DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	Continued from page 1 Based on a revisit survey and an abbreviated complaint survey completed on April 23, 2025, it was determined that Aventura at Terrace View corrected the federal deficiencies cited during the survey of March 21, 2025, however failed to correct the federal deficiencies cited during the survey of March 28, 2025 and continued to be out of compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0573 SS=D		F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 2 483.10(g)(2)(i)(ii)(3) Right to Access/Purchase Copies of Records §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described	F 0573	An approved Plan of Correction is not on file.	Completion Date: **04/29/2025** Status: **NEW** Date: **04/29/2025**

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 3 in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by:	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 4 Based on review of select facility policy, clinical records and staff interviews, it was determined the facility failed to provide a copy of a discharged resident's clinical record within two working days as requested by the legal representative for one of 4 residents sampled (Resident 18). Findings include: Review of the facility policy titled "Access to Residents' Medical Records Policy and Procedure" last reviewed by the facility on January 22, 2025, indicated that written consent of the resident or the resident representative is required for release of information and the facility shall assign overall supervisory responsibility for the medical record service to the medical records practitioner and the facility shall employ sufficient personnel competent to carry out the functions of the medical record service. Review of the facility policy titled " Medical Records Fee Policy and Procedure" last reviewed by the	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 5 facility on January 22, 2025, indicated the facility shall charge a "reasonable, cost-based" fee to fulfill medical records request. The facility's fee schedule shall be as follows: $20 per hour for the cost of labor; and $0.15 per page. The facility shall not charge a per page fee for copies of personal health information (PHI) that are maintained electronically (ePHI). However, the facility shall charge a reasonable, cost-based fee for the medium on which is provided ePHI. Review of Resident 18's clinical record revealed admittance to the facility on November 19, 2024, and discharged from the facility on December 27, 2024. Review of a letter dated January 14, 2025, revealed that Resident 18's resident representative (RP) submitted a formal written request for an electronic copy of the resident's complete medical record, specifically requesting Adobe Acrobat (.pdf) format on a CD.	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 6 Review of the facility form "Authorization for Use or Disclosure of Protected Health Information" dated February 18, 2025, revealed a signed request for release of Resident 18's medical record by Resident 18's RP. As of the survey ending April 23, 2025, Resident 18's RP had not been provided with the requested medical records. Interview with the Medical Records Director on April 23, 2025, at 2:00 PM, confirmed that the signed authorization was received in February 2025 and forwarded to the Director of Nursing and Corporate Risk Compliance for review. for review. The Medical Records Director acknowledged the RP was verbally advised of a paper-based fee structure but was not provided a written fee schedule. The Medical Records Director also admitted she was unaware of the federal requirement mandating record production within two working days and confirmed the facility's failure to produce the requested records. Further interview	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 7 revealed that although the facility maintains electronic health records, the Medical Records Director was unaware of how to fulfill electronic requests, and facility practice does not include providing electronic records despite specific requests. Interview with the Medical Records Director on April 23, 2025, at 2:00 PM revealed that Resident 18's authorization for medical records request was received in February 2025. After receiving the authorization form it was forward to the Director of Nursing and Corporate Risk Compliance for review. The RP called the facility a few days later to see if the records were ready. At that time, the RP was verbally informed that there was a fee, and she would need to pay for the records. The RP was verbally quoted an amount based on the number of paper copies. The RP responded that she was not notified there was a cost and that she would be getting a lawyer. Medical Records Director called the RP on March 10, 2025, to determine if she still wanted the records but there was no answer. The	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 8 Medical Records Director could not recall if she left a voicemail message. Further interview revealed the Medical Records Director was unaware of the federal requirement to provide copies of medical records with 2 working days advanced notice. The Medical Records Director revealed