and health care decision-making work best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves. A health care agent can only be appointed through an advanced health care directive or a health care power of attorney,) was completed September 14, 2023. The POLST indicated do not attempt resuscitation (allow natural death), comfort measures, use of antibiotics if life prolonging, and a trial period of artificial hydration and nutrition by feeding tube. The POLST documented review with the resident despite evidence of severe cognitive impairment and lacked documentation of an advance directive (written instruction, such as a living will or medical power of attorney, that identifies a person authorized to make health care decisions if the individual becomes unable to make decisions independently) or documentation the resident was offered information regarding the right to formulate an advance directive. Resident 13's clinical record revealed a Pennsylvania Physician Orders for Life-Sustaining Treatment (POLST- The POLST is not intended to replace an advance health care directive document or other medical orders. The POLST process and health care decision-making work best when the person has (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appointed a health care agent to speak for them when they become unable to speak for themselves. A health care agent can only be appointed through an advanced health care directive or a health care power of attorney), but no documented evidence of an Advance Directive written instruction, such as a living will or medical power of attorney, that identifies a person authorized to make health care decisions if the individual becomes unable to make decisions independently or if the facility asked the resident if he would like information to formulate an advanced directive. During an interview on April 2, 2026, at 1:00 PM, the Assistant Director of Nursing indicated when Resident 13 requires medical decisions, the physician or administrator is involved in decision making due to the resident's inability to make decisions independently. During an interview on April 2, 2026, at 2:20 PM, the Social Services Director indicated the facility had not initiated court appointment of a representative for Resident 13 despite his ongoing medical issues, and need for decision making. Interview with the Nursing Home Administrator (NHA) on April 2, 2026, at 1:25PM, denied that the NHA was making medical decisions for the resident. Interview with the facility appointment Dietician on April 2, 2026, at 2:00PM revealed she only speaks with the physician regarding medical decisions related to Resident 13's condition, and the physician is the one who makes the medical decisions for the resident since he is unable to make decisions himself. Documentation provided by the facility on April 3, 2026, at 9:00 AM revealed the facility initiated the process of obtaining a court-appointed representative for Resident 13 on April 2, 2026. A review of Resident 27's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including malnutrition (deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients), and schizophrenia (a chronic, severe brain disorder that causes psychosis, hallucinations, and delusions. A review of Resident 27's quarterly MDS dated [DATE], revealed Resident 27 was severely cognitively impaired with a BIMS score of 7. A review of the clinical record revealed no documentation identifying a legally authorized representative for medical decision making. A review of the clinical record revealed ongoing medical treatment decisions, including use of psychotropic medications and completion of a POLST dated November 5, 2025, signed by the resident despite documentation of severe cognitive impairment. The POLST indicated preferences for attempted resuscitation, full treatment, use of antibiotics, and refusal of artificial tube feeding. The POLST lacked physician signature and reflected signatures of the incapable resident and Social Services Director. During an interview on April 2, 2026, at 2:00 PM, the Nursing Home Administrator indicated the facility informs Resident 27 of medical decisions despite documentation of cognitive impairment. Documentation provided April 3, 2026, at 9:00 AM revealed the facility initiated the process of obtaining a court-appointed representative for Resident 27 on April 2, 2026. A review of Resident 51's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included intellectual disabilities (a developmental condition characterized by significant limitations in intellectual functioning (learning, reasoning, problem-solving), and depression(a serious, common mood disorder causing persistent sadness, loss of interest, and functional impairment, affecting how one thinks, feels, and act). A review of the quarterly MDS dated [DATE], revealed a BIMS score of 4, indicating severe cognitive impairment. A review of resident 51's clinical record revealed ongoing medical decision making, including vaccination consents and psychotropic medication authorizations, completed by the resident despite documented inability to make medical decisions independently. A review of a POLST uploaded to Resident 51's clinical record on April 17, 2023, revealed the form was signed by the resident (printed name) but not signed or dated by the physician. The POLST indicated preferences for attempted resuscitation, full treatment, use of antibiotics, and artificial hydration if life prolonging. The form lacked documentation identifying who the treatment decisions were reviewed with, despite the presence of a designated section for this information. During an interview on April 3, 2026, at 9:00 AM, the Nursing Home Administrator indicated the facility had not identified an individual authorized to make medical decisions for Resident 51. Documentation provided revealed the facility initiated the process of obtaining a court-appointed representative April 2, 2026. