STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365783	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Assumption Village	9800 Market Street North Lima, OH 44452

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of the medical record, interview, and review of facility policy, the facility failed to ensure Resident #24 received pain management medication as ordered to ensure an effective pain management program was in place. This affected one resident (Resident #24) of three residents reviewed for pain management. The facility census was 106.Findings include:Review of the medical record for Resident #24 revealed an admission date of 01/10/25 with diagnoses including multiple sclerosis (MS), type two diabetes mellitus, essential hypertension, protein-calorie malnutrition, major depressive disorder, anxiety disorder, paraplegia, colostomy status, chronic kidney disease, long-term use of aspirin, and chronic pain.Review of the care plan last completed 04/25/25 revealed Resident #24 received pain medication therapy secondary to chronic pain, MS, and wounds. Interventions included administration of routine and as indicated pain medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment completed on 07/18/25 revealed Resident #24 had intact cognition and no behaviors or rejection of care. Further review of the MDS revealed Resident #24 was on a scheduled pain regimen, had taken analgesics (pain medications) on an as-needed basis, received non-pharmacological pain interventions, and reported pain that occurred almost constantly which occasionally affected sleep and participation in therapy, and frequently interfered with day-to-day activities pain was rated a six (on a numerical rating scale from 00 - 10) at the time of the assessment.Review of the physician orders for Resident #24 revealed the pain management regimen included the following pain management related orders:an order dated 01/14/25 to assess for pain every shiftan order dated 01/10/25 for Voltaren Arthritis Pain External Gel one percent (1%), apply to bilateral knees topically every 12 hours as needed for painan order dated 01/14/25 for Methocarbamol oral tablet 750 milligrams (mg), one tablet by mouth four times a day for pain related to multiple sclerosisan order dated 03/29/25 for Hydrocodone-Acetaminophen tablet 7.5-325 mg, one tablet by mouth every four hours as needed for painan order dated 01/10/25 for Lyrica oral capsule 100 mg (pregabalin), give one capsule by mouth two times a day for painan order dated 01/14/25 for Acetaminophen extra strength oral tablet, give 1, 000 mg by mouth every eight hours as needed for headache with special instructions not to exceed 4,000mg in 24 hoursan order dated 01/14/25 for Acetaminophen 325 mg tablet, give 650 mg by mouth every four hours as needed for pain with special direction not to exceed 4,000mg per 24 hoursReview of the medication administration record (MAR) revealed Resident #24 did not receive the ordered doses of Lyrica, 100 mg twice daily by mouth for pain the evening of 07/19/25, the morning and evening of 07/20/25, the morning and evening of 07/21/25, and the morning of 07/22/25, for a total of six missed doses. Review of the electronic MAR (eMAR) progress notes from 07/19/25 through 07/22/25 revealed documentation the scheduled doses of Lyrica were held on 07/19/25 at 7:47 P.M. and 07/21/25 at 7:20 P.M. with no reason given. Further review of the progress notes revealed the scheduled doses of Lyrica were held on 07/20/25 at 8:47 A.M., 07/21/25 at 8:35 A.M., and 07/22/25 A.M. because the medication was on order. Review of the progress note dated 07/20/25 and timed 8:10 P.M. revealed the Lyrica was held because the facility was waiting for the prescription from the Nurse Practitioner (NP).Interview at 11:05 A.M. with Resident #24 confirmed there were several days the ordered Lyrica was not received, stating they ran out and revealing the pain over those few days was worse than her typically experienced discomfort. During the interview, Resident #24 confirmed she continued to receive other pain medication as needed. During the interview, Resident #24 also revealed an increase in the frequency and severity of headaches on the days Lyrica was not administered. Interview on 07/24/25 at 11:15 A.M. with Registered Nurse (RN) #379 confirmed facility nurses were to ensure orders were prepared for NP #477 to sign when nurses noted a resident's controlled substance medication was running low so that the medication could be ordered timely and the resident did not miss any doses. Interview on 07/24/25 at 11:30 A.M. with the Assistant Director of Nursing (ADON) confirmed the facility was aware Resident #24 had not received a total of six ordered