that the facility does not provide electronic copies of medical records even when a request is made for an electronic copy. She indicated she does not know how to provide an electronic copy of the records despite the facility utilizing an electronic health record system for all the residents' medical/personal health information. Interview with the Director of Nursing on April 23, 2025, at 2:15 PM confirmed the electronic health record system allows for records to be converted into a .pdf format for delivery electronically, demonstrating the facility had the technical capability but failed to comply. Interview with the Nursing Home Administrator	F 0573		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0573 SS=D	Continued from page 9 (NHA) on April 23, 2025, at approximately 2:30 PM confirmed that the facility failed to provide Resident 18's RP with access to the complete clinical record as requested several months earlier. The facility was unable to provide documentation that a written fee schedule was presented to Resident 18's RP prior to quoting fees, or that reasonable efforts were made to fulfill the electronic record request as submitted. 28 Pa. Code 201.29(a)Resident rights.	F 0573		
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection	F 0686	An approved Plan of Correction is not on file.	Completion Date: **04/29/2025** Status: **NEW** Date: **04/29/2025**

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 10 and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 11 Based on observations, review of select facility policies, facility investigative documentation, clinical record review, and staff interviews, it was determined the facility failed to consistently provide care and services to prevent the development of pressure ulcers and to promote healing of existing wounds for one resident (Resident 2) out of 21 sampled residents. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to the body) best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 12 national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of facility policy entitled "Pressure Ulcer/Injury Care and Management" last reviewed January 22, 2025, revealed residents will receive care consistent with professional standards of practice, to prevent pressure ulcer/injury unless the individual's clinical condition demonstrates they were unavoidable. Residents will receive necessary	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 13 treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. Residents with a pressure ulcer will have wound measurements weekly by the physician or registered nurse. Observation of the wound should be completed with each dressing change and should include at a minimum: A. Location and staging B. Size, depth, the presence and location of any undermining or tunneling C. Exudate if present the type, color, odor, and amount D. If pain is present the nature and frequency E. Wound bed to include the color and type of tissue F. Description of the wound edges A review of Resident 2's clinical record revealed admission to the facility on May 12, 2021, with diagnoses, which included dementia, a history of blood clots in the lower legs and peripheral	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 14 insufficiency (decreased blood flow to the lower legs) and has been receiving hospice services since October 17, 2024, for a diagnosis of senile degeneration of the brain (dementia). A review of a Quarterly Minimum Data Set assessment dated January 21, 2025, (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed the resident was severely cognitively impaired and was at risk for developing pressure ulcers. A review of a quarterly Braden scale for predicting pressure sore risk assessment dated January 30, 2025, revealed the resident responded to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits the ability to feel pain or discomfort. The resident walks occasionally and was at risk for pressure ulcer development. A review of Resident 2's comprehensive care plan,	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 15 initially developed on May 13, 2021, identified the resident as being at risk for skin breakdown related to incontinence and the need for extensive assistance with activities of daily living. The care plan included a goal that the resident would have no additional skin breakdown. Interventions to address this risk included: monitoring the resident's skin condition daily during care and reporting any areas of redness or open skin to nursing and medical staff; use of a pressure-reducing mattress on the resident's bed (identified as the facility's standard pressure-reducing mattress); use of a pressure-reducing cushion in the resident's chair (a chair pad); and completion of biweekly skin assessments in conjunction with showers. However, a review of the facility's "Documentation Survey Report" for April 2025 revealed that Resident 2 experienced daily episodes of bowel and bladder incontinence. Despite this, there was no documented evidence that incontinence care was consistently provided with each episode or that a barrier cream was applied as required by the	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 16 resident's needs and consistent with