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (a)(b) Resident rights.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, Resident Council meeting minutes, grievance documentation provided by the facility, and resident and staff interviews, it was determined the facility failed to make reasonable efforts to address concerns raised by the Resident Council and failed to keep residents informed regarding the status and outcome of identified concerns. The facility failed to ensure ongoing communication and timely follow-up regarding issues presented by eight of eight residents attending a Resident Council group meeting (Residents 8, 14, 22, 33, 35, 54, 55, and 68).Findings include: A review of the facility policy titled Grievance Policy, last reviewed September 25, 2025, indicated residents, families, and their representatives have the right to voice grievances regarding care and treatment, staff behavior, or other concerns related to their stay. The policy indicated the designated grievance official is responsible for following up on concerns and grievances reported by residents or resident representatives. A review of a grievance dated January 9, 2026, submitted by Resident CR1 revealed concerns regarding extended call bell response times on January 8, 2026. Documentation indicated staff assigned to the shift were interviewed and the facility determined the call bell was answered timely based on staff interviews. Documentation indicated staff received re-education regarding call bell response expectations and call bell response audits were initiated. The grievance was documented by the facility as resolved. A resident group meeting conducted on April 3, 2026, at 11:30 AM with eight cognitively intact residents (Residents 8, 14, 22, 33, 35, 54, 55, and 68) revealed all residents in attendance reported continued concerns regarding call bell response times. Residents indicated they believed call bell response times remained inconsistent. Residents further indicated concerns regarding call bell response times had been discussed during Resident Council meetings held in January, February, and March 2026; however, the meeting minutes did not reflect documentation of these concerns. A review of documentation provided by the facility revealed call bell audit results that did not identify extended response times. The facility was unable to provide documented evidence residents were re-interviewed following implementation of corrective actions to determine whether residents perceived improvement in call bell response times. The facility was unable to provide documented evidence demonstrating communication to the Resident Council regarding actions taken to address concerns or the outcomes of the concerns raised related to call bell response times. During an interview conducted April 3, 2026, at 9:10 AM, the Nursing Home Administrator was unable to provide documented evidence demonstrating resident satisfaction with actions taken in response to grievances or concerns raised through Resident Council meetings. 28 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident Rights. 28 Pa. Code 211.10 (d) Resident care policies.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interview, it was determined the facility failed to provide housekeeping services necessary to maintain a clean and sanitary environment, including resident care equipment, for two of 19 residents reviewed (Residents 9 and 28).Findings include: Observations in Resident 9's room on April 1, 2026, at 11:00 AM and 1:30 PM revealed dried tube feeding residue in multiple locations within the resident's room. Specifically, dried nutritional formula (liquid nutrition administered through a feeding tube when a resident cannot eat by mouth) was observed on the base of the resident's tube feeding pole, on the fall mat positioned on the floor to the right side of the bed, and on the privacy curtain located to the right side of the bed. Observations conducted on April 1, 2026, at 1:00 PM revealed Resident 28's Broda chair (a specialized, highly adjustable medical chair used to assist with positioning, pressure injury prevention, and mobility for individuals with complex care needs) was positioned in the resident's room unoccupied and was not maintained in a clean condition. The chair was observed to contain multiple pieces of debris on the seat and footrest. The cushion contained stains from an unknown substance. Multiple strands of hair were observed adhered to the Dycem (a non-slip material used to prevent sliding and improve positioning stability) located on the chair surface. Crumbs were observed throughout the seating area of the chair. During an interview conducted on April 2, 2026, at 2:20 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) reviewed the above findings that the facility failed to ensure housekeeping services were provided to maintain a clean and sanitary environment and resident care equipment, consistent with maintaining a safe, comfortable, and homelike environment for residents. 28 Pa code 201.18 (b)(1) Management.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, resident observation, and staff interviews, it was determined the facility failed to identify the use of a physical restraint and failed to implement facility policy regarding the use of restraints for one of 19 residents reviewed (Resident 10).Findings include: Clinical record review revealed Resident 10 was admitted to the facility on [DATE], with diagnoses that included cerebral palsy (a neurological disorder that begins in early childhood and permanently affects muscle coordination, body movement, and posture). A review of Resident 10's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 1, 2026, revealed that Resident 10 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 15 reflects normal cognitive abilities). A review of the facility policy titled Use of Restraints, last reviewed September 25, 2025, revealed that restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. When the use of a restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. A restraint is defined as a device or equipment is attached or adjacent to the individual's body that an individual cannot remove, which restricts freedom of movement. Restraints may only be used if the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention. The policy documented that prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve symptoms. Restraints shall only be used after obtaining the written order of a physician and after obtaining consent from the resident and / or resident representative. Care plans will reflect the use of restraints and interventions implemented to systematically eliminate the need for restraint. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident/resident representative. The policy indicated that once a restraint is initiated, the resident is observed at least every 30 minutes by nursing personnel, and the resident's condition documented in the clinical record. The opportunity for motion and exercise will be provided for a period of not less than 10 minutes during every 2 hours the restraint is applied. Documentation regarding the restraint shall include full documentation of the episode leading to the use of physical restraint, a detailed description of the medical symptoms, how the restraint benefits the resident, the type of restraint, the length of effectiveness, observations, range of motion (movement of joints to maintain flexibility and prevent stiffness) provided, and repositioning efforts. The use of the restraint shall be reviewed regularly (at least quarterly) to evaluate for restraint reduction, less restrictive methods of restraints, or total restraint elimination. The care plan should reflect the measures taken to reduce or eliminate the need for restraints. A review of the care plan dated November 16, 2011, revealed Resident 10 was at risk for falls and included interventions of a wheelchair with a buckle belt for positioning. The care plan also indicated the use of a wheelchair with a cut-out cushion (a specialized cushion designed to relieve pressure on the tailbone), Dycem (a non-skid material used to prevent sliding of items such as cushions), and leg rests (supports used to position the legs while seated in a wheelchair) for transportation. The care plan directed staff to release the buckle belt every two hours. An observation conducted on April 1, 2026, at 1:15 PM revealed Resident 10 was seated in a wheelchair at the nurses' station with a belt secured across the waist using a buckle attached to the wheelchair. Resident 10 was unable to verbalize the purpose of the belt and did not demonstrate movement of the upper (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities (arms, hands, wrists, or trunk) during the observation. A review of Resident 10's physician orders revealed an order originally dated March 1, 2013, for a high-back wheelchair with foam seat cushion and buckle belt. The order also indicated that when Resident 10 leaves the facility with family, a collapsible wheelchair is required. The presence of the buckle belt in physician orders since 2013 indicates the device has been in use for an extended period of time. On December 5, 2025, the order was revised to include a wheelchair with pressure-relieving cushion and buckle belt for positioning (intended to assist with maintaining body alignment while seated). The order was most recently reviewed by the physician on January 9, 2026. Despite long-term use of the buckle belt, the clinical record lacked documentation demonstrating the interdisciplinary team (a group of healthcare professionals such as nursing, therapy, and medical providers who collaborate to plan and evaluate care) evaluated whether the device met the definition of a restraint (a device attached to or placed next to the resident's body that the resident cannot remove and which restricts freedom of movement), whether the device was clinically necessary to treat a medical symptom (a physical or clinical condition that requires treatment), or whether the buckle belt represented the least restrictive intervention for positioning. The clinical record lacked documentation demonstrating periodic reassessment of the continued need for the device, attempts to reduce the use of the device, or evaluation of alternative positioning interventions. During an interview conducted on April 1, 2026, at 2:20 PM, the Assistant Director of Nursing (ADON) and Nursing Home Administrator (NHA) stated the buckle belt was used to reduce the risk of falls and to maintain Resident 10's safety while seated in the wheelchair. The ADON and NHA acknowledged Resident 10 was unable to remove the device independently and confirmed the buckle belt restricted Resident 10's movement. A device the resident cannot remove that restricts freedom of movement meets the definition of a physical restraint. The stated purpose of fall prevention does not represent a medical symptom that justifies restraint use without evidence that less restrictive interventions were attempted and determined ineffective. The clinical record lacked documentation demonstrating the interdisciplinary team evaluated whether the buckle belt was necessary for positioning, whether less restrictive positioning interventions were attempted, or whether the use of the buckle belt was clinically justified based on an assessed medical symptom. The clinical record failed to demonstrate interdisciplinary team and resident or resident representative involvement in the decision-making process regarding the use of the buckle belt. The clinical record lacked documentation demonstrating the buckle belt was assessed as the least restrictive intervention or that alternative interventions were attempted and determined ineffective prior to use. The