

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Aventura at West Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 West Park Drive Cincinnati, OH 45238	

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)
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731</p> <p>Based on medical record review, physician interview, and staff interview, the facility failed to ensure physician notes were signed at the time service was rendered. This affected three (#51, #52, and #60) of three residents reviewed for physician visits. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record of Resident #51 revealed an admitted [DATE]. Diagnoses included emphysema, dementia, Alzheimers, anxiety, depression, hypertension, gastro-esophageal reflux disease, chronic pain syndrome, and atrial fibrillation.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident was independent with eating, supervision with toileting, and partial/moderate assistance with bathing, dressing, bed mobility, and transfers.</p> <p>Review of a physician visit dated 01/27/25 revealed the physician did not sign the progress note until 02/09/25.</p> <p>Interview on 03/27/25 at 1:43 P.M. Physician #340 stated he signs his notes the minute he completes them.</p> <p>Interview on 03/27/25 at 1:58 P.M. the Director of Nursing (DON) verified the physician did not sign his progress note at the time of service.</p> <p>2. Review of the medical record of Resident #52 revealed an admitted [DATE]. Diagnoses included stage 3 chronic kidney disease, depression, and rheumatoid arthritis.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision for eating, bed mobility, and transfers, partial/moderate assistance for toileting, substantial/maximal assistance for bathing, and dressing.</p> <p>Review of a physician visit dated 09/10/24 revealed the physician did not sign the progress note until 10/19/24.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Aventura at West Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 West Park Drive Cincinnati, OH 45238	

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)
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a physician visit dated 10/07/24 revealed the physician did not sign the progress note until 10/19/24.</p> <p>Interview on 03/27/25 at 1:58 P.M., the DON verified the physician did not sign his progress note at the time of service.</p> <p>3. Review of the medical record of Resident #60 revealed an admitted [DATE]. Diagnoses included pulmonary embolism, chronic kidney disease, post-traumatic stress disorder, chronic pain syndrome, polyneuropathy, depression, osteoarthritis, hypertension, anxiety, barrett's esophagus, history of bariatric surgery.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision with eating, bed mobility and transfers, and partial/moderate assistance with toileting, showering, dressing.</p> <p>Review of a physician visit dated 10/21/24 revealed the physician did not sign the progress note until 11/16/24.</p> <p>Interview on 03/27/25 at 1:58 P.M., the DON verified the physician did not sign his progress note at the time of service.</p> <p>This deficiency was an incidental finding that was discovered during the complaint investigation.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Aventura at West Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 West Park Drive Cincinnati, OH 45238	

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)
<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731</p> <p>Based on medical record review, physician interview, and staff interview, the facility failed to ensure residents were seen by the physician at least every 60 days. This affected one (#52) of three residents reviewed for physician visits. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record of Resident #52 revealed an admitted [DATE]. Diagnoses included stage 3 chronic kidney disease, depression, and rheumatoid arthritis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision for eating, bed mobility, and transfers, partial/moderate assistance for toileting, substantial/maximal assistance for bathing, and dressing.</p> <p>Review of physician visits revealed Resident #52 was last seen by the physician on 12/23/24.</p> <p>Interview on 03/27/25 at 1:43 P.M., Physician #340 verified he had not seen Resident #52 since 12/23/24.</p> <p>Interview on 03/27/25 at 1:58 P.M., the Director of Nursing (DON) verified Resident #52 had not been seen by the physician since 12/23/24 and should be seen by the physician every 60 days.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162751.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Aventura at West Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 West Park Drive Cincinnati, OH 45238	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>51069</p> <p>Based on observation and interview, the facility failed to secure all medications in a locked storage area and to limit access to authorized personnel. This had the potential to affect 12 residents (#3, #7, #11, #13, #24, #25, #26, #28, #34, #41, #66 and #74) that are independently mobile on the 400 floor. The facility census was 90.</p> <p>Findings include:</p> <p>Observation of medication administration on 03/27/25 at 8:29 A.M. revealed Licensed Practical Nurse (LPN) #315 to retrieve a medication that needed to be re-stocked on the cart. LPN #315 went to the medication storage room on level 4 of the facility. The door was observed to be unlocked. Interview with LPN #315 on 03/27/25 at 8:29 A.M. revealed that the medication storage room was never locked and had not been since the electronic key pad lock was taken off the door.</p> <p>On 03/27/25 at 8:41 A.M. this surveyor went back to the medication storage room and was able to gain access due to the door not being locked.</p> <p>Observation on 03/27/25 at 8:47 A.M. revealed that the door to the medication storage room was ajar. Interview on 03/27/25 at 8:48 A.M. with Employee #360 revealed that she was restocking a wound supplies cart. Employee #360 revealed that she has keys somewhere if the door gets locked but usually it was left unlocked.</p> <p>Interview with the Director of Nursing (DON) on 03/27/25 at 2:00 P.M. revealed that a key pad lock had been placed on the medication storage room door that day in an attempt to correct the deficiency.</p>		