doses of Lyrica and that although facility nursing staff had prepared the prescription order for signature, there had been a miscommunication, and the prescription renewal was not signed timely to prevent the missed doses. During the interview, the ADON further acknowledged that controlled substances should not be stopped abruptly. Review of the policy titled Pain Assessment and Management 03/24/25 revealed the facility was to manage resident pain consistent with the plan of care, professional standards of practice, and were to collaborate with physicians or prescribing practitioners and implement non-pharmacological and pharmacological intervention as ordered. This deficiency represents non-compliance investigated under Complaint Number 1263104

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure Resident #60's insulin was administered properly. This affected one resident (Resident #60) of three residents observed for medication administration.Findings include:Review of the medical record for Resident #60 revealed an admission date of 04/18/25 with diagnoses including mixed hyperlipidemia, muscle weakness, primary hypertension, acquired absence of the left leg below the knee, primary open-angle glaucoma of the left eye, peripheral vascular disease, and type two diabetes mellitus.Review of the care plan dated 04/22/25 revealed Resident #60 had diabetes mellitus and used insulin to control blood sugar levels. Interventions included checking blood sugars and administering diabetes medications as ordered. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 04/25/25 revealed Resident #60 had intact cognition and received insulin injections and hypoglycemic medications.Review of the orders revealed an order dated 04/21/25 for Humalog Injection Solution (Insulin Lispro) 100 units per milliliter (units/ml) to be administered per sliding scale subcutaneously before meals as follows: if finger-stick blood sugar (FSBS) is zero to 200, no insulin coverage is needed; if FSBS is 201 to 250, inject three units; if FSBS is 251 to 300, inject five units; if FSBS is 301 to 350, inject nine units; if FSBS is 351 to 400, inject 12 units; if FSBS is 401 to 450, inject 15 units; if FSBS is greater than 450, call the physician. Observation on 07/23/25 from 11:35 A.M. to 11:40 A.M. revealed Registered Nurse (RN) #460 460 checked Resident #60's blood sugar, which was 238. RN #460 was then observed preparing and administering the insulin by placing a new needle onto Resident #60's Insulin Lispro KwikPen(R), dialing the dose knob to three (the ordered dose per sliding scale), then administering the insulin into the left upper arm of Resident #60 after cleansing the injection site. During the procedure, RN #460 did not prime the insulin pen prior to dialing the knob to three units (dose required per sliding scale) and administering the insulin to Resident #60. Interview on 07/23/25 after observation with RN #460 confirmed the insulin pen needle was not primed prior to dialing to the ordered dose and that the needle should have been primed until insulin was observed leaving the tip of the needle prior to administration. During the interview, RN #406 reported dialing the pen to one unit and depressing the knob may have been sufficient for priming but was uncertain whether there were specific directions for priming the pen. Review of the policy titled, Administering Medications last revised August 2022 revealed medications were to be administered in accordance with physician orders and appropriate vital signs were to be checked prior to medication administration as necessary per the order instructions. Review of the Insulin Lispro KwikPen(R) manufacturer instructions for use revealed the insulin pen was to be primed with two units prior to administration by turning the dose knob to two units, holding the pen upright so that air bubbles collected on top, and pushing the dose knob in slowly until it stopped at 0 (viewed in the dose window), so that insulin could be seen at the tip of the needle. The instructions further revealed failure to prime the insulin pen needle may cause the resident to receive the wrong dose of insulin. This deficiency represents non-compliance investigated under Complaint Number 1263104.