professional standards of practice. This lack of documentation suggests that interventions identified in the resident's care plan were not consistently implemented to prevent the development or worsening of skin breakdown. A nurse's note dated April 11, 2025, at 10:43 AM, documented that Employee 5 (LPN) was called to Resident 2's room by another staff member to evaluate a potential wound. Upon assessment, Employee 5 noted the presence of an open area located in the intergluteal cleft (the area between the right and left buttocks, only visible when the skin is separated). The wound bed contained light yellow slough (occlusive dead tissue), and the area was moist with no observable drainage. The surrounding peri-wound skin appeared flesh-toned and intact. The resident, who was incontinent of bowel and bladder, was also noted to intermittently refuse incontinence care, repositioning/offloading, and showers. The resident expressed no pain or discomfort at the time of assessment. The physician	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 17 was notified, and new treatment orders were received for the application of calcium alginate with silver, a dry cover dressing, and the addition of a low air loss mattress to the resident's bed. A review of a witness statement dated April 11, 2025, at 11:30 AM, revealed that Employee 5 (LPN) stated he had been informed by another unidentified staff member (no witness statement available at the time of the survey to identify this staff member) of a possible area of skin concern on the resident's buttocks. Following this notification, Employee 5 assessed the resident and confirmed the presence of a small slit-like open area in the intergluteal cleft. The RN Supervisor was also notified and conducted an additional assessment of the area. A review of the initial skin assessment completed by Employee 5 (LPN) on April 11, 2025, described the wound in the intergluteal cleft as unstageable (defined as full-thickness tissue loss in which the base of the ulcer is covered by slough-yellow or	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 18 white dead tissue). The slough measured 3.5 cm x 0.5 cm, and the surrounding skin remained flesh-toned and intact. Further review of the clinical record revealed subsequently, documented at 10:43 AM on the same day, the Infection Preventionist (LPN) was called to evaluate Resident 2's wound. The LPN documented a wound in the intergluteal cleft, only found when the skin was pulled apart, with light yellow slough in the wound bed, moist but without drainage. The peri-wound skin was flesh-toned and intact. The resident was noted to be incontinent of bowel and bladder and occasionally refused incontinence care, repositioning, and showers. The Certified Registered Nurse Practitioner (CRNP) and the contracted wound physician were notified, and new recommendations included the application of calcium alginate with silver covered with a dry dressing and the use of a low air loss mattress. At 11:02 AM, the facility CRNP evaluated the resident's wound, noting the presence of a wound in	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 19 the intergluteal cleft, only found when the skin was pulled apart. The area was open with light yellow slough in the wound bed, moist but without drainage. The peri-wound skin was flesh-toned and intact. The resident was incontinent of bowel and bladder and occasionally refused incontinence care, repositioning, and showers. The physician was notified, and new recommendations included the application of calcium alginate with silver covered with a dry dressing and the use of a low air loss mattress. A review of the shower records indicated that Resident 2 received a shower on April 12, 2025, during the 3 PM to 11 PM shift. Documentation from this time did not note any skin impairments. On April 13, 2025, at 8:30 AM, Employee 7 (CNA) reported discovering skin openings on Resident 2's right side near the hip area during routine brief changing. The nurse was promptly notified.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 20 Subsequently, at 8:50 AM, Employee 5 (LPN) documented in the nursing notes that during morning care, two small, reddened areas were observed on Resident 2's right buttock. The first area measured 2 cm x 2 cm, and the second measured 1.5 cm x 1.5 cm. These areas were not present during the skin assessment conducted during the resident's shower on April 12, 2025. The physician was notified, and treatment orders were obtained. The resident was scheduled to be seen by the consultant wound physician during weekly wound rounds. A witness statement from Employee 5 (LPN), dated April 13, 2025, at 11:00 AM, corroborated the earlier findings, stating that during morning care, the nurse aide reported two small, reddened areas on Resident 2's right buttocks. The right proximal buttock had an open area measuring 2 cm x 2 cm, and the right distal buttock measured 1.5 cm x 1.5 cm. These areas were not present during the skin assessment completed by Employee 5 during the resident's shower on April 12, 2025.