STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395414	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Terrace View	260 Terrace Drive Peckville, PA 18452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 13456 Based on observations and staff interviews, it was determined the facility failed to maintain a resident's right to privacy and confidentiality during a physician visit for one resident (Resident 4) and failed to provide personal privacy during a transfer in a mechanical lift for one resident (Resident 5) out of five sampled residents Findings include: During an observation of the C2 unit dining room at 11:51 PM multiple residents were observed assembled in this dining room awaiting lunch. Resident 4 was observed seated in a reclining chair near the window in the back of the room with another resident seated next to her in a reclining chair. There were also multiple residents seated at tables also awaiting their lunch service. Resident 4's physician arrived in the dining room to greet the resident, the resident replied that she was happy to see him. The physician was observed to ask the resident about her her recent hospitalization and the was heard asking the resident in a loud voice how are your bowels? The physician continued to ask the resident questions and check her abdomen in the presence and hearing distance of other residents. A review of nursing documentation dated June 25, 2024 at 12:57 indicated the physician was in and examined the resident. The physician visited this resident in the common area and asked personal health questions while in the presence of other residents. The physician failed to ensure the resident's personal privacy was maintained during this visit. A review of Resident 5's clinical record revealed this resident had a diagnosis of quadriplegia (condition in which both the arms and legs are paralyzed and lose normal motor function) and cerebral palsy (group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth) and required the use of a mechanical lift for transfers in and out of bed as per her comprehensive care plan of June 24, 2022. During an observation on the C2 unit at 1:30 PM while walking past Resident 4's room the door was open and two staff members were transferring the resident in a mechanical lift. The privacy curtain was not drawn nor the door closed. This resident could be viewed, elevated in the lift, from the hallway by any residents or visitors passing by the room. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure this resident was provided with privacy while staff were providing care and transferring her in a mechanical lift. The facility administrative staff confirmed the door to the residents room should be closed or a privacy curtain should be used when residents are provided personal care. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.2 (d)(4) Medical director 28 Pa. Code 211.12 (c) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 13456 Based on observation and staff interview, it was determined the facility failed to maintain a safe and orderly environment for residents, including comfortable temperatures. Findings include: During observations on June 25, 2024, at 8:30 AM it was determined the facility air conditioning was not functioning. Interview with the facility's director of maintenance at 10:00 AM revealed the hallway air conditioning was not functioning on the D unit since before June 10, 2024, and the air conditioner that supplied the two large activity rooms on the D unit were also not functioning. Each area required two separate repairs. The D units air conditioners were not functioning as of June 25, 2025, and alternate sources of portable air were placed in the halls and in the window of one activity room when the temperatures exceeded 90 degrees F Fahrenheit outside, which began on June 17, 2024. One activity room was closed due to the excessively hot temperature. A review of the temperatures obtained from the facility on the D unit that were provided for review ranged as follows: June 19, 2024 74 degrees Fahrenheit to 84 degrees Fahrenheit June 21, 2024 74 degrees Fahrenheit to 80 degrees Fahrenheit June 22, 2024 72 degrees Fahrenheit to 84 degrees Fahrenheit June 23, 2024 70 degrees Fahrenheit to 86 degrees Fahrenheit Outside environmental temperatures for the above dates were upwards from 93 to 97 degrees Fahrenheit. A review of facility temperatures for the C2 unit obtained by the facility on the following dates revealed: June 19, 2024 79 degrees Fahrenheit to 85 degrees Fahrenheit June 21, 2024 79 degrees Fahrenheit to 80 degrees Fahrenheit June 22, 2024 77 degrees Fahrenheit to 88 degrees Fahrenheit June 23, 2024 75 degrees Fahrenheit to 86 degrees Fahrenheit Interview with the director of maintenance and NHA on June 25, 2024, at approximately 10:00 AM revealed the facility was aware the rooftop air conditioner that cooled the C1 and C2 units was not working and needed to be repaired. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident 1's room at 8:00 AM revealed a portable air conditioner vented through the window to the outside. The air conditioner was plugged into an extension cord which ran along the floor and around the wall in the back of Resident 2's bed and was plugged into the outlet. Resident 1 stated her daughter brought the air conditioner in because it was too hot in her room. An observation of Resident 3's room revealed three fans. One free standing fan in the middle of the floor between the two beds in the room, plugged in an outlet next to the sink, creating a tripping and accident hazard. A second large tabletop fan was on top of the dresser against the wall. A smaller third fan was located on the dresser near the mirror. The resident stated that he purchased all three fans. These fans were not secured in any manner to prevent accidental tippage or impediments to safe mobility. Observation on June 25, 2024 at 7:50 AM on the C2 unit the following was observed: A free standing air conditioning unit was observed in the doorway of a closet in the hallway, connecting both side of the hallways, with the ventilation tube extending up into the ceiling of hallway, next to the resident dining room. The closet door remained open and the air conditioning unit was not secured and the plugged into an extension cord which extended across the floor to the wall outlet creating a potential tripping hazard. The open door allowed for access to the inside of this closet, which housed an inoperable ice machine the drainage tube from the air conditioner went into the drain on the floor of the room. This open closet door was now positioned between two hand rails impeding continued to access to the handrails. Observation on June 25, 2024, revealed a resident bathroom in the corner of the the dining room on the C2 unit. The door was open and a free standing air conditioning unit was positioned in the doorway to the resident bathroom. The ventilation tubing went through a hole