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interview and review of facility policy, the facility failed to ensure the medical record for Resident #60 contained complete and accurate documentation of specified assessment criteria to safely administer ordered medications. This affected one resident (Resident #60) of three residents observed for medication administration. The facility census was 106. Findings include:Review of the medical record for Resident #60 revealed an admission date of 04/18/25 with diagnoses including mixed hyperlipidemia, muscle weakness, primary hypertension, acquired absence of the left leg below the knee, primary open-angle glaucoma of the left eye, peripheral vascular disease (PVD), and type two diabetes mellitus.Review of the care plan dated 04/22/25 revealed Resident #60 had an altered cardiovascular status related to hyperlipidemia, hypertension, and PVD. Interventions included administering medications as ordered and monitoring, reporting, and documenting signs of coronary artery disease and malignant hypertension, which included Resident #60's blood pressure. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 04/25/25 revealed Resident #60 had intact cognition and no behaviors or rejection of care. Review of the orders revealed an order dated 05/15/25 for Carvedilol tablet 6.25 milligrams (mg), give one tablet by mouth two times a day related to essential (primary) hypertension and hold for systolic blood pressure (SBP) less than 130.Observation on 07/22/25 at 8:33 P.M. revealed Resident #60 was given the Carvedilol 6.25 mg tablet by Licensed Practical Nurse (LPN) #346 but the blood pressure was not observed being taken during the medication administration observation. Interview with LPN #346 at the time of the observation revealed the blood pressure (BP) was taken prior to the medications being prepared and administered, and the BP result was within the ordered parameters. There was no documentation to support the BP was checked prior to medication administration.Review of the vital signs and weight monitoring documentation revealed the last recorded blood pressure for Resident #60 was recorded on 7/18/2025 at 6:41 P.M. as 124/78 millimeters of mercury (mmHg). Further review of the vital sign documentation revealed the only other blood pressures recorded in the medical record since the date of admission [DATE]) were on 05/05/25 at 10:11 A.M. (140/77), 05/18/25 at 9:32 A.M. (132/64), and 06/18/25 at 10:24 A.M. (152/84). Review of the medication administration record (MAR) revealed the evening dose of Carvedilol was signed off as given on 07/18/25 (order to hold for SBP less than 130) and there were no progress notes indicating the physician or the Nurse Practitioner were notified that the SBP was less than 130 or nursing staff were given orders to administer the medication despite the blood pressure result outside the ordered parameter. There was no evidence in the medical record that Resident #60 had a blood pressure re-check which resulted in the blood pressure reading meeting ordered carvedilol dose parameters on the evening of 07/18/25. Further review of the MAR revealed no prompt for the nurse to enter blood pressures in the Carvedilol row, or elsewhere on the MAR, other than once a month vital signs to be recorded once daily on the 18th of each month (time unspecified). Further review revealed the blood pressure was prompted on the MAR to be taken with vital signs monthly on the 18th of each month, not twice daily before administering the Carvedilol. Interview on 07/23/25 at 11:45 A.M. with Registered Nurse (RN) #460 confirmed there was no order to check blood pressure twice a day but since the medication order specified BP parameters, it was typical to check the Resident #60's BP before giving the medication but there was nowhere to chart the results on the MAR and it only got charted if it pops up to chart it. During the interview, RN #460 confirmed the BP was taken prior to administering the Carvedilol to Resident #60 but could not produce written or documented evidence. Instead, RN #460 picked up an electronic wrist BP cuff and presented the last BP reading of 124/97, and stated the last BP checked with that cuff was most likely for Resident #60 (the SBP was not in the ordered parameter) but then stated the blood pressure taken on Resident #60 was within the ordered parameters. Follow-up interview on 07/24/25 at 5:30 P.M. with LPN #346 confirmed Resident #60 should have blood pressure checks twice daily before giving the Carvedilol and that Resident #60's BPs were within the ordered parameters, but the results were not documented in the electronic medical record (EMR) and if and when they were written on report sheets, the sheets went into the shredder, leaving no record of blood pressure results. Interview on 07/24/25 at 12:15 P.M. with the Assistant Director of Nursing (ADON) confirmed the MAR did not prompt recording of the BP and none of the nurses had informed nursing administrative staff of the missing documentation prior to the survey.Review of the policy titled Charting and Documentation dated August 2022 revealed documentation of services, treatments and/or procedures