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	05/20/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of resident council minutes, and staff and resident interviews, the facility failed to ensure concerns raised by the resident council were thoroughly documented, effectively addressed, and resolved. The facility also failed to ensure consistent followˆup for repeated concerns voiced across multiple council meetings from 05/02/25 through 04/03/26. This had the potential to affect all 107 residents residing in the facility.Findings include:Review of the monthly resident council minutes from 05/02/25 through 04/03/26 revealed the following concerns:-05/02/25 residents expressed dietary concerns (nothing specific was documented). Concerns were referred to the Dietary Manager.-06/06/25 Resident #11 complained about a missing blanket, and 1500 hall residents voiced issues with a housekeeper stating she spends more time talking in halls than cleaning rooms. Food committee meeting was held before the resident council meeting. Residents wanted more soups for meals, less deli sandwiches, more choices for breakfast, and more input on meals. Residents were informed the menus were up to the dietitians and corporate staff. -07/16/25 no concerns noted during resident council. Food committee was held before the resident council meeting. Resident #11 stated the food was terrible and the soup was greasy. Residents requested fried bologna sandwiches. They also stated they were tired of scrambled eggs; would like more omelets and hard-boiled eggs. They also requested Italian ice instead of ice cream. Some residents stated the food had improved in the last two weeks. -08/08/25 no concerns noted during resident council. Food committee was held before the resident council meeting. Residents continued to request more variety for breakfast, would like grits in the morning, would like fish and grits, n more ham and bean soup; it's too salty, residents complained that the vendor's food quality is horrible and disgusting. They also requested fresh fruit in the morning; they were told they would have to check prices. -09/05/26, residents expressed concerns regarding staff being on their cell phones in hallway. Resident #11 voiced concern about her husband being sent out in an ambulance and she was not notified. Food committee was held before the resident council meeting. Residents stated they would like more homestyle meals, would like more say in meals, more variety of soups, and would like homemade omelets. They requested Italian ice instead of ice cream. Some residents stated the food had improved. -10/10/25 residents voiced concerns about clothes being returned wrinkled and housekeeping knocking over items when cleaning rooms. Food committee was held before the resident council meeting. Residents would like to have suggestion cards to give us ideas. Resident #11 does not like any casseroles and says the turkey is too salty. Residents stated the meat is tough, they would like more fall (hearty) soups, more creativity when cooking and plating, would like baked sweet potatoes on the always available menu, and would like more beans.-11/07/25, Resident #11 expressed concerns about her clothes being delivered to her husband's room, and his clothes being delivered to her room. Food committee was held before the resident council meeting. Residents asked if more of their food could be grilled; they were told it was a good possibility. They also requested romaine lettuce and creamed corn.-12/12/25 no concerns voiced in resident council. Food committee was held before the resident council meeting. Residents complained about food being too spicy; they were told staff would work on that. They stated meals were much better with the new Fall/Winter menu. Residents were concerned that the kitchen runs short on certain foods. -01/09/26 Residents stated nurses do not keep track of certified (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nursing assistants (CNAs) and he believed that was wrong, getting showers on days different than scheduled, CNAs continue to be on their cell phones in the hallway, and wheelchairs and equipment need cleaned. Food committee was held before the resident council meeting. Residents requested plain yogurt, romaine lettuce, would like apple juice, sweet potatoes, rice/gravy, buttered noodles, Brussel sprouts and beets. They complained that kielbasa was not cut up and real turkey is not deli turkey. They were informed the side dishes would be added to the menu. -02/06/26 Residents stated ear buds were an issue with CNAs, staff tell them I'll be back but never return, rooms were not thoroughly cleaned, and trash was not always picked up. Food committee was held before the resident council meeting. No food committee notes were provided. -03/06/26 Residents were concerned that CNAs were not making beds and poor communication between nurses and CNAs. Residents stated the facility could benefit from staffing a specific shower aide, and the laundry aide was not hanging clothes in closets; just hanging them on the room doors. Food committee was held before the resident council meeting. No food committee notes were provided. -04/03/26 No concerns voiced in resident council. Food committee was held following the resident council meeting. No food committee notes were provided.A review of the facility's Resident Council Follow^Up Summary, dated 05/01/25 through 03/31/26, showed multiple concerns listed as closed even though similar complaints persisted:-05/01/25, Environmental Services: Housekeeping concerns about dusting; intervention stated rooms were cleaned and staff were re-educated. The issue was closed, but complaints continued.-05/02/25, Dietary: Dietary concerns were referred to the Dietary Manager.-05/03/26, Dietary: Concerns were reviewed, and staff were re^educated. The issue was closed; however, dietary complaints continued.-06/02/25, Environmental Services: Housekeeping not completing duties; staff performance review and education initiated, issue closed; however, complaints continued.-09/01/25, Nursing: CNA cell^phone use; staff re^educated and monitoring initiated; however, complaints continued.-09/02/25, Nursing: Resident not notified before spouse's ambulance transfer; staff were re^educated. -10/01/25, Environmental Services: Wrinkled clothing; laundry process reviewed and staff re^educated; however, complaints continued.-10/02/25, Environmental Services: Items knocked over during cleaning; staff were re^educated; issue closed.-11/01/25, Laundry: Incorrect clothing in closets; staff were re^educated; issue marked satisfied and closed.-12/02/25, Dietary: Document stated residents reported improvement; marked satisfied without intervention; however, complaints continued.