in the ceiling and the unit was plugged into a cord into the outlet next to the sink. The condensation tubing was placed through the support bar/handrail of the toilet under the toilet seat to drain into the toilet. This rendered the bathroom inaccessible to residents and created a tripping hazard if a resident were to enter this bathroom. There was an unidentified staff member in the dining room at the time of the observation and when asked if residents used this bathroom he indicated yes. An observation of the D unit, a secured unit for residents with impaired cognition and behaviors, at 8:15 AM on June 25, 2024, revealed multiple residents ambulating up and down the hallway and self-propelling in their wheelchairs. Upon entry to the unit on the right side of the hallway in front of the handrails, a portable free standing air conditioning unit and small fan (in use) were plugged into an outlet. The ventilation tubing went into a hole in the ceiling and the condensation hose was draining into a large bucket. The items were freely moveable and not secured in anyway and obstructed the handrails on that side of the corridor. A second setup was located around the corner of the nursing station, to the left in the hallway on the right hand side of this hallway obstructing access to the handrails and were also not secured in any manner to prevent tipping. Throughout the day of the survey on June 25, 2024, a small portable fan was observed plugged into an outlet and running in the middle of the hallway on the C2 unit. The fan was also not secured with the potential to cause a tripping hazard or risk of tipping over. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview the nursing home administrator (NHA) and maintenance director on June 25, 2024 at approximately 10:00 AM revealed the facility air conditioning which cooled the C unit failed on approximately June 18, 2024. The D unit hallway air conditioning unit was also not working since approximately since June 10, 2024, and the facility was awaiting parts to repair. The D unit activity room air conditioner was also not working and awaiting repair. The facility placed portable cooling units and fans throughout the facility due to elevated temperatures in the facility but failed to do so in safe manner. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 13456 Based on observations and staff interviews it was determined the facility failed to maintain essential electrical and mechanical equipment in safe operating condition, to include central air conditioning on the C and D units and failed to inspect electrical equipment brought in from outside of the facility to ensure it was in safe operating condition. Findings include: During observations on June 25, 2024, it was determined that the facility's air conditioning was not functioning. Interview with the facility's director of maintenance at 10:00 AM revealed the hallway air conditioning on the D unit had not been functioning since before June 10, 2024 and the air conditioner that supplied the two large activity rooms on the D unit were also not functioning. Each unit required two separate repairs according to the interview with the director of maintenance. As of June 25, 2025, the facility attempted to use alternate sources for cooling the air, to include portable air conditioners and fans placed in the halls and in the window of one activity room when the temperature outside exceeded 90 degrees Fahrenheit beginning on June 17, 2024. One activity room was closed due to the excessive warm temperature. A review of the interior temperatures obtained by facility staff on the D unit provided for review during the survey revealed that the temperatures ranged as follows: June 19, 2024 74 degrees Fahrenheit to 84 degrees Fahrenheit June 21, 2024 74 degrees Fahrenheit to 80 degrees Fahrenheit June 22, 2024 72 degrees Fahrenheit to 84 degrees Fahrenheit June 23, 2024 70 degrees Fahrenheit to 86 degrees Fahrenheit Outside environmental temperatures on the above dates were greater than 93 to 97 degrees Fahrenheit. According to the director of maintenance, during interview on June 25, 2024, the D unit hallway air conditioning was being repaired. However, during this survey the facility was awaiting a repair technician to visit to make repairs to D unit activity room air conditioning. At the time of the survey, the facility was unable to provide a date the visit was scheduled or or estimated date when repairs will be made. A review of the interior temperatures obtained by facility staff on the C unit provided for review during the survey revealed that the temperatures ranged as follows: June 19, 2024 79 degrees Fahrenheit to 85 degrees Fahrenheit June 21, 2024 79 degrees Fahrenheit to 80 degrees Fahrenheit (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	June 22, 2024 77 degrees Fahrenheit to 88 degrees Fahrenheit June 23, 2024 75 degrees Fahrenheit to 86 degrees Fahrenheit Interview with the director of maintenance and NHA on June 25, 2024 at approximately 10:00 AM revealed the facility was aware the rooftop air conditioner that cooled the C1 and C2 units was not working and needed to be repaired. The director of maintenance obtained a quote for repair of this system on June 20, 2024, from a local company but this quote was not approved by the corporate office. The facility's corporate office then obtained a second quote. The second quote for repair was approved during the survey on June 25, 2024.The facility did not timely act upon making the repairs of the cooling system until a week after extremely hot temperatures. An observation of Resident 1's room at 8:00 AM revealed a portable air conditioner vented through the window to the outside. The air conditioner was plugged into an extension cord which ran along the floor and around the wall in the back of Resident 2's bed and was plugged into the outlet. Resident 1 stated during interview at that time that her daughter brought the air conditioner in to the facility because it was too hot in her room. An observation of Resident 3's room revealed three fans positioned about the room. One free standing floor fan in the middle of the room between the two beds in the room, plugged into an electrical outlet next to the sink. A second large tabletop fan was observed on top of the dresser against the wall. A smaller third fan was located on the dresser near the mirror. The resident stated that he purchased all three fans for use in the facility. Interview with the NHA on June 25, 2024, at 11 AM revealed that the facility had no established policy or functioning protocol that ensures electronics, such as portable AC units and fans, brought into the facility by an outside source were inspected for safety for use in the facility. Observation of each of the above electrical revealed no indication that the facility had checked and inspected to ensure they were properly maintained and safe for use in the facility. 28 Pa. Code 201.18 (e)(2.1) Management