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 21 A skin assessment completed by Employee 8 (Agency RN Supervisor) on April 13, 2025, revealed that the proximal right buttock exhibited Moisture Associated Skin Damage (MASD), measuring 2 cm x 2 cm x 0.5 cm, with surrounding skin noted as "normal tissue." The distal right buttock also exhibited MASD, measuring 1.5 cm x 1.5 cm x 0.5 cm, with surrounding skin noted as "normal tissue." A physician's order was noted to cover the area with a foam border daily and as needed and consult wound care team. A review of a consultant wound assessment dated April 15, 2025 (two days after identification of the wounds), revealed the following pressure injuries for Resident #2: Coccyx Area: A Stage 2 pressure ulcer (open area through layer of skin creating shallow open wound) measuring 2.3 cm (length) x 0.5 cm (width) x 0.2 cm (depth) was observed. The wound bed exhibited exposed dermis with moderate serosanguinous drainage.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 22 Right Superior Buttock: A Stage 2 pressure ulcer measuring 0.6 cm x 0.6 cm x 0.1 cm was noted, presenting with an open wound bed, exposed dermis, and moderate serosanguinous drainage. Right Inferior Buttock: A Stage 2 pressure ulcer measuring 0.6 cm x 0.5 cm x 0.1 cm was identified, also displaying an open wound bed with exposed dermis and moderate serosanguinous drainage. In response to these findings, the wound consultant ordered the application of calcium alginate with silver dressings to all three pressure ulcers. The treatment plan specified that the dressings be covered with gauze and changed daily and as needed. Calcium alginate with silver dressings are recognized for their high absorbency and antimicrobial properties, making them suitable for managing moderate to heavily exuding wounds and reducing the risk of infection.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 23 After the identification of pressure areas on April 11 and April 13, 2025, the following wound prevention interventions were documented: On April 13, 2025, prompted toileting was initiated at 7 AM, 10 AM, 6 PM, 9 PM, and as needed. On April 17, 2025, the application of barrier cream to the buttocks with each incontinence episode was implemented. On April 18, 2025, a turning and repositioning schedule every 2-3 hours was established. However, a continence evaluation was not completed until April 23, 2025, despite the resident's increased incontinence. Additionally, there was no evidence that the physician-ordered low air loss mattress was placed on the resident's bed until April 13, 2025. Observations conducted on April 22nd, 2025, revealed that Resident 2 was seated in his wheelchair at multiple times: at 9:30 AM outside of	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 24 his room, at 11 AM in the activity room, and at 12:30 PM prior to being returned to bed for evaluation by the contracted wound consultant. During all three observations, the resident was utilizing the gel cushion on his wheelchair. The resident utilized a gel cushion on his wheelchair, which was noted to be very worn, uneven, and lacking support. The cushion was also dirty with dried food and liquid stains. These observations were confirmed by the infection control/wound nurse. An observation conducted on April 22, 2025, of Resident 2's sacral wound, in the presence of the contracted wound physician, measured 1.8 cm x 0.3 cm. The physician stated that the depth could not be measured due to the presence of "dermal" skin in the center of the wound, which was white in color. A scant amount of serosanguinous drainage was noted, with the wound bed appearing pink/red and the surrounding skin blanchable.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 25 Further observations of the upper and lower right buttock areas revealed wounds measuring 0.3 cm x 0.4 cm and 0.4 cm x 0.3 cm, respectively. Both wound beds were white, with surrounding skin blanchable and a scant amount of serosanguinous drainage noted. There was no evidence of a thorough investigation into the development of these pressure areas to identify possible causes and corresponding interventions. Additionally, interventions were not timely implemented to prevent the pressure areas for this resident, who was at risk for pressure sore development. During an interview conducted on April 23, 2025, at 2:00 PM, the Director of Nursing confirmed that an investigation was not completed into the development of the noted pressure areas and further confirmed that interventions were not timely implemented for this resident to prevent the development of pressure areas.	F 0686		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0686 SS=D	Continued from page 26 28 Pa code 211.12 (d)(1)(3)(5) Nursing services	F 0686		
F 0689 SS=G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	An approved Plan of Correction is not on file.	Completion Date: **04/29/2025** Status: **NEW** Date: **04/29/2025**