-Follow-up: 02/01/26- staff were re-educated on device use policy; compliance monitoring initiated. Marked as satisfied; however, residents continue to voice complaints at resident council; 02/02/26, staff saying I'll be back and not returning- staff re-educated on communication and follow-though expectation; however, this follow-up was dated four days before the complaint was voiced in the resident council meeting on 02/06/26; 02/03/26, cleaning rooms and trash removal- staff re-educated on performance, and monitoring was initiated. This was marked as satisfied; however, this follow-up was dated four days before the complaint was voiced in the resident council meeting on 02/06/26.There was no follow-up documentation provided for July 2025, August 2025, or January 2026. This was verified by the Administrator on 05/07/26 at 9:47 A.M. Additionally at this time all education and monitoring that was stated to be completed or started was requested but was not provided to the survey team.Interviews conducted during the Resident Council meeting held on 05/06/26 at 3:00 P.M. with Residents #8, #14, #17, #20, #23, #44, #48, #49, #50, #93, #102 and #122, while the Administrator was present revealed each resident expressed the following complaints:- Issues with dining room being closed- The kitchen ran out of items a lot- Menus were always wrong- Medications not being available- Quality of food- The residents stated they continued to tell staff about all the same problems and they were never fixed. Interview on 05/06/26 at 4:15 P.M. with the Administrator and the Director of Nursing (DON) revealed when questioned about if the residents' concerns were addressed, they stated they felt the issues were addressed to the best of their ability. Multiple interviews on 05/07/26 confirmed ongoing, unresolved concerns, particularly repeated dining^room closures:- During an interview on 05/07/26 at (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12:05 P.M. Licensed Practical Nurse (LPN) #648 stated the dining room was closed a couple times a week due to staffing, residents complain every time, and administrative staff are not doing anything to correct it.- During an interview on 05/07/26 at 12:10 P.M. Certified Nursing Assistant (CNA) #532 confirmed the dining room was closed multiple times a week, and residents often were not informed until mealtime and were told to return to their rooms.- During an interview on 05/07/26 at 12:15 P.M. Dietary Aide #681 reported the dining room was closed most days at lunch and dinner, that five dietary workers left in March 2026 and were not replaced, and staffing cuts were ordered. She added: they run out of food a lot, including milk and cereal; they do not buy replacements and wait for deliveries; snacks were only put out because state was in the building; and items on the menu were often unavailable.Multiple requests were made for the facility policy regarding Resident Council Meetings and procedure for addressing residents' concerns. The Administrator, DON nor the Activity personnel provided this policy.This deficiency represents non-compliance investigated under Complaint Number 2724006.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview, the facility failed to ensure nursing staff adhered to professional standards of practice for accurate, complete, and truthful documentation to reflect the care and/or services provided to residents at the date/time completed. This affected two residents (#4 and #14) reviewed for documentation and had the potential to affect all 107 residents residing in the facility. Findings include:Record review for Resident #4 revealed an admission date of 02/13/26, with diagnoses including Parkinson's disease, asthma, quadriplegia, and obesity. Review of Resident #14's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. The assessment revealed the resident required partial to moderate assistance for eating, personal and oral hygiene, substantial to maximum assistance for showering, and was dependent on staff for toileting. Record review for Resident #14 revealed an admission date of 10/05/25, with diagnoses including pneumonia, chronic obstructive pulmonary disease (COPD), anxiety, kidney disease, and heart failure. Review of Resident #14's comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact. The assessment revealed the resident required supervision for oral care, setˆup help for eating, partial to moderate assistance for showering and personal hygiene, and substantial to maximum assistance for toileting. During an interview on 05/13/26 at 9:10 A.M., Licensed Practical Nurse (LPN) #556 stated Registered Nurse (RN) #586 asked her to date an existing dressing on Resident #14's coccyx as 05/09/26. LPN #556 reported the dressing originally had no date. She stated she complied but did not feel right about it and feared getting in trouble if she refused. During an interview on 05/13/26 at 9:45 A.M., RN #586 verified she told LPN #556 to put a date on Resident #14's coccyx dressing. When asked why she would do this, she did not answer.During an interview on 05/19/26 at 9:00 A.M., RN #522 reported the Director of Nursing (DON) asked her to backdate a Gradual Dose Reduction (GDR) form for Resident #4 because it took the physician too long to sign it. RN #522 stated she refused to alter the date. She confirmed the date currently on the GDR form reads 04/20/26, which she stated was not the date she originally documented. Review of the Medication Regimen Review (MRR) dated 03/16/26 revealed Pharmacist #696 completed a review of Resident #4's medications and requested physician input. Changes were noted by RN #522 and dated with an indecipherable date. During an interview on 05/19/26 at 7:21 A.M., the DON denied knowledge of staff being asked to inaccurately document information regarding resident care.During an interview on 05/19/26 at 10:21 A.M., the Administrator denied knowledge of staff being asked to withhold documentation or incorrectly record dates. Review of the American Nurses Association Principles for Nursing Documentation indicates that nursing documentation should be accurate, complete, timely and reflective of the nursing care actually provided. In addition, State nurse practice standards and administrative rules including requirements from the Ohio Board of Nursing require nurses to document assessments, implementation of care and the nursing process in an accurate and timely manner. Review of the facility policy titled Guidelines for Charting and Documentation (April 2012) revealed all medical documentation must be complete, accurate, factual, timely, and reflective of the resident's condition and services provided. Entries must be dated, timed, authenticated, and corrections must follow approved amendment procedures without altering or obscuring original information. This deficiency represents non-compliance investigated under Master Complaint Number 3016164 and Complaint Number 2993517.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, staff and resident interviews, and facility policy review, the facility failed to ensure bathing and grooming in accordance with Resident #119's assessed needs and stated preferences. This affected one resident (#119) out of three residents reviewed for activities of daily living (ADL). The facility census was 107.Findings include:Medical record review for Resident #119 revealed an admission date of 04/30/26 with diagnoses including encounter for other orthopedic aftercare, type II diabetes mellitus without complication, hypertensive heart disease with heart failure, neuromuscular dysfunction of bladder, hypothyroidism, anxiety disorder, gastro-esophageal reflux disease without esophagitis, retention of urine, depression, dysphagia, oropharyngeal phase, and cognitive communication deficit.Review of the care plan dated 05/02/26 identified Resident #119 as being at risk for decline in ADL functioning due to impaired mobility and required staff assistance for hygiene. The plan directed that Resident #119 receive showers twice weekly with twoˆstaff assistance.Observation on 05/05/26 