clinical record failed to include documentation of informed consent (permission granted by the resident or representative after receiving sufficient information to make a decision) for the use of the buckle belt as a restraint. The clinical record also lacked documentation of ongoing monitoring of the resident's condition and safety while the restraint was in place, including documentation of routine observations, release of the device, provision of range of motion (movement of joints to maintain flexibility and prevent stiffness), or evidence the restraint was used for the least amount of time necessary. During an interview on April 3, 2026, at 9:15 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated the facility had not identified the wheelchair buckle belt as a restraint. The facility was unable to provide documentation demonstrating the restraint policy was implemented, including interdisciplinary team assessment, identification of a medical symptom, informed consent, care plan interventions to reduce or eliminate restraint use, or ongoing monitoring of Resident 10 while the buckle belt was in use. The facility failed to demonstrate ongoing interdisciplinary team reassessment of a device that had been in place since at least 2013 and failed to ensure the use of the least restrictive intervention to meet Resident 10's assessed needs. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa. Code 211.8(c.1)(1)(2)(3)(i)(ii)(d)(e) Use of Restraints.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on a review of the facility's abuse prohibition policy, employee personnel files and staff interviews, it was determined the facility failed to implement procedures to fully screen three employees out of five to ensure they were eligible for employment in a long term nursing care facility. (Employees 1, 2, and 3).Findings include: A review of the facility's Resident Abuse policy last reviewed by the facility on September 25, 2025, revealed the requirement for screening potential employees to determine their appropriateness in working with individuals with specific conditions and needs; including obtaining references from previous and current employers. Review of employee personnel files revealed the following: Employee 1 (Licensed Practical Nurse): Hired on February 26, 2026. The application listed previous employers, but there was no documentation showing the facility had contacted any former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Employee 2 (Registered Nurse): Hired on February 20, 2026. The application listed previous employers, but there was no documentation showing the facility had contacted any former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Employee 3 (Licensed Practical Nurse): Hired on March 9, 2026. The application listed previous employers, but there was no documentation showing the facility had contacted any former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Interview with the Nursing Home Administrator (NHA) on April 2, 2026, at 1:15 PM was unable to provide evidence that previous employers were contacted for information regarding the employees past work history. The facility failed to follow its own abuse prohibition policy by not verifying previous employment for three out of five new hires. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.19 (1) Personnel records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual, clinical records, and staff interviews, it was determined the facility failed to complete an accurate Minimum Data Set (MDS) for three of 19 residents reviewed (Resident 10, Resident 11, and Resident 23).Findings include: The Long-Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the MDS dated [DATE], requires the assessment accurately reflects the resident's status. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A clinical record review revealed Resident 10 was admitted to the facility May 18, 2011, with diagnoses that included cerebral palsy (brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination). The annual Minimum Data Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 1, 2026, Section P (section addressing restraints and alarms) indicated Resident 10 does not use a restraint when in a chair, including a trunk restraint, or limb restraint. An observation on April 1, 2026, at 1:15 PM revealed Resident 10 was seated in his wheelchair, at the nurses' station. Resident 10 was observed to have a belt that was attached to the wheelchair; the belt included a buckle and was secured in the front of Resident 10's waistline. Resident 10 was not able to verbalize what the purpose of the belt with a buckle was and could not demonstrate any movement in his upper extremities (including arms, hands, wrists, or trunk) at the time of the observation. An interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on April 1, 2026, at 2:20 PM confirmed Resident 10 was not able to release the belt, and the intent of the belt was for Resident 10's safety. The DON and NHA further elaborated that due to Resident 10's underlying medical condition and the potential for unexpected loss of control over muscle movement consistent with his admission diagnosis, the belt's purpose is for safety. The DON and NHA acknowledged the belt is attached to the wheelchair, secured Resident 10 in the wheelchair, and limited Resident 10's movements. The DON and NHA did not consider the use of the buckle belt as a restraint. A clinical record review revealed Resident 11 was admitted to the facility July 26, 2022, with diagnoses that included chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs which results in swelling and irritation, inside the airways that limit airflow into and out of the lungs). The quarterly MDS dated [DATE], Section J (section related to health conditions, including fall history) documented Resident 11 experienced no falls since admission/ readmission or prior assessment. Upon