

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Aventura at Assumption Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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)

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the facility self-reported incident (SRI) and facility policy review, the facility failed to accurately document controlled drug administration for Resident #12 to prevent a potential significant medication error and/or misappropriation. This affected one resident (#12) of two residents reviewed for controlled drug administration. The facility identified 27 residents (#1, #4, #6, #7, #8, #12, #16, #19, #23, #25, #26, #30, #31, #32, #33, #34, #35, #37, #40, #44, #45, #48, #49, #51, #64, #66, and #78) who received controlled medications. The facility census was 98. Findings include: Review of the medical record for Resident #12 revealed an admission date of 04/19/25 with diagnoses of hereditary motor and sensory neuropathy, morbid (severe) obesity due to excess calories, type II diabetes mellitus with diabetic neuropathy, essential primary hypertension, hyperlipidemia, unspecified muscle weakness (generalized), low back pain, gastro-esophageal reflux disease without esophagitis, anemia, generalized anxiety disorder, chronic pain syndrome, major depressive disorder, recurrent, post-traumatic stress disorder, neuralgia and neuritis, and peripheral vascular disease. Review of the facility SRI tracking number 268375 created by the Administrator on 12/08/25 revealed an allegation of misappropriation of medication. On 12/08/25, Resident #12 alleged that on 12/06/25, Licensed Practical Nurse (LPN) #480 gave her the wrong medication and stole her medication, a Percocet (opioid pain medication). LPN #480 was suspended immediately. LPN #480 was drug screened, tested positive for benzodiazepines, alleged stolen medication was an opioid. LPN #480 had a prior prescription for Ativan that was now outdated. Facility cameras were reviewed, LPN #480 did administer a medication during the allegation; however, camera footage was not detailed enough to confirm if the medication was correct or not. No camera footage shows LPN #480 taking medication. The facility unsubstantiated the allegation as the evidence was inconclusive. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment and required assistance with medications, activities of daily living, self-care, and mobility. Review of Resident #12's December 2025 physician orders revealed an order dated 10/01/25 for oxycodone-acetaminophen (Percocet) (opioid pain medication) 5-325 milligram (mg) per tablet take one tablet by mouth every eight hours as needed (PRN) for pain. Review of the medication administration record (MAR) and controlled drug records (CDR) for Resident #12's Percocet from 10/01/25 to 12/08/25 revealed administration of Percocet was documented as follows: 10/24/25 at 8:15 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. 11/14/25 at unknown time it was removed for PRN administration on the CDR but not documented as administered on the MAR. 12/01/25 at 8:00 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. 12/06/25 at 7:15 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. 12/06/25 at 9:10 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. 12/07/25 at 12:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. 12/07/25 at 5:42 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR. Interview with LPN #416 on 12/18/25 at 10:13 A.M. revealed Resident #12 complained LPN #480 did not administer her as needed (PRN) Percocet but, gave her Tylenol instead. LPN #416 notified corporations and LPN #480 was sent home and investigation was initiated. Interview on 12/22/25 at 9:49 A.M. with the Director of Nursing (DON) verified the above findings, and confirmed the nurses were required to administer and document controlled medications using both the MAR and CDR to prevent medication errors. LPN #480 was terminated on 12/25/25 for violation of the facility's drug policy. LPN #480 tested positive for benzodiazepines without active prescription. A police report was filed with the local police department. Ohio Department of Health, Ohio Board of Nursing and Ohio Board of Pharmacy were notified of investigation findings. Interview with the Administrator on 12/22/25 at 10:10 A.M. revealed LPN #480 had no other violations substantial to medication documentation errors. Resident #12 had complained about LPN #480 taking her medications several months prior after this incident presented itself to facility. Review of the facility policy, Administering Medications, revised April 2019, revealed medication errors are documented, reports, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training and if the drug is withheld, refused, or given at a time other than scheduled time, medication shall be initiated and circled on the MAR. All medications administered shall be documented on the MAR. This deficiency</p>		