at 10:24 A.M., Resident #119 was observed wearing soiled clothing and was not well groomed or cleanˆshaven.Interview on 05/05/26 at 10:25 A.M., Resident #119 stated he had not received a shower at any point since admission (five days). He also reported he preferred staff assistance with shaving despite owning his own shaver.Review of the admission Minimum Data Set (MDS) assessment, dated 05/06/26, revealed Resident #119 was cognitively intact and required extensive assistance for all ADL. Review of the medical record revealed Resident #119's assigned shower days were Thursday and Saturday. Review of the shower documentation from 04/30/26 through 05/06/26 showed no showers or bed baths were provided during this period.Interview on 05/06/26 at 11:11 A.M. with Registered Nurse (RN)/Unit Manager (UM) #586 confirmed Resident #119 had scheduled shower days assigned upon admission and verified the resident did not receive any showers or bed baths for the first five days of his stay.Review of the facility policy titled, Activities of Daily Living (ADL), Supporting dated 04/25, states residents must receive care to maintain grooming and personal hygiene. This deficiency represents non-compliance investigated under Complaint Number 2993517.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of emergency medical services (EMS) records, review of hospital documentation, facility policy review and interview, the facility failed to recognize and respond timely and appropriately to an acute significant change in condition for Resident #108 to ensure prompt and necessary medical intervention was provided. This resulted in Immediate Jeopardy and Actual Harm with subsequent death beginning on 03/09/26 at 1:38 A.M. when Resident #108 was documented to have respiratory distress and abdominal pain. The resident's oxygen saturation was 84% (with oxygen increased to 6 liters per minute (L) nasal cannula). However, record review revealed no evidence of monitoring or comprehensive re-assessment of the resident until 6:14 A.M. at which time the resident's oxygen remained abnormally low. On 03/09/26 at 7:14 A.M. the physician gave an order to transport Resident #108 to the hospital. Consequently, Emergency Medical Services (EMS) was not contacted until 7:58 AM. Resident #108 experienced continued respiratory distress, was found by EMS to have a blood glucose of 33 g/dl (hypoglycemic) and remained hypoxic at 84% on 6L oxygen. The resident passed away at the hospital on [DATE]. A concern identified as Actual Harm that was not Immediate Jeopardy occurred on 04/26/26 after the facility failed to ensure Resident #53 received care and services consistent with professional standards when staff did not follow physician orders and did not report significant changes in condition resulting in a hospitalization requiring treatment for sepsis and abdominal wall abscess. On 04/23/26, the physician ordered a stool specimen to rule out Clostridioides difficile (C. diff), a highly contagious bacterium that causes severe diarrhea and inflammation of the colon; however, after one unsuccessful attempt on 04/24/26, staff made no further attempts and did not notify the physician of their inability to obtain the ordered specimen. Additionally, on 04/24/26, a nurse observed the resident's surgical abdominal wound dressing was odorous and approximately 60 percent necrotic but failed to notify the physician or Wound Nurse Practitioner of this significant deterioration. There was no documented evidence of monitoring or assessment of the wound site following this date until 04/26/26 when the resident was transferred to the hospital. The resident was subsequently admitted to the hospital on [DATE] with sepsis and an abdominal wall abscess.This affected two residents (#108 and #53) of three residents reviewed for quality of care and treatment/change in condition. The facility census was 107.On 05/11/26 at 1:45 P.M., the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were notified Immediate Jeopardy began on 03/09/26 when facility staff failed to recognize and respond timely and appropriately to an acute significant change in condition for Resident #108. On 03/09/26 at 1:38 A.M. staff documented the resident had respiratory distress (abnormally low oxygen saturation) and abdominal pain. Despite this change in condition, there was no documented monitoring or reassessment until 6:14 A.M., when the resident's oxygen remained critically low at 85%. A physician ordered hospital transfer at 7:14 A.M., but EMS was not contacted until 7:58 A.M. When EMS arrived, the resident was still in respiratory distress, had a dangerously low blood glucose level of 33 g/dL, and remained hypoxic. Resident #108 passed away at the hospital later that day. The Immediate Jeopardy was removed on 05/11/26 when the facility implemented the following corrective actions:- On 05/11/26 at 2:32 P.M., Medical Director #684 was notified by the LNHA of the Immediate Jeopardy (IJ) determination related to Resident #108.- On 05/11/26 at 2:55 P.M., the LNHA and DON were educated by Regional Nurse Consultant #688 on Change in a Resident's Condition or Status, Resident Examination and Assessment, Physician Services, Situation, Background, Assessment, and Recommendation (SBAR), Stop and Watch, Contacting the Physician, and Staff response to emergency situations - On 05/11/26 at 2:55 P.M., an Adˆhoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the LNHA, DON, Human Resources (HR) #541, Business Office Manager (BOM) #613, Social Services Designee (SSD) #569, Minimum Data Set RN (MDS) #518, Therapy Director #515, Activity Director #535, Dietary Manager #674, Unit Managers (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#522 and #586 , Medical Director #684 reviewing the IJ situation and receiving the above education.- On 05/11/26 from 3:05 P.M. to 10:08 P.M., the DON educated facility licensed nurses on Change in a Resident's Condition or Status, Resident Examination and Assessment, Physician Services, SBAR, Stop and Watch, Contacting the Physician, Staff response to emergency situations, Acute Condition Changes and General IJ Education. Any nurse not educated during this time would be educated prior to their next working shift. Training would be part of new hire orientation and mandatory for as needed (PRN) staff before working on the floor.- On 05/11/26 from 3:05 P.M. to 6:19 P.M., the DON educated facility staff on Change of condition, Stop and Watch and When to notify the nurse of changes. Any staff not educated during this time would be educated prior to their next working shift. Training would be part of new hire orientation and mandatory for as needed (PRN) staff before working on the floor. - On 05/11/26 between 3:15 P.M. and 8:11 P.M., an audit was initiated by the DON for all current residents. This audit was conducted via a skilled daily note form. All residents in house were evaluated with a head-to-toe assessment, including vital signs, and ensuring no active signs or symptoms of respiratory distress or abdominal cramping. A progress note was entered for all residents. The audits were completed by the DON, Unit Manager #522 and #586, MDS RN #518 and two floor nurses, Licensed Practical Nurses (LPN) #611 and (LPN) #644. - On 05/11/26 at 3:40 P.M., an audit of the previous 24 HR report with a lookback of 72 hours was completed by the Regional Clinical Nurse #688 to monitor for any resident change in condition that required a hospital transfer. - On 05/11/26 at 4:00 P.M. Medical Director #684, LNHA, and Regional Nurse #688 revised the facility daily clinical process and the contacting the physician policy.