clinical review, Resident 11 experienced falls on November 16, 2025, January 4, 2026, and January 14, 2026. The three falls were not reflected on the quarterly MDS dated [DATE]. A clinical record review revealed Resident 23 was admitted to the facility on [DATE], with diagnoses that included dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (condition characterized by cognitive decline and affects memory, thinking, behavior, and the ability to perform activities of daily living such as bathing, dressing, walking, and eating). The quarterly MDS dated [DATE], Section J (section related to health conditions, including fall history) documented Resident 23 experienced no falls since admission/ readmission or prior assessment. Upon clinical record review, Resident 23 experienced a fall on November 24, 2026. The fall on November 24, 2026, was not reflected on the quarterly MDS dated [DATE]. The above information reflecting the MDS coding for Resident 10, Resident 11, and Resident 23 was reviewed with Employee 4 Licensed Practical Nurse, MDS Coordinator on April 3, 2026 at 11:15 AM. Employee 4 LPN acknowledged the MDS did not accurately reflect the health conditions for the three residents. The information was communicated to the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 3, 2026, at 2:15 PM. 28 Pa. Code 211.5(f)(ix) Medical records. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to ensure the comprehensive person-centered care plan was implemented consistently and accurately reflected resident-centered measures to meet each resident's assessed needs for two of 19 residents reviewed (Residents 10 and 11). Findings include: A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, last reviewed September 25, 2025, revealed a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs are developed and implemented for each resident. The policy further revealed that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. A clinical record review revealed Resident 10 was admitted to the facility May 18, 2011, with diagnoses that included cerebral palsy (brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination). A review of Resident 10's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 1, 2026, revealed that Resident 10 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 15 reflects normal cognitive abilities). A review of Resident 10's comprehensive care plan, initiated November 16, 2011, revealed the resident required assistance with activities of daily living (routine personal care tasks such as transferring, bathing, dressing, toileting, and eating), including transfers. The care plan indicated Resident 10 required the assistance of two staff members for transfers, with the intervention initiated May 19, 2021. The care plan indicated as of November 8, 2024, Resident 10 required a Hoyer lift (a mechanical lifting device used to safely transfer individuals with limited mobility between surfaces such as bed and wheelchair) for all transfers. The care plan included two different transfer methods (assistance of two staff members and use of a Hoyer lift) without clear direction regarding which intervention was to be implemented. Lack of clear direction in the comprehensive care plan has the potential to result in staff performing transfers using an inappropriate method, which may compromise Resident 10's safety and physical well-being. A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a progressive lung disease that causes airflow blockage and difficulty breathing). A review of Resident 11's quarterly MDS dated [DATE], revealed Resident 11 was cognitively intact with a BIMS score of 11 (a score of 11 indicates moderate cognitive impairment requiring additional support with memory and decision-making). Review of Resident 11's comprehensive care plan, initiated August 3, 2022, revealed the resident was identified as at risk for falls related to weakness and arthritis (joint inflammation causing pain and limited mobility). Fall prevention interventions included placement of Dycem (a non-slip material designed to stabilize objects and prevent sliding) above and below the wheelchair cushion to reduce movement and improve positioning safety. An observation conducted on April 2, 2026, at 1:15 PM revealed Resident 11's wheelchair contained a blue piece of Dycem positioned on top of the wheelchair cushion. Observation of the wheelchair cushion revealed Dycem was not present below the cushion as indicated in the comprehensive care plan. The facility failed to implement the fall prevention intervention as written in the resident-centered comprehensive care plan, which has the potential to increase risk for falls and injury. An interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 3, 2026, at 2:20 PM. The above findings were reviewed related to the facility's failure to ensure the comprehensive person-centered care plan accurately reflected resident needs and was implemented consistently for Resident 10 related to (continued on next page)

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	395984	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Creekside	45 North Scott Street Carbondale, PA 18407