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 27 Based on review of clinical records, select policy and select resident investigative reports and staff interview, it was determined the facility failed to implement effective interventions to prevent falls to include the provision of supervision necessary to prevent falls and serious injury, closed head injury with intracranial bleeding,(Resident 4) and lacerations requiring sutures (Resident 3) for two residents of 21 sampled. Findings include: A review of a select facility policy for "Falls and Fall Risk Management", reviewed July 2024 revealed, it is the policy of the facility that based on evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to attempt to minimize the complications from falling. Clinical record review revealed that Resident 4 was admitted to the facility on September 9, 2024 with diagnosis to include, dementia (a condition in which	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 28 a person loses the ability to think, remember, learn, make decisions, and solve problems) with behavioral disturbance, anoxic brain damage (brain injuries are characterized by brain damage from a lack of oxygen to the brain) and a history of falling. A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated March 17, 2025, revealed the resident's cognition was severely 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 0-7 indicates severe cognitive impairment) and required assistance with activities of daily living and had repeated falls. A review of the resident's fall risk care plan-initiated September 9, 2024, indicated the resident was at risk for falls related to the need for staff assistance	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 29 with activities of daily living, incontinence, and the use of high-risk psychoactive medication. Interventions to include, the resident to be out of bed and dressed during 11-7 shift, maintain a safe, well-lit clutter free environment, non-skid footwear, offer naps after dinner, and safety interventions per physician's order An additional care plan-initiated September 10, 2024, addressed potential distressed mood and behavioral symptoms related to anxiety and depression as evidenced by restlessness, tearfulness, yelling out, with interventions including verbal support and medication administration as needed. Documentation from February 2025 through the survey revealed ongoing behaviors of wandering, agitation, crying, and yelling. A physician's order dated February 6, 2025, prescribed Geodon (an antipsychotic medication) 20 mg by mouth in the morning and 40 mg by mouth twice daily for "unspecified dementia with behavioral	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 30 disturbance." A physician's order dated December 30, 2024, also prescribed Ativan (an antianxiety medication) 1 mg three times daily with the same diagnosis. A review of facility documentation dated April 3, 2025, at 6:00 AM revealed that Resident 4 was found on the floor with dark discoloration noted to her forehead. The physician was contacted, and the resident was transferred to the hospital for evaluation. Documentation indicated the resident had last been seen and toileted at approximately 5:30 AM, at which time she was awake in her wheelchair and noted to be combative with staff. A review of a witness statement from Employee 12 (no time indicated) revealed that Resident 4 had been assigned to Employee 12 for the 11:00 PM to 7:00 AM shift. Employee 12 documented the resident was observed asleep on the floor near the nurses' station during the night. Upon awakening, the resident was toileted, provided a snack, and returned to bed at approximately 2:00 AM. At 5:30	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 31 AM, the resident was described as very combative, uncooperative, yelling, hitting, and scratching, and was attempting to get out of her chair. Staff attempted to redirect her, but she scratched Employee 12's arm. Employee 12 reported that she left the resident unattended to inform the nurse, during which time the resident's alarm sounded, and she was found on the floor. A review of a witness statement from Employee 13 (LPN), dated April 3, 2025, at 6:30 AM, indicated that while passing medications, Employee 13 was made aware that Resident 4 was sitting on the floor in front of her room, holding her head. Upon moving her hand, a hematoma was noted to be developing on her forehead. A review of a nurse's note dated April 3, 2025, at 8:15 AM documented that Resident 4 was transferred to the hospital for evaluation following the fall. Hospital documentation dated April 3, 2025,	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 32 revealed the resident arrived at the emergency department at 7:39 AM for evaluation following the fall. A CT scan (computed tomography scan a medical imaging technique that uses X-rays and a computer to create detailed cross-sectional images of the body) of the brain was performed, and the results identified a scalp hematoma (a collection of blood) overlaying the frontal bone. A review of a nurse's note dated April 3, 2025, at 12:34 PM indicated that Resident 4 returned from the hospital. The resident was noted to have a bump on the right side of her forehead with associated bruising. She was reported to have some pain and discomfort in the area. A Certified Registered Nurse Practitioner (CRNP) assessed the resident, and no new medical orders were issued at that time. Further review of a nurse's note dated April 3, 2025, at 2:09 PM revealed that Resident 4 continued to exhibit agitation and crying behaviors, attempting to get up without assistance. Multiple redirection