STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365603	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at West Park	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)
F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, Self-Reported Incident (SRIs) review, hospital record review, review of emergency medical services (EMS) run sheet review, observation, staff interview, review of the facility investigation, review of the United States Food and Drug Administration (FDA) Guide to Bed Safety: Bed Rails in Hospitals, Nursing Homes and Home Healthcare, review of the Direct Supply Multi-Bed Pivoting Assist Device Owner's Manual, and policy review, the facility failed to thoroughly assess residents for the risk of entrapment and appropriateness for the use of bed rails. This resulted in Immediate Jeopardy and serious life-threatening harm/death when Resident #11's head and neck became wedged between the mattress and the bed rail. Resident #11 asphyxiated and died. This had the potential to affect 40 residents (Residents #4, #5, #12, #16, #20, #21, #22, #26, #30, #33, #35, #36, #37, #39, #40, #42, #43, #46, #48, #51, #53, #54, #57, #63, #67, #70, #74, #75, #77, #80, #85, #86, #88, #89, #91, #94, #95, #98, #99, and #100) with bed rails attached to their beds. The facility census was 93 residents. On 06/02/26 at 4:14 P.M. the Administrator, the Director of Nursing (DON), Regional Director of Operations (RDO) #250, and the Director of Clinical Services (DCS) #251 were notified Immediate Jeopardy began on 05/23/26 at 12:49 P.M. when Resident #11 was discovered sitting on his buttocks next to the left side of the bed with both legs extended toward the window. Resident #11's head and neck were caught between mattress and assist bar with his lower jaw stuck inside the handle of the assist bar. Certified Nursing Assistant (CNA) #138 assisted Registered Nurse (RN) #50 in removing the mattress from the right side of the bed to free Resident #11 and lower him to the floor. RN #50 started cardiopulmonary resuscitation (CPR) until EMS arrived and took over rescue efforts. At approximately 1:05 P.M. EMS advised staff Resident #11 had a pulse and was being transported to a local hospital where the resident was admitted , intubated, mechanically ventilated. Resident #11 expired on 06/01/26. The Immediate Jeopardy was removed on 05/24/26 and continued at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) until it was corrected on 05/31/26 when the facility implemented the following corrective actions: On 05/23/26 at 12:50 P.M., RN #50 notified the DON of the incident involving Resident #11. The DON immediately called the Administrator who then notified the appropriate corporate support required. (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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/23/26 the Administrator and the DON completed a root cause analysis of the incident. Contributing factors to the incident included the following: communication between the nursing department and the maintenance department did not occur per the facility's room readiness process, maintenance was not informed the previous resident had discharged from the facility, maintenance did not remove or checked the assist bars on Resident #11's bed, the facility failed to assess Resident #11 for the appropriateness of the use bed rails, the facility did not obtain consent from the resident and/or the resident's representative for the use of bed rails. On 05/23/26 at 2:33 P.M., the Administrator, the DON, and Licensed Practical Nurse (LPN) #203 notified the Medical Director of the incident and the facility's Quality Assurance Performance Improvement (QAPI) Plan to correct. On 05/23/26 at 2:45 P.M., RDO #250 reviewed the facility's policy and procedure for Bed Safety and Assist Rails, process for communication of assist bar needs and ongoing bed inspection form (including side rails) with no revisions deemed necessary. On 05/23/26 at 3:05 P.M, DCS #251 and RDO #250 educated the Administrator and the DON on the following: communication of assist bar needs upon admission and discharge, assessments for side rail/assist bars and appropriate usage/risks, applying side rails/assist bars, consent forms, care plan/kardex accuracy, physician orders, monthly inspection of beds (including side rails/assist bars) On 05/23/26 at 3:40 P.M., the DON initiated education to licensed nurses and CNAs on the following: communication of assist bar needs upon admission and discharge, assessments for side rail/assist bars and appropriate usage/risks, applying side rails/assist bars, consent forms, care plan accuracy, physician orders. Training was completed on 05/24/26 at 4:36 P.M. For staff on leave of absence or vacation, training will be completed in-person before staff begin their next shift. Staff will not be allowed to work until training is completed. Training will also become part of new hire orientation and mandatory for per diem staff before working on the floor. On 05/23/26 at 3:40 P.M., the Administrator educated the Maintenance Director on the following: communication of assist bar needs upon admission and discharge, monthly inspection of beds (including side rails/assist bars) On 05/23/26 at 4:20 P.M., the nursing administration team consisting of the DON, RN #181, and LPN #203 completed walking rounds to identify beds with assist bar(s) in place. On 05/23/26 at 5:20 P.M., the DON, RN #181, and LPN #203 audited bed rail/assist bar assessments, physician