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers and Resident 11 related to fall prevention interventions. 28 Pa. Code 211.12(d)(1)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of personnel records, and staff interviews, it was determined the facility failed to ensure nursing services met professional standards of quality as required by the Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to verify Licensed Practical Nurses possessed the required education, training, and demonstrated competency for the administration of an intravenous (IV) medication via peripheral inserted central venous catheter (PICC) for one of 19 residents reviewed (Resident 5).Findings include: A review of Pennsylvania Code Title 49, Professional and Vocational Standards, Department of State, State Board of Nursing, S21.145 Functions of the Licensed Practical Nurse (LPN) indicates the LPN functions as a member of the health care team and administers medications and therapeutic treatments in accordance with established standards of safe nursing practice. Section 21.145(b) IV therapy curriculum requirements indicate an LPN may perform IV therapy functions only when the LPN has completed the required education and training and possesses the knowledge, skill, and ability to perform the procedure safely, and only under appropriate direction and supervision of a licensed professional nurse or other authorized health care provider. Permitted IV therapy functions include administration of IV medications and fluids, monitoring of the IV site, maintenance of IV access devices, and recognition and reporting of adverse reactions. Clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that included surgical site infection (infection occurring at the location of a surgical procedure). The clinical record revealed Resident 5 had a PICC line (peripherally inserted central catheter, a long flexible tube inserted into a vein in the arm and advanced into a large vein near the heart to allow long-term administration of intravenous medications). A review of physician orders revealed an order dated March 20, 2026, for Meropenem (an antibiotic medication used to treat serious bacterial infections) 1 gram intravenously every eight hours via PICC line for treatment of the surgical site infection through April 11, 2026. Review of the electronic Medication Administration Record (eMAR, an electronic system used to document medication administration in the clinical record) revealed Employee 5, Licensed Practical Nurse (LPN), documented administration of Meropenem 1 gram intravenously via PICC line on March 21, 2026. The eMAR further revealed Employee 6, Licensed Practical Nurse (LPN), documented administration of Meropenem 1 gram intravenously via PICC line on March 29, 2026. The facility failed to produce evidence that Employee 5 or Employee 6 completed IV therapy education and training consistent with the requirements of Pennsylvania Code Title 49 S21.145(b). The facility was unable to provide documentation of competency validation (process used to confirm staff have demonstrated the ability to safely perform a clinical skill), supervision documentation, or evidence of training specific to administration of IV medications through a PICC line. During an interview conducted on April 2, 2026, at 11:50 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the facility was unable to provide documentation demonstrating Employees 5 and 6 completed the required IV therapy education or competency validation necessary to administer IV medications through a PICC line. 28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure licensed nurses accurately administered medication in accordance with physician orders for one of 19 residents reviewed (Resident 20). Findings include: A review of the facility policy titled Administering Medications last reviewed by the facility on September 25, 2025, revealed that medications are administered as prescribed in a safe, timely manner. Medications are administered in accordance with prescriber orders, and information is verified prior to administering medication including vital signs (measurements of basic body functions such as blood pressure, pulse, temperature, and breathing), are verified prior to administering medications when parameters are ordered. A review of the clinical record revealed Resident 20 was admitted to the facility on [DATE], with diagnoses to include hyperkalemia (high levels of potassium in the blood which can affect heart and muscle function). A review of Resident 20's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 10, 2026, revealed that Resident 20 was moderately cognitively impaired with a BIMS score of 8 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). A review of the physician's order dated May 5, 2025, directed staff to administer Midodrine HCl (medication used to treat low blood pressure) 5 milligrams (mg) orally three times a day for orthostatic hypotension (a sudden drop in blood pressure occurring within 3 minutes of standing or shifting to an upright position which may cause dizziness or fainting). The physician's order specified to hold (not give) the medication if the systolic blood pressure (top number in a blood pressure reading, representing pressure when the heart contracts) was greater than 145 millimeters of mercury (mm/Hg) and the diastolic blood pressure (bottom number in a blood pressure reading, representing pressure when the heart rests between beats) was greater than 95 mm/Hg. A review of the September 2025 Medication Administration Record (MAR) (a legal document used to record when medications are given) revealed Midodrine was administered 11 times without documentation of a blood pressure reading prior to administration, as required by the physician's order, on the following dates and times: September 5, 2025, at 12:00 PMSeptember 5, 2025, at 4:00 PMSeptember 6, 2025, at 08:00 AMSeptember 6, 2025, at 12:00 PMSeptember 6, 2025, at 4:00 PMSeptember 7, 2025, at 08:00 AMSeptember 7, 2025, at 12:00 PMSeptember 7, 2025, at 04:00 PMSeptember 8, 2025, at 08:00 AMSeptember 8, 2025, at 04:00 PMSeptember 9, 2025, at 08:00 AM Administration of Midodrine without obtaining the required blood pressure reading prevented nursing staff from determining whether the medication was safe to administer according to the physician's ordered parameters. A review of the February 2026 MAR revealed Midodrine was not administered four times when the medication should have been given according to the physician's order. Documentation indicated the medication was held because the systolic blood pressure exceeded 145 mm/Hg; however, the diastolic blood pressure did not exceed 95 mm/Hg as required by the order. The physician's order required that both the systolic blood pressure exceed 145 mm/Hg and the diastolic blood pressure exceed 95 mm/Hg in order to hold the medication. The following blood pressure readings were documented at the time the medication was held: February 5, 2026, at 12:00 PM for a blood pressure reading of 148/90 mm/HgFebruary 12, 2026, at 04:00 PM for a blood pressure reading of 152/62 mm/HgFebruary 13, 2026, at 05:00 AM for a blood pressure reading of 158/76 mm/HgFebruary 24, 2026, at 08:00 AM for a blood pressure reading of 161/84 mm/HgThese findings demonstrated nursing staff did not follow the physician's order because the medication was administered without required clinical information (blood pressure readings) and was also withheld when the ordered criteria to hold the medication were not met. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above findings were reviewed with the Director of Nursing on April 3, 2026, at 7:48 AM. The Director of Nursing acknowledged the medication was administered without obtaining required blood pressure readings and was withheld when the physician-ordered parameters to hold the medication were not met. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure pain management was provided according to physician orders, including implementation of ordered parameters and nonpharmacological interventions, for one of 19 residents reviewed (Resident 1). Findings include: According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Draft Final Report May 6, 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. A review of a facility policy titled Pain Management and Assessment last reviewed by the facility on September 25, 2025, revealed the facility staff will implement the medication regimen as ordered. The policy revealed it is the staff responsibility to administer the medication as ordered, monitor, and document the resident's response to the medication. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including heart failure (a chronic, serious condition where the heart cannot pump enough blood to meet the body's needs, often caused by coronary artery disease, high blood pressure, or weak heart muscles) and muscle weakness. A physician order dated January 9, 2026, revealed Resident 1 was prescribed Tramadol 50 milligrams (mg) (an opioid pain medication used to treat moderate to moderately severe pain) to be administered by mouth every 12 hours as needed for severe pain rated 8-10. A pain scale is a standardized tool used to measure pain intensity, typically ranging from 0 to 10, where 0 indicates no pain, 1-3 indicates mild pain, 4-7 indicates moderate pain, and 8-10 indicates severe pain. A review of the January 2026 Medication Administration Record (MAR) revealed staff administered Tramadol 50 mg 16 times. Of the 16 administrations, 3 doses were administered outside physician ordered parameters for severe pain rated 8-10: January 20, 2026, at 3:49 PM, administered for pain scale rating of 3 (mild pain)January 22, 2026, at 5:07 PM, administered for pain scale rating of 0 (no pain)January 27, 2026, at 7:13 PM, administered for pain scale rating of 0 (no pain) A review of the February 2026 MAR revealed staff administered Tramadol 50 mg 13 times. Of the 13 administrations, 1 dose was administered outside physician ordered parameters: February 22, 2026, at 11:07 AM, administered for pain scale rating of 3 (mild pain) A review of the clinical record revealed the physician order was revised on February 25, 2026, to Tramadol 50 mg, administer one tablet every 6 hours as needed for moderate shoulder pain, with nonpharmacological interventions attempted prior to administration of the medication. Nonpharmacological interventions are treatments that do not involve medications and may include repositioning, application of heat or cold, massage, relaxation techniques, distraction, or other comfort measures. A review of the clinical record revealed the following administrations occurred without documentation of nonpharmacological interventions attempted prior to administration as ordered: February 25, 2026, at 7:38 PMFebruary 26, 2026, at 1:40 AM A review of the March 2026 MAR revealed staff administered Tramadol 50 mg 88 times. Of the 88 administrations, 16 doses were administered outside physician ordered parameters: March 1, 2026, at 03:40AM, the medication was administered for a pain scale of 8.March 1, 2026, at 10:41PM, the medication was administered for a (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain scale of 8.March 2, 2026, at 05:25AM, the medication was administered for a pain scale of 3.March 6, 2026, at 7:42PM, the medication was administered for a pain scale of 8.March 8, 2026, 11:29AM, the medication was administered for a pain scale of 8.March 13, 2026, 7:04PM, the medication was administered for a pain scale of 0.March 15, 2026, 08:33PM, the medication was administered for a pain scale of 8.March 20, 2026, 7:20PM, the medication was administered for a pain scale of 8.March 21, 2026, at 11:00AM, the medication was administered for a pain scale of 8.March 21, 2026, at 8:45PM, the medication was administered for a pain scale of 8.March 23, 2026, at 05:58AM, the medication was administered for a pain scale of 8.March 26, 2026, at 7:52PM, the medication was administered for a pain scale of 8.March 27, 2026, at 7:40PM, the medication was administered for a pain scale of 8.March 29, 2026, at 1:19AM, the medication was administered for a pain scale of 8.March 29, 2026, at 7:46PM, the medication was administered for a pain scale of 8.Match 30, 2026, at 05:06AM, the medication was administered for a pain scale of 0. An interview with the Director of Nursing on April 3, 2026, at 11:00 AM included review of the above findings which revealed the facility failed to ensure staff administered opioid pain medication according to physician orders, including adherence to ordered pain scale parameters and implementation of ordered nonpharmacological interventions prior to medication administration. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure the attending physician acted upon and documented a clinical rationale regarding consultant pharmacist identified medication regimen irregularities for one of 19 residents reviewed (Resident 4). Findings include: A review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (a mental health condition that causes significant changes in mood, energy, and ability to function, including episodes of depression and mania, which is a period of abnormally elevated mood or irritability). A review of the November 2025 consultant pharmacist Medication Regimen Review (MRR) (a monthly evaluation of a resident's medications conducted by a licensed pharmacist to identify potential medication concerns such as unnecessary medications, excessive doses, or risk of side effects) revealed the pharmacist identified the resident's order for Mirtazapine 15 mg (an antidepressant medication used to treat depression and certain mood symptoms) and recommended consideration of a gradual dose reduction (GDR) (a step-by-step lowering of a medication dose to determine whether the medication is still necessary or whether symptoms can be managed with a lower dose or without the medication). Review of the November 2025 MRR revealed documentation from the facility's contracted psychiatric services Nurse Practitioner indicated the resident previously failed a gradual dose reduction of Seroquel (an antipsychotic medication used to treat mood and behavioral symptoms) and the resident was considered stable on the current medication regimen. However, the clinical record lacked documentation that the attending physician reviewed the pharmacist's recommendation regarding Mirtazapine or provided clinical rationale explaining why a gradual dose reduction was not attempted or was clinically contraindicated (not recommended due to potential harm). A review of the clinical record failed to reveal documentation from the attending physician addressing the pharmacist's identified irregularity, including the reason for continuing the current dose of Mirtazapine without a gradual dose reduction. During an interview conducted on April 3, 2026, at approximately 1:00 PM, the Assistant Director of Nursing (ADON) stated the facility had experienced an ongoing issue obtaining documentation from the attending physician in response to consultant pharmacist recommendations. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure a resident's drug regimen was free from the use of an unnecessary antibiotic for one of 19 residents reviewed (Resident 8).Findings Include:A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive condition involving decline in memory, thinking ability, and reasoning beyond normal aging) and muscle weakness. A review of the facility policy titled Antibiotic Stewardship, last reviewed by the facility on September 25, 2025, indicated antibiotics are prescribed only when there is sufficient clinical evidence of an active infection. The policy further indicated prescribers are expected to provide complete antibiotic orders including the medication name, dose, duration of treatment, and the clinical indication (medical reason) for use. The facility utilized the McGeer's Criteria Checklist to determine the need for initiation of antibiotics. McGeer's Criteria is defined as an evidence-based surveillance tool used in long-term care facilities to identify when clinical signs and symptoms are present that support the presence of an infection and justify antibiotic treatment. A review of a physician order dated January 20, 2026, revealed an order for Ceftriaxone (a broad-spectrum antibiotic used to treat bacterial infections) 1 gram injection to be administered intramuscularly (into the muscle) at bedtime for three days for a urinary tract infection (UTI, an infection involving the bladder, urethra, or kidneys).A review of Resident 8's clinical record revealed a McGeer's Criteria Checklist dated January 17, 2026. The checklist documented Resident 8 did not exhibit symptoms consistent with a urinary tract infection, including absence of fever (elevated body temperature), leukocytosis (increased white blood cells indicating possible infection), acute mental status change (sudden confusion or altered thinking), or acute functional decline (sudden worsening in ability to perform usual activities). Despite the absence of required clinical criteria, the checklist indicated the UTI criteria had been met. A review of a urinalysis with culture report (a laboratory test used to detect the presence of bacteria and identify the most effective antibiotic treatment) dated January 21, 2026, at 8:42 AM revealed the presence of Escherichia coli (E. coli, a common bacterium from the intestinal tract that can cause urinary tract infections). The culture report further revealed the identified bacteria was resistant (not effectively treated) to Ceftriaxone, indicating the antibiotic ordered was not an appropriate treatment for the identified organism. The clinical record did not contain documentation of clinical signs or symptoms consistent with infection prior to the initiation of the antibiotic. The facility failed to ensure Resident 8's drug regimen was free from unnecessary antibiotics by initiating Ceftriaxone without sufficient clinical indication supported by McGeer's Criteria and without evidence the medication would be effective based on culture results. During an interview on April 3, 2026, the Director of Nursing reviewed the above findings related to the facility's failure to ensure Resident 8 was free from the use of an unnecessary antibiotic. 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(d)(3)(5) Nursing services 28 Pa Code 211.10 (c) Resident care policies.