- On 05/11/26 at 4:30 P.M. Medical Director #684 provided education to Physician #689 and at 4:50 P.M. education to Physician #682. Education topics included Resident Examination and Assessment, Physician Services, SBAR, Stop and Watch, Contacting the Physician and Staff response to emergency situations- On 05/11/26 at 6:12 P.M., VP of Clinical #688 and LNHA educated DON, Unit Managers #522 and #586, SSD #569, Therapy Director #515, Activities Director #535, and MDS RN #518 on updated daily clinical process.- On 05/11/26 at 10:00 P.M., the DON and LNHA educated Physicians #682, #684, and #689 on Acute Condition Changes and General IJ Education. - To ensure ongoing compliance, three days a week for four weeks, the LNHA, DON, Unit Managers #522 and #586, SSD #569, and Therapy Director #515 would review the prior 24/72 hours, to ensure any resident with a change of condition had proper notification to the physician, a proper assessment, and appropriate interventions were put in place.- A summary of the IJ and corrective actions would be reviewed by the QAPI Committee:a. Weekly for four weeks or until substantial compliance is achieved.b. Then monthly for 90 days to ensure ongoing compliance- Interviews on 05/11/26 at 11:10 A.M. with LPNs #586, #611, and #644 confirmed they had been educated on resident change in condition. - Review of the facility binder revealed assessments and interviews of all residents on 05/11/26 with no concerns.Although the Immediate Jeopardy was removed on 05/11/26, the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Findings include:1. Review of the closed medical record for Resident #108 revealed an admission date of 01/19/26 and a discharge date of 03/09/26. Resident #108 had diagnoses including pneumonia, type two diabetes mellitus, chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Review of the physician's order dated 01/19/26 revealed the resident had an order for oxygen at 4-6 liters per minute (LPM) nasal cannula continuous to maintain pulse oximetry above 90%. Review of a Do Not Resuscitate directive dated 01/19/26 signed by both Resident #108 and the physician revealed Resident #108 had wishes to be Do Not Resuscitate Comfort Care (DNR-CC). The form listed providers would conduct an assessment, provide basic medical care, and if necessary for (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	comfort or to relieve distress may administer oxygen, Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP) (both machines help people breathe by delivering pressurized air through a mask). It also listed providers would not perform cardiopulmonary resuscitation (CPR), administer resuscitation medications, insert an airway, defibrillate, cardiovert, or initiate pacing, or (initiate) continuous cardiac monitoring. Review of the care plan dated 01/20/26 revealed Resident #108 was at risk for altered respiratory status related to diagnoses. Interventions included administering medication as ordered and reporting any abnormal findings to the physician. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #108 had intact cognition. The assessment revealed Resident #108 required partial to moderate (staff) assistance for all activities of daily living. Review of the medical record progress notes from 02/26/26 through 03/03/26, consistently documented Resident #108 was stable, with multiple physician assessments stating she was doing good, appeared comfortable, had stable vital signs, was afebrile, and demonstrated normal neurological findings, with each assessment concluding she was stable. A physician note on 02/26/26 confirmed continued clinical stability, and the next physician note on 03/02/26 again reaffirmed the resident was comfortable, stable, and without new concerns. A care conference note entered on 03/06/26 (late entry for 03/04/26) reflected routine care planning, indicating the resident was progressing in therapy and discussing oxygen needs, but did not identify any acute medical decline. No clinical notes documented any deterioration or instability between 02/26/26 and 03/03/26, and no further entries appeared until the note dated 03/09/26 at 1:38 A.M. which reflected a sudden significant change in condition documented. Review of the Medication Administration Record (MAR) for March 2026 revealed an order dated 01/27/26 to assess for antidepressant side effects such as dry mouth, blurred vision, constipation, urinary retention, hypotension, appetite changes, and dyspepsia twice daily. The administration record revealed No was answered twice daily from 03/01/26 to 03/08/26 until the night shift on 03/08/26 where it was marked Yes. Review of the nursing progress note dated 03/09/26 at 1:38 A.M. authored by LPN #640 revealed Resident #108 had increased shortness of breath with poor appetite during the shift. The note included Resident #108 was alert and oriented and responsive. Vital signs included temperature 97.8 degrees Fahrenheit, pulse 90 beats per minute, respirations 24, blood pressure 100/64, and pulse oximetry 84% on oxygen at 6 L via nasal cannula. Resident #108 was using accessory abdominal muscles to breath while at rest. Respirations were deep and labored. Resident #108 was also complaining of stomach pains. Resident #108's abdomen was soft and non-distended. Bowel sounds present times two quadrants and last bowel movement was on 03/07/26. Resident #108's last blood glucose was 60 at 10:00 P.M. Resident #108 was refusing food intake at the time. The note included the physician (Physician #582) was notified and Resident #108 would be closely monitored. Review of the resident's medical record revealed no written documentation the resident's responsible party was notified of this change in condition. However, continued review of the resident's medical record revealed no further monitoring or re-assessment of Resident #108 following the above note until 03/09/26 at 6:55 A.M. when the resident was assessed to have an oxygen saturation of 84% with oxygen at 6 LPM via nasal cannula. (continued on next page)

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	365783	A. Building B. Wing	05/20/2026