attempts were documented as	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 33 ineffective. Staff continued to monitor the resident. There was no documented evidence that new or revised interventions were implemented following this fall to address the resident's ongoing fall risk and behavioral symptoms. Later, the same day, on April 3, 2025, a review of nursing documentation at 10:40 PM revealed that Resident 4 was observed wandering around the nurses' station when she fell out of her wheelchair, striking the right side of her forehead. The resident's fall alarm was sounding at the time of the incident. The RN Supervisor was called to assess the resident, and the physician was notified. Resident 4 was subsequently transferred to the hospital for further evaluation. An investigative progress note dated April 3, 2025, at 10:55 PM documented that Resident 4 was found sitting on the floor with her back against the wall. A dark, raised area was noted to the right side of her forehead, and a laceration approximately 0.5	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 34 centimeters in length was observed beneath her right eyebrow, with minimal bleeding. A review of a witness statement dated April 3, 2025 (no time indicated) from Employee 14 (LPN) revealed that while working at the nurses' station, Employee 14 heard a "thud." Upon investigation, Resident 4's fall alarm was sounding, and the resident was found on the floor next to her wheelchair. Hospital documentation reviewed for April 3, 2025, indicated that Resident 4 was evaluated in a local emergency department following the fall. Assessment and imaging were completed at that time. Due to the need for advanced imaging, the resident was subsequently transferred on April 5, 2025, at 6:05 PM to a second hospital. During this evaluation, Resident 4 underwent a Magnetic Resonance Imaging (MRI) scan (a diagnostic procedure that uses powerful magnets, radio waves, and a computer to create detailed images of the body). The MRI of the cervical spine was negative	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 35 for fracture. The resident continued to be noted with a frontal scalp hematoma and a small laceration below the right eyebrow, which was cleaned during the hospital stay. Despite sustaining 2 falls on April 3, 2025, resulting in a scalp hematoma and laceration, there was no evidence the facility implemented revised or enhanced fall prevention interventions for Resident 4. On April 5, 2025, two days after the prior incidents, Resident 4 experienced a third fall result resulting in an additional injury. Following two falls sustained by Resident 4 on April 3, 2025, a review of nursing documentation dated April 5, 2025, at 3:41 AM revealed that the resident was readmitted to the facility from the hospital. Documentation noted the resident was crying, whining, fighting sleep, and attempting to wiggle off the stretcher. Upon transfer to bed, interventions included placing the bed in the lowest position,	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 36 ensuring the resident's alarm was intact, and positioning floor mats at the bedside. Bruising was observed on the resident's left hand and forearm. Resident 4 was placed on 1:1 supervision at that time. A subsequent nursing note dated April 5, 2025, at 4:45 PM documented that Resident 4 was witnessed by staff falling out of her wheelchair and striking the left side of her forehead on the floor. The resident was noted to have a large contusion to the left side of the forehead. While the skin remained intact and no bleeding was observed, the resident's neurological status was noted to be abnormal, as she was not opening her eyes or responding to verbal prompts. The physician was notified, and Resident 4 was transferred to the hospital for evaluation. There was no documented evidence that active 1:1 supervision was in place at the time of the fall. No employee was identified in facility documentation as supervising Resident 4 when the fall occurred.	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 37 During an interview conducted on April 23, 2025, at 1:00 PM, the Director of Nursing stated that the aide assigned to Resident 4's 1:1 supervision had left her unsupervised to assist another resident who had fallen and was noted to be bleeding in the same hallway. During the aide's absence, Resident 4 stood up from her wheelchair and fell to the floor. A review of hospital emergency documentation dated April 5, 2025, indicated that Resident 4 underwent assessments, including a CT scan of the head and neck. The scan showed no new injuries compared to imaging obtained after her previous falls on April 3, 2025. A nursing note dated April 6, 2025, at 2:15 AM documented that Resident 4 returned to the facility via ambulance accompanied by two attendants. The only intervention noted following this third fall was an adjustment to the resident's psychotropic medication, with an order to increase Geodon to 40 mg twice daily (total daily dose of 80 mg). There	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 38 was no documented evidence that additional fall prevention measures or effective interventions were implemented at the time of the survey to address Resident 4's continued high risk for falls. A review of the clinical record for Resident 3 revealed that the resident was admitted to the facility on September 1, 2022, with diagnoses that included dementia, macular degeneration (a progressive eye disease leading to vision loss), diabetes, brain aneurysm (a bulge in a blood vessel in the brain that can rupture and cause life-threatening bleeding), and a history of repeated falls. A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated February 14, 2025, indicated that Resident 3 had severely impaired cognition, required assistance with activities of daily living, and had experienced repeated falls.	