orders, bed rail/assist bar consents, and Kardex and care plans to ensure accuracy updating as needed. On 05/23/26 at 5:40 P.M, the Maintenance Director removed the assist bar from Resident #12's bed as they were assessed as not needing the bars. The Maintenance Director then ensured appropriate placement on beds of those who were deemed appropriate with required assessment, physician order and consent with correct measurements according to FDA and Manufacturer Guidelines. On 05/23/26 at 5:50 P.M., the Administrator educated Human Resources Director (HRD) #257 on the required new hire education for nursing and maintenance employees regarding the following: communication of assist bar needs upon admission and discharge, assessments for side rail/assist (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bars and appropriate usage/risks, applying side rails/assist bars, consent forms, care plan/Kardex accuracy, physician orders, monthly inspection of beds (including side rails/assist bars. On 05/23/26 at 10:03 P.M., the Administrator filed a Self-Reported Incident (SRI) to the Ohio Department of Health (ODH) regarding the incident involving Resident #11. Starting on 05/23/26, the Administrator will audit the monthly bed inspection forms for one month. Starting on 05/24/26, to ensure ongoing compliance, the DON/designee will audit new and re-admissions to ensure the residents were assessed for side rails/assist bars, physician orders, consents, care plan and Kardex accuracy three times per week for a period of four weeks. Starting on 05/24/26, the Administrator/designee will audit rooms ready for admission three times per week for a period of four weeks. On 06/02/26 at 4:35 P.M., the facility held a QAPI Committee meeting to review the Immediate Jeopardy which was called by ODH related to the event on 05/23/26 and to review the corrective action plan the facility initiated on 05/23/26. The following Interdisciplinary Team (IDT) members were in attendance: the Administrator, the Medical Director, the DON, the ADON, the Unit Manager, RDO #250, the Regional Director of Clinical Operations (RDCO), the Activities Director, the Dietary Director, the Social Services Director, the Social Services Assistant, the Marketing Director, the Admissions Coordinator, the Business Office Manager, the Maintenance Director, the Housekeeping Director The QAPI Committee determined no revisions to the corrective action plan were deemed necessary. Starting on 06/02/26, the QAPI Committee will review the IJ corrective action plan weekly for four weeks and then monthly for 90 days to ensure ongoing compliance. Interviews on 06/02/26 and 06/08/26 with LPN #205, RN #8, CNA #104, CNA #180, and Maintenance Assistant (MA) #147 confirmed they received education from the facility regarding bed rails and assist bars in May 2026. Findings include: Review of the medical record for Resident #11 revealed an admission date of 05/22/26 with diagnoses including right hip fracture, anxiety disorder, orthostatic hypotension, depression, and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severe cognitive deficits, was dependent on staff for activities of daily living including the ability to roll from lying on back to left and right side and return to lying back on the bed. Review of medical record revealed no documentation that Resident #11 had been assessed to determine the appropriateness for the use of side rails. There were no documented alternatives attempted prior to placing Resident #11 into a bed equipped with bed rails. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing note dated 05/23/26 at 3:44 P.M. per RN #50 revealed at approximately 12:49 P.M., CNA #138 called the nurse to Resident #11's room for assistance. Upon entering the room, RN #50 saw Resident #11 sitting on his buttocks next to left side of the bed with his legs extended toward the window. Resident #11's head and neck were caught between the mattress and the assist bar with his lower jaw inside the handle of assist bar. CNA #138 assisted RN #50 in removing mattress from the right side of the bed which allowed staff to free Resident #11 and lower him to the floor. Resident #11 was not breathing and was non-responsive. RN #50 started CPR. CPR continued until EMS arrived at approximately 1:05 P.M. and took over rescue efforts. At 1:21 P.M. EMS advised the nurse Resident #11 had a pulse and would be transported to the hospital. Review of the facility SRI #274903 dated 05/23/26 revealed staff saw Resident #11 resting in bed, but when the staff member returned to the room approximately15-20 minutes later she discovered Resident #11's head was stuck in the bed rail, the resident was unresponsive, and there was feces all over the bed and on the floor next to the resident's body. Staff believed Resident #11 either tried to get up out of bed and passed out due to history of orthostatic hypotension or rolled over and fell out of bed. All staff working at the time of the incident were interviewed with no unusual circumstances or other issues were voiced. The facility did not substantiate neglect or abuse had occurred. Review of a witness statement dated 05/23/26 per CNA #138 revealed around 12:30 P.M. the aide entered Resident #11's room and saw the resident had been incontinent of bowel. The nurse had toileted the resident 15-20 minutes prior. CNA #138 told Resident #11 she was going to get supplies and finish assisting another resident and would come back shortly to help clean the resident. When CNA #138 returned to Resident #11's room, the resident's feet were on the floor. CNA #138 called out Resident #11's name with no response. CNA #138 ran to the other side of the bed and found the resident sitting upright on the side of the bed with his buttocks on the floor and his neck stuck between the side rail and the side of bed. Resident #11 was unresponsive, and CNA #138 called for the nurse and requested immediate assistance. The nurse started compressions and told CNA #138 to call 911 and to call a code blue indicating CPR was in progress. Review of a witness statement dated 05/23/26 per RN #50 revealed at approximately 12:45 P.M. CNA #138 called out to the nurse from Resident #11's room. Upon entering the room, the nurse observed Resident #11 sitting on the floor at his bedside with his legs extended toward the window. Resident #11's jaw was inside the assist bar, and his head and neck were between the mattress and assist bar obstructing his airway. At 12:49 P.M. the nurse contacted the DON and Unit Manager to notify them of incident. CNA #138 assisted RN #50 with removing the mattress from the opposite side of the bed which made it possible to lower Resident #11's upper body to the floor where CPR could be performed effectively. At 12:53 P.M., RN #50 gave two rescue breaths and started chest compressions. The other nurse on the unit called a code blue and brought the crash cart. RN #50 along with other staff continued CPR alternating cycles until paramedics, first responders, and EMS arrived and took over at approximately 1:05 P.M. At 1:21 P.M. EMS staff advised that Resident #11 had a pulse and they were transporting the resident to the hospital. Review of the EMS run sheet dated 05/23/26 revealed upon arrival at the facility EMS staff found Resident #11 lying on his back on the floor. Staff stated they found Resident #11 not breathing with his head stuck between the bed railing and the bed and was not breathing. EMS noted some redness to Resident #11's neck and took over CPR and once they obtained a pulse they transported the resident to the hospital. Review of hospital records for Resident #11 dated 06/01/26 revealed the resident presented to the (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital after being found down in between the bed and an assist rail. Resident #11 was admitted to the hospital, and his status was cardiac arrest with diffuse hypoxic injury. He was intubated and placed on mechanical ventilation. After ongoing discussion with Resident #11's family the resident was transitioned to comfort-focused care and withdrawal of life-supporting measures. Resident #11's code status was changed from full code to do not resuscitate comfort care (DNRCC.) Mechanical ventilation was withdrawn on 05/30/26 and the resident expired on 06/01/26 at 10:14 A.M. During a telephone interview on 06/02/26 at 12:43 P.M., RN #50 stated she was at her cart when CNA #138 hollered for help. RN #50 stated when she entered the room Resident #11 was sitting on the floor with his head and neck between the assist bar and mattress and his neck was hooked on top which obstructed the resident's breathing. RN #50 stated she and CNA #138 removed the mattress in order to free Resident #11 from the assist bar and then lowered the resident to the floor to perform CPR. RN #50 stated Resident #11 did not appear to be agitated that last time she had been in the room. During a phone interview on 06/02/26 at 12:38 P.M., CNA #138 refused to answer any questions regarding Resident #11. During an interview on 06/02/26 at 1:20 P.M., the DON reported staff notified her of Resident #11's head and neck being stuck between the assist bars and bed with his jaw stuck in the rail on 05/23/26 at approximately 1:00 P.M. and she then notified the Administrator. During an interview on 06/03/26 at 11:30 A.M., the DON verified Resident #11 was given a bed with assist rails and Resident #11 had not been properly assessed for the use of the rails. Review of the owner's manual for the Direct Supply Multi-Bed Pivoting Assist Device revealed an optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of and in compliance with the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the US FDA. Review of the FDA Guide to Bed Safety and Bed Rails in Hospitals, Nursing Homes, and Home Care, undated, revealed the FDA had issued detailed guidance to help hospitals, nursing homes, and home care providers reduce the risk of bed entrapment (when a patient/resident becomes caught between bed rails and the mattress, or between rails themselves) which could cause strangulation, suffocation, or serious injury. Bed rails could be safe and beneficial when used appropriately, but they must be assessed individually, installed correctly, and maintained to prevent entrapment injuries. Review of the facility policy titled Bed Safety and Bed Rails dated August 2022 revealed the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The resident assessment to determine risk of entrapment included the following: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, resident size and weight, sleep habits, medications, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication; mobility (in and out of bed); and risk of falling. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following accident hazards; restricted mobility, and psychosocial outcomes. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This deficiency represents the noncompliance investigated under Complaint Number 3029840.