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed no evidence the physician was contacted at this time. Review of the nursing note dated 03/09/26 at 7:14 A.M. authored by LPN #640 revealed Physician #582 called the facility and gave a new order to send Resident #108 to the emergency room (ER). Review of the Emergency Medical Services (EMS) run report dated 03/09/26 revealed EMS was called at 7:58 A.M. (44 minutes after the order was received), arrived at 8:03 A.M., were enroute to ER at 8:16 A.M., and arrived at ER at 8:19 A.M. EMS records noted Resident #108 was confused the whole trip, her blood glucose was 33 milligrams per deciliter (mg/dL) (dangerously low and is considered severe hypoglycemia) and her oxygen was 85% on 6 L of oxygen. Resident #108 was administered glucose and placed on a non-rebreather oxygen mask. Review of the ER physician note dated 03/09/26 at 8:21 A.M. revealed Resident #108 presented to the ER for shortness of breath with a low pulse oximetry. Resident #108 also had low blood glucose. Resident #108 was listed as a DNR-CC; however, the hospital note indicated the resident's daughter was contacted and wanted the resident evaluated in the ER, beginning several hours ago. (Please note- review of the resident's facility medical record contained no written evidence when Resident #108's daughter was notified of the change in condition. The report noted an extensive conversation with the resident's daughter and son-in-law was held discussing that Resident #108 was declining and unresponsive. She was severely acidotic (the blood pH is dangerously low, often because acid is building up faster than the body can clear it which can cause organ failure, shock, heart rhythm problems, respiratory failure and death) with an elevated lactate of 15 (normal is 0.5 – 2 millimoles per liter (mmol/L)). The physician also reported Resident #108 had suspected mesenteric ischemia (not enough blood flow to part of the intestines). Resident #108's code status was DNR-CC, and the daughter decided to make the resident comfortable and consult hospice care. Resident #108 was discharged from the ER to the hospice house where she passed later that day. Interview on 05/11/26 at 10:00 A.M. with the DON and LNHA revealed staff should not have waited that long for the physician to call back or to send Resident #108 to the ER which resulted in a delay in the resident receiving medical intervention for this acute change in condition on 03/09/26. A telephone interview on 05/11/26 at 11:38 A.M. with Physician #682 revealed the night of 03/09/26 he was notified of Resident #108's change in condition via the WhatsApp application. He reported the facility put him on this app five years ago, but they had been instructed for emergencies to call him directly or call the medical/dental bureau to get him immediately. Physician #682 reported staff should have sent the resident to the hospital when they first identified the decline in her condition and then just should have notified him of this instead of waiting for him to respond to a message. Attempts to interview LPN #640 during the investigation were unsuccessful. Calls were placed on 05/11/26 at 9:10 A.M. and 12:30 P.M. and 05/13/26 at 8:15 A.M. and 8:59 A.M. with no answer by the LPN and the surveyor was unable to leave a voice mail. Attempts to interview Resident #108's daughter as part of the investigation were also unsuccessful as there was no answer when calls were placed to her. A telephone interview on 05/13/26 at 8:25 A.M. with Certified Nursing Assistant (CAN) #609 revealed she had cared for Resident #108 on 03/08/26 from 7:00 A.M. to 7:00 P.M. CNA #609 reported on 03/08/26, Resident #108 was alert and oriented but lethargic (which was not her normal behavior). Resident #108 only got out of bed to use the restroom and had CNA #609 change her bed sheets. CNA #609 revealed she did not think Resident #108 was short of breath during her shift, but her appetite (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing note dated 04/24/26 at 6:57 P.M. authored by LPN #621 revealed the wound vac was not placed on Resident #53's wound because the wound bed had necrotic slough above 60 percent of the wound, and the wound was odorous. There was no evidence that the physician or wound nurse practitioner was notified of the change in the wound. Review of the nursing progress note dated 04/26/26 at 12:51 P.M. revealed Resident #53 had increased confusion, was pulling off her dressing and taking off all her clothing. The note included the resident's abdominal wound smelled foul with large amounts of drainage. The physician was notified and ordered the resident sent to the emergency department (ED) for evaluation and treatment. Review of the nursing progress note dated 04/26/26 at 12:59 A.M. authored by LPN #611 revealed Resident #53 was admitted to the hospital with sepsis and an abdominal wall abscess. Interview on 05/19/26 at 9:49 A.M. with the Administrator confirmed there was no evidence of attempts to collect a stool sample from Resident #53 after 04/24/26, and no evidence the physician had been notified the sample had not been collected. Interview on 05/19/26 at 1:37 P.M. with WNP #695 revealed she saw Resident #53 on 04/22/26 and felt the wound to her abdomen was improving. The WNP revealed if it had been noted to be odorous and 60% neurotic two days later, she would be concerned and the facility should have called her or another provider. WNP #695 revealed had she known about this change, she would have asked for the resident to be sent to the hospital immediately or asked for her to be seen by the general surgeon. Interview on 05/20/26 at 12:17 P.M. with LPN #549 revealed she was certain she passed along the need for a stool sample for Resident #53; however, she could not recall who she had spoken to or if she documented it. She also revealed she would tell the physician if an order could not be followed through, such as a stool sample could not be obtained. She again could not confirm whether she had notified the physician in this particular case. Interview on 05/20/26 at 12:21 P.M. with LPN #621 revealed he recalled observing Resident #53's wound on 04/24/26. He stated he reviewed the notes from prior assessments, and the wound was noted to be improving; however, he felt the wound was putrid with purulent drainage everywhere and the wound was dark brown to black in color. He stated he would have called someone based on a significant change in the wound status; however, he could not recall who he had spoken to or if he documented it. He revealed facility policy was to notify a physician or manager regarding any change in condition such as a significant change in a wound. During the interview, LPN #621 denied knowledge of Resident #53 ever needing a stool sample collected. Review of the facility policy titled Change in a Resident's Condition or Status, revised December 2025, revealed the nurse would notify the resident's attending physician, provider, or physician on call when there had been a significant change in the resident's physical, emotional, or cognitive condition; a need to alter the resident's medical treatment significantly; and the need to transfer the resident to a hospital/treatment center. A significant change of condition was a major decline or improvement in the residents' status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. This deficient practice represents non-compliance investigated under Master Complaint Number 3016164 and Complaint Numbers 2991884 and 2803701.