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 39 A review of the physician's orders dated September 2, 2022, revealed an order for Eliquis 5 mg (an anticoagulant or blood thinning medication), to be administered orally twice daily due to the resident's diagnosis of brain aneurysm. A review of the resident's care plan, initiated September 1, 2022, identified the resident as being at risk for falls related to ambulatory dysfunction, impaired cognition, weakness, and a history of multiple falls. Interventions initiated August 29, 2023, included assistance of two staff for transfers, assistance of one staff member for bed mobility, use of a wheelchair with a ROHO cushion (a cushion designed to prevent pressure ulcers) and anti-rollback tippers (safety devices that prevent wheelchairs from tipping backward), a clip alarm (alerts staff of resident movement) at all times, and placement of Dycem (a non-slip material) on the top and bottom of the wheelchair cushion. A review of nursing documentation dated April 12, 2025, at 5:37 PM, revealed that Resident 3 was	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 40 found sitting on the floor in front of her wheelchair in the activity room. Employee 10 (Licensed Practical Nurse) stated the resident had been seated in her wheelchair and slid onto the floor despite the foam cushion being in place. The resident sustained a left posterior forearm skin tear, measuring 4.8 cm x 2.2 cm x 0.1 cm. The physician was notified, and treatment orders were received to cleanse the wound with normal saline, apply Xeroform and a non-adherent dressing, wrap with Kling (gauze wrap), and secure with paper tape. Additional interventions included reinforcing the Dycem application to the wheelchair pad. A witness statement dated April 12, 2025 (time not documented), provided by Employee 10 (LPN), indicated that at approximately 5:30 PM, Resident 3 was seated in her wheelchair in the day room watching television when she slid from the wheelchair onto the floor, landing on her buttocks. The RN Supervisor was notified, and an assessment was completed.	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 41 Review of nursing documentation dated April 14, 2025, at 8:45 PM, revealed that Resident 3 experienced another fall at 7:55 PM. Employee 11 (Nursing Assistant) reported that while transporting the resident into her room for evening care, the resident fell forward from her wheelchair, striking her forehead and nose on the floor. The resident was observed to be bleeding from the forehead and nose. The physician was notified, and the resident was transferred to the hospital for evaluation. A witness statement dated April 14, 2025 (time not documented), provided by Employee 11 (NA), indicated that while turning the resident's wheelchair parallel to the bed, the resident fell forward quickly from the wheelchair. A subsequent interview with the Director of Nursing (DON) confirmed that upon further clarification with Employee 11, the resident had been stationary next to the bed when the nursing assistant turned away to gather supplies for evening care, at which time the resident lurched forward and fell before assistance could be rendered.	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 42 A witness statement dated April 14, 2025 (time not documented) by Employee 2 (RN Supervisor) corroborated that upon entering the room, the resident was observed lying on the floor between two beds, bleeding from her forehead. Employee 11 reported that the resident had "lurched forward" while seated in her wheelchair. A telephone interview conducted with Employee 11 (NA) on April 23, 2025, at 2:00 PM, further confirmed the resident was positioned next to the bed and that Employee 11 had turned away to gather supplies when the resident independently lurched forward out of the wheelchair and fell, striking her face on the floor. Employee 11 stated she could not recall the exact position of the wheelchair in relation to the bed or whether the resident struck any objects during the fall. A review of hospital documentation revealed that Resident 3 was admitted to the emergency room on April 14, 2025, at 8:52 PM. The resident initially complained of head and nasal pain and was noted to	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 43 have sustained a large stellate-shaped (star-shaped) forehead laceration measuring 3 cm and a nasal laceration. The forehead laceration was repaired with six sutures, and the nasal laceration was repaired with two sutures. Resident 3 returned to the facility on April 15, 2025, at 12:50 AM. An interview conducted with the Director of Nursing on April 23, 2025, at approximately 3:00 PM, confirmed that Resident 3 had experienced a prior fall two days earlier from her wheelchair, had a known history of falls in the facility, and that consistent supervision had not been provided to prevent falls with injury. At the time of the survey, there was no documented evidence that the facility had implemented effective interventions, including consistent supervision, to prevent further falls with injury for Resident 3. The facility's failure to implement and maintain effective fall prevention and supervision practices resulted at repeated falls and actual harm to two	F 0689		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 44 residents, Resident 3 and Resident 4. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.	F 0689		
F 0758 SS=D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort	F 0758	An approved Plan of Correction is not on file.	Completion Date: **04/29/2025** Status: **NEW** Date: **04/29/2025**

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 45 to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 46 Based on clinical record review and staff interviews, it was determined the facility failed to ensure that medication regimens were managed and monitored to promote or maintain the residents' highest practicable physical, mental, and psychosocial well-being, as evidenced by the lack of resident-specific rationale to support the increase for an antipsychotic medication and the use of psychoactive medications for one resident out of 21 residents sampled (Resident 4). Findings include: A review of clinical records revealed Resident 4 was admitted to the facility on September 9, 2024, with diagnoses to included dementia with mood disturbances (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety and a history of falling. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated	F 0758		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 47 standardized assessment process conducted periodically to plan resident care) dated March 17, 2025, revealed that Resident 4 was severely cognitively impaired with a BIMS score of 4 (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 -7 indicates severe cognitive impairment). The resident's care plan, initiated September 10, 2024, identified the potential for distressed mood and behavioral symptoms, such as restlessness, tearfulness, and yelling out. Interventions included medicating per physician order, observing for effectiveness, and conducting gradual dose reduction (GDR) per facility policy. A physician's order dated February 6, 2025, prescribed Geodon (an antipsychotic medication) 20 mg by mouth in the morning and 40 mg by mouth twice daily for "unspecified dementia with behavioral disturbance." A physician's order dated December	F 0758		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	260 TERRACE DRIVE PECKVILLE, PA 18452

STATE LICENSE NUMBER: 134902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 48 30, 2024, also prescribed Ativan (an antianxiety medication) 1 mg three times daily with the same diagnosis. Between April 3 and April 5, 2025, Resident 4 sustained three falls with injury, requiring emergency room visits. Following the third fall and return to the facility, the CRNP documented on April 7, 2025, the resident continued to experience behavioral symptoms and had received multiple medications for behaviors without success. On that same day, the Geodon dosage was increased to 40 mg twice daily (a total of 80 mg daily), despite no documented behavioral evaluations, psychiatric reassessments, or other non-pharmacological interventions preceding the increase. Review of the clinical record failed to reveal a psychiatric diagnosis that would specifically justify the concurrent use of both an antipsychotic (Geodon) and an antianxiety medication (Ativan). Additionally, the CRNP's April 7, 2025, note did not include a resident-specific rationale for the	F 0758		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 49 increase of Geodon or for the continued administration of Ativan. There was also no documentation reflecting consideration of gradual dose reduction or evidence of interdisciplinary team discussion supporting the medication changes. An observation April 23, 2025 at 11:30 AM, Resident 4 was seated in a chair in the activity room. She was noted to be sleeping at this time. There were 10 additional residents in the room participating in an activity. During an interview on April 23, 2025, at approximately 1:00 PM, the Director of Nursing confirmed that the clinical record lacked resident-specific documentation to support the increase in antipsychotic medication or the continued use of both psychoactive medications for Resident 4. Cross refer F689 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services	F 0758		

DRAFT NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395414	A. BLDG: 00 B. WING:	04/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVENTURA AT TERRACE VIEW	**260 TERRACE DRIVE PECKVILLE, PA 18452**

STATE LICENSE NUMBER: **134902**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0758 SS=D	Continued from page 50 28 Pa. Code 211.9(a) (1) Pharmacy Services	F 0758		