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of medical records, interviews with staff, review of hospital records, review of the National Pressure Injury Advisory Panel (NPIAP) and review of the facility policy, facility failed to provide the necessary care and services to prevent the development, worsening, and to promote the healing of a facilityˆacquired pressure ulcer for Resident #14. This affected one resident (#14) of three residents reviewed for pressure ulcers. The facility census was 107.Actual harm occurred on 12/23/25, when documentation first identified that the wound had progressed from Stage II to Stage III, with deeper tissue involvement and worsening characteristics because the facility failed to ensure consistent wound assessments, adherence to physicianˆordered treatments, proper pressureˆrelief interventions, infectionˆcontrol practices, or accurate clinical documentation.Findings include:Resident #14 was admitted to the facility on [DATE] with diagnoses including pneumonia, Methicillin Resistant Staphylococcus Aureus (MRSA), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), atrial fibrillation, anxiety, renal dialysis dependence, and Stage IV hypertensive chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #14 was cognitively intact and required extensive assistance with all activities of daily living (ADL), including bed mobility and transfers.On 10/07/25, Licensed Practical Nurse (LPN) #699 completed a wound assessment identifying a facilityˆacquired Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) to the coccyx measuring 1.5 centimeters (cm) by 1 cm by 0.1 cm, with an order for zinc oxide ointment to the bilateral buttocks twice daily.Resident #14 had a treatment order dated 10/07/25 to cleanse the wound to the coccyx with an antiseptic solution, apply silver alginate (protective gel that releases antimicrobial silver), and cover with a bordered foam dressing.Between 10/07/25 and 10/21/25, there were no documented wound assessments. A Wound Assessment and Plan note dated 10/21/25 stated Resident #14 was not seen due to dialysis.Review of the Treatment Administration Records (TAR) for October, November and December 2025 revealed no documentation that treatments were completed on 10/18/25, 11/04/25, 11/06/25,12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/25, 12/11/25, 12/15/25, 12/18/25, 12/19/25, 12/22/25 and 12/30/25.No further wound documentation was found until 12/23/25, which identified the wound had worsened to Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling), measuring 1.4 cm by 1 cm by 0.4 cm, with 20 percent granulation, 80 percent slough, serosanguineous drainage, and odor. Weekly wound assessments were done thereafter, although some were missed due to dialysis.On 01/02/26, the treatment order was to cleanse the wound to the coccyx with normal saline, apply wound gel (used to treat minor cuts, scrapes, and skin irritations), and cover with a dry dressing.Review of the TAR for January and February 2026 revealed no documentation treatments were completed on 01/05/26, 01/10/26, 01/11/26, 01/20/26, 01/21/26, 01/21/26, 01/22/26, 01/22/26, 01/23/26, 01/25/26, 01/28/26, 01/30/26, 01/31/26, 02/04/26, 02/09/26 and 02/13/26.On 02/20/26, the treatment order was changed to cleanse the coccyx wound with normal saline, apply collagen (promotes healing in chronic, stalled, or complex wounds), and cover with a dry dressing every three days.The care plan dated 03/05/26 directed staff to administer treatments as ordered, monitor wound healing, report changes, follow pressureˆulcer protocols, apply a Roho cushion, monitor pain and nutrition, assess for infection, and consult wound care as necessary.Review of Wound Assessment and Plan note dated 04/15/26 revealed the wound measured 1.3 cm by 0.5 cm by 0.5 cm with 100 percent granulation tissue with no signs of infection. Under the comment sections it stated Please note dressing order and apply what is ordered. Turn and reposition per facility policy and offload to prevent further breakdown and wound healing.During an observation on 05/13/26 at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	8:00 A.M., wound care was observed being performed by RN #586. During the dressing change, RN #586 touched the sterile center pad of an occlusive dressing with ungloved hands. She then applied collagen, not collagen with silver as ordered, before covering the wound.During an interview on 05/13/26 at 8:20 A.M., Wound Care Nurse Practitioner (WCNP) #695 stated she had concerns and had expressed them to the Administrator. The wound was unchanged and healing had stalled; she stated staff are either using the wrong products on the wound or they are just not doing the treatment. WCNP #695 confirmed this in her notes and continually documents to ensure wounds are changed per physician orders and with the right wound care supplies.During an interview on 05/13/26 at 8:55 A.M., RN #586 stated she changed the physician's order that morning to collagen because collagen with silver was unavailable. She acknowledged she altered the order without consulting the physician or WCNP #695. During an interview on 05/13/26 at 9:00 A.M., WCNP #695 verified the correct order was collagen with silver.During an interview on 05/13/26 at 9:10 A.M., LPN #556 reported RN #586 instructed her to date the resident's old dressing as 05/09/26, even though the dressing originally had no date. LPN #556 stated she complied but felt uncomfortable.During an interview on 05/13/26 at 9:45 A.M., RN #586 confirmed she had asked LPN #556 to date the dressing but did not give a reason.Review of the facility's policy Prevention of Pressure Injuries, revised April 2026, outlines procedures for identifying pressureˆinjury risk factors and implementing appropriate interventions.This deficiency represents non-compliance investigated under Complaint Number 2991884.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that required preˆ and postˆdialysis assessments were completed for one resident (Resident #14) of two residents reviewed for dialysis services. The facility census was 107. Findings include:Record review showed Resident #14 was admitted on [DATE] with diagnoses including pneumonia, Methicillin-resistant Staphylococcus aureus MRSA infection, endˆstage renal disease, hypertension, and dependency on hemodialysis. The resident's care plan, dated 02/25/26, identified a need for ongoing dialysis management, including monitoring of labs, infectionˆprevention measures, monitoring of the arteriovenous (AV) shunt, and assessment for symptoms related to fluid balance, toxicity, or complications. Physician orders directed staff to monitor the hemodialysis shunt every shift, including assessment for bruit and thrill.Review of dialysis assessment records from 01/01/26 through 05/12/26 revealed significant gaps and inconsistencies in both preˆ and postˆdialysis documentation. For the entire month of January, no preˆdialysis assessments were completed. After that period, multiple dates contained incomplete assessments, errors, assessments noted as in progress, or were entirely missing. Postˆdialysis assessments were also absent from 01/01/26 through 02/28/26, with numerous additional missing entries throughout March, April, and May. Interview on 05/12/26 at 9:54 P.M. with Dialysis Manager #686 reported that while they provide the facility with communication sheets, the facility does not send any communication back, nor do they send his binder to dialysis appointments. She also stated that Resident #14 had missed three dialysis appointments since 01/01/26 due to transportation issues. The missed dates were 01/27/26, 01/29/26, and 04/21/26. Interview on 05/12/26 at 10:35 A.M. with the Administrator, the Director of Nursing (DON), and the [NAME] President of Clinical Services (VPCS) #688 that facility staff were responsible for performing both preˆ and postˆdialysis assessments and acknowledged that these assessments had not been completed. They further confirmed that there was no order for preˆ and postˆdialysis assessments in the Electronic Medical Record (EMAR). This deficiency represents non-compliance investigated under Complaint Number 2991184.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and medication administration policy review, the facility failed to provide physician^prescribed medications to three residents (Residents #46, #52, and #110), resulting in missed doses of multiple medications across several dates. This affected three residents (#46, #52, and #110) of five residents reviewed for missed medications. The facility census was 107.Findings include:1. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including myasthenia gravis with (acute) exacerbation, dementia with other behavioral disturbance, type II diabetes mellitus, chronic obstructive pulmonary disease, Alzheimer's disease, bipolar disorder, major depressive disorder, recurrent, anxiety disorder, and mixed obsessional thoughts and acts. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/02/26, revealed Resident #46 was cognitively intact and independent with activities of daily living (ADL); care planned for medication administration.Review of April 2026 physician orders noted multiple prescribed medications. Medication Administration Record (MAR) review showed Resident #46 missed doses of:- Carvedilol (treats high blood pressure) on 04/16/26, 04/20/26, 04/21/26- Depakote (mood stabilizer) on 04/16/26- Donepezil (treats memory loss) on 04/16/26- Vitamin D3 (supplement)on 04/16/26- Apixaban (anticoagulant) on 04/16/26 (A.M.)- Buspirone (antianxiety) on 04/16/26 (A.M. and Afternoon)- Oxybutynin (anticholinergic) on 04/16/26 (AM)- Pyridostigmine (treats muscle weakness) on 04/16/26 (AM and Afternoon)- Vistaril (antihistamine) on 04/16/26 (AM & PM)2. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, acute neurologic, type II diabetes mellitus with hyperglycemia, vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, essential (primary) hypertension, peripheral vascular disease, cardiovascular and coagulations, hyperlipidemia, calculus of ureter, infectious gastroenteritis and colitis, other specified disorders of brain, acute long term (current) use of antithrombotic/ antiplatelets, and major depressive disorder.Review of the quarterly MDS assessment, dated 04/15/26, revealed Resident #52 had mild cognitive impairment and required set-up and partial to moderate assistance with ADL; care planned for medication administration. Review of April 2026 physician orders noted multiple prescribed medications. MAR review showed Resident #52 missed doses of:- Remeron (antidepressant) 15 mg on 04/11/26- Latanoprost eye drops (treats glaucoma) on 04/11/26, 04/12/26, 04/16/263. Review of the medical record revealed Resident #110 was admitted to the facility on [DATE] with diagnoses including hypokalemia, type II diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, atrial fibrillation, fall, subsequent encounter, essential (primary) hypertension, mixed hyperlipidemia, major depressive disorder, anxiety disorder, mood [affective] disorder, gastro-esophageal reflux disease without esophagitis, arthritis, multiple sites, low back pain, chronic kidney disease, stage III (moderate), and age-related osteoporosis without current pathological fracture.Review of the resident's discharge MDS assessment, dated 03/12/26, revealed Resident #110 had intact cognition and was independent with ADL; care planned for medication administration.Review of April 2026 physician orders noted multiple prescribed medications. MAR review showed Resident #110 missed doses of:- Atorvastatin (lowers cholesterol) on 02/13/26, 02/14/26- Furosemide (diuretic) on 02/14/26, 02/15/26- Prevacid (acid reducer) on 02/14/26- Tylenol PM (analgesic with sleep support) on 02/13/26, 02/14/26- Synthroid (hormone) on 02/14/26, 02/15/26- Apixaban (anticoagulant) on 02/13/26, 02/14/26- Buspirone (antianxiety) on 02/13/26 (AM), 02/14/26 (AM & PM), 02/15/26 (AM)- Potassium Chloride(supplement) on 02/13/26, 02/14/26- Doxazosin (treats high blood pressure) on 02/13/26, 02/14/26 (PM)- Metoprolol (treats high blood pressure) on 02/13/26 (PM), 02/14/26 (AM & PM), 02/15/26 (AM)Interview on 05/07/26 at 7:08 A.M., (continued on next page)

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Aventura at Assumption Village	9800 Market Street North Lima, OH 44452

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) #680 stated several residents went without medications when the medical director changed. She did not know the number or identity of affected residents. She confirmed all medication orders had to be manually entered into the electronic medical record (EMR) for pharmacy to supply medications. Interview on 05/13/26 at 8:53 A.M. LPN #611 reported the facility had been without medications for several residents for several consecutive days and notified physician, pharmacy, unit managers, Administrator, and Director of Nursing (DON) via unsecured textˆmessaging.Interview on 05/14/26 at 11:14 A.M., Physician #684 stated he was unaware residents had missed medications. He confirmed the previous prescriber wrote prescriptions only through 04/01/26, and when he began, he wrote all current prescriptions.Review of a facility policy Administering Medications, revised 04/19, states the facility is responsible for administering and providing medications to residents as prescribed.This deficiency represents non-compliance investigated under Complaint Numbers 2993517 and 2803701.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that pharmacy medication regimen review (MRR) recommendations, including gradual dose reductions (GDRs), safety-related medication changes, and required clinical rationales, were addressed timely and completely for three (Residents #4, #31, and #57) of five residents reviewed for unnecessary medications. The facility census was 107.Findings include: 1. Record review showed Resident #57, admitted [DATE] with dementia and major depressive disorder, was receiving Buspirone (antianxiety) 10 milligrams (mg) twice daily. An MRR dated 01/14/26 recommended a GDR; however, the nurse practitioner (NP) marked disagree without providing the required clinical rationale and did not date the form. A psychiatric follow^up note dated 01/26/26 indicated that a GDR would worsen the resident's symptoms; however, this information was not incorporated into the pharmacy MRR response. The care plan dated 03/03/26 included evaluating GDRs as indicated, yet the facility did not ensure the recommendation was addressed with required justification. During interview on 05/06/26 at 1:40 P.M., the Director of Nursing (DON) confirmed the psychiatric note supported not reducing the medication but acknowledged the information had not been included on the MRR form. 2. Record review showed Resident #4 was admitted [DATE] with diagnoses of acute transverse myelitis and Parkinson's disease. Physician orders included Benadryl (antihistamine) 25 mg with no discontinue date. Review of the MRR dated 03/16/26 recommended addressing Benadryl due to increased fall risk. Interview on 05/06/26 at 2:59 P.M., Registered Nurse (RN) Manager #522 reported receiving the recommendation on 04/26/26 but did not obtain a discontinue order until 04/30/26.Review of the physician's orders on 05/06/26 revealed the Benadryl remained active despite the recommendation. On 05/12/26 at 10:15 A.M., the DON stated that recommendations from pharmacy should be handled the same day, confirming that the delay was inconsistent with facility expectations. 3. Record review revealed Resident #31 was admitted on [DATE] with multiple diagnoses, including anxiety disorder, major depressive disorder, hypothyroidism, atrial fibrillation, essential hypertension, muscle weakness, and pain in the right shoulder. Active physician orders included Citalopram 20 mg orally once daily, Alprazolam (Xanax) 0.25 mg twice daily for anxiety, and Buspirone 15 mg twice daily for anxiety and depression. The resident was independent with activities of daily living and had a Brief Interview for Mental Status (BIMS) score of 15 on the quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE]. Review of the care plan revealed the resident was at risk for adverse effects related to psychotropic medications. Interventions included administering medications as ordered, evaluating for GDR as indicated, monitoring for adverse effects, notifying the physician for any adverse reactions, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist review per protocol, physician review per protocol, and psychiatric consults as needed. The care plan did not include nonˆpharmacological interventions, and no associated orders were present. Review of the MRRs revealed multiple pharmacy recommendations for GDRs that were not completed timely, not completed at all, or completed without required clinical rationale:- On 01/13/25, pharmacy recommended GDRs for Citalopram 20 mg daily and Xanax 0.5 mg twice daily. The provider marked No, stating a reduction would destabilize the resident; however, the recommendations were not signed until 02/04/25.- On 04/10/25, pharmacy recommended a GDR for Buspirone 10 mg twice daily; the recommendation was not addressed until 05/10/25.- On 10/14/25, pharmacy again recommended a GDR for Xanax 0.25 mg twice daily, which was completed on 10/20/25. A GDR for Buspirone was also recommended; however, no reductions were made and no rationale was provided for declining the recommendation.- On 01/14/26, pharmacy recommended a GDR for Citalopram 20 mg. The nurse practitioner (NP) marked disagree and wrote please offer rationale below, but did not write a rationale or date the form. Record review revealed documentation in psychiatric NP notes stating the resident was educated on medication side effects and interactions; however, there was no documentation that risks and benefits of medications were reviewed with the resident. During an interview on 05/11/26 at 10:30 A.M., Resident #31 stated the risks and benefits of his medications were not reviewed with him. During an interview on 05/11/26 at 11:35 A.M., the DON confirmed there were no physician orders for nonˆpharmacological interventions and no care plan addressing nonˆpharmacological approaches. The DON also confirmed there was no documentation showing nonˆpharmacological interventions had been attempted. This deficiency represents nonˆcompliance investigate under Complaint Number 2719642.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, manufacturer instructions, and facility policy review, the facility failed to ensure that insulin pens were dated when opened. This affected three of three insulin pens observed during the medication storage review (Residents #21, #42, and #99). This had the potential to affect an additional 11 residents (#3, #13, #28, #40, #50, #59, #63, #75, #94, #101, and #101) who were identified as receiving insulin. The facility census is 107.Findings include:1. Record review revealed Resident #21 was admitted on [DATE] with multiple diagnoses including Type II diabetes with neuropathy and angiopathy. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact and independent with activities of daily living (ADL). Physician orders included Lantus SoloStar (17 units twice daily) and Humalog KwikPen (4 units before meals).2. Record review revealed Resident #42 was admitted on [DATE] with diagnoses including metabolic encephalopathy and Type II diabetes with hyperglycemia. The admission MDS assessment dated [DATE] indicated severely impaired cognition and dependence for all ADL. Physician orders included Lispro 100 units/mL per sliding scale.3. Record review revealed Resident #99 was admitted on [DATE] with multiple diagnoses including Type II diabetes with neuropathy, chronic kidney disease, and dementia. The quarterly MDS assessment dated [DATE] indicated mild cognitive impairment and independence with ADL. Orders included Humulin 70/30 KwikPen, 10 units at bedtime.Observation on 05/11/26 at 9:23 A.M., the 1500-unit medication cart contained an opened insulin pen for Resident #42 with no documented open date.Observation on 05/11/26 at 9: 33 A.M., the 1200-unit cart contained an opened insulin pen for Resident #21 with no documented open date.Observation on 05/11/26 at 9: 47 A.M., the 1300-unit cart contained an opened insulin pen for Resident #99 with no documented open date. Interview on 05/11/26 at 10:08 A.M. with Registered Nurse (RN) Unit Manager #586 confirmed all three insulin pens were opened without documented open dates.Interview on 05/11/26 at 10:10 A.M. with the Director of Nursing (DON) confirmed that facility policy requires all insulin pens to be dated when opened.Review of the manufacturer instructions for Humalog KwikPen state that opened pens must be discarded no later than 28 days after first use.Review of the manufacture's instructions for Lantus SoloStar state that opened pens must be discarded 28 days after first use.Review of the facility policy Medication Labeling and Storage (revised 02/23) requires all medications to be labeled per federal/state requirements and accepted pharmaceutical practices, including expiration dating,This deficiency represents non-compliance investigated under Complaint Number 2993517.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to provide food that was nutritious and palatable. This deficient practice had the potential to affect all residents, excluding Residents #9, #42, and #70, who consumed nothing by mouth. The facility census was 107.Findings include:During an observation on 05/07/26 at 12:01 P.M., the lunch menu indicated fruit; however, no residents were served fruit. One resident directly requested fruit, and Certified Nursing Assistant (CNA) #699 provided oranges and applesauce in individual cups. CNA #699 obtained three additional fruit cups and offered them to other residents.An interview on 05/04/26 at 11:06 AM with Dietary Manager #674 revealed the facility did not maintain a substitution log for meal changes. The manager presented a binder containing only blank substitution log forms.During the Resident Council meeting held on 05/06/26 at 3:00 P.M., with the Administrator present, Residents #8, #14, #17, #20, #23, #44, #48, #49, #50, #93, #102, and #122 reported multiple concerns, including:-Frequent closure of the dining room-The kitchen running out of food items-Menus being incorrect-Poor food qualityResidents stated they repeatedly reported these concerns to staff, but the issues were not resolved.Interview on 05/07/26 at 12:15 P.M. Dietary Aide #681 reported the dining room was closed most days at lunch and dinner, that five dietary workers left in March 2026 and were not replaced, and staffing cuts were ordered. She added: they run out of food a lot, including milk and cereal; they do not buy replacements and wait for deliveries; snacks were only put out because state was in the building; and items on the menu were often unavailable.A review of Food Committee meeting minutes from February 2025 to January 2026 showed ongoing concerns related to food palatability. In December 2025, residents complained that food was too spicy. In October 2025, residents reported tough meat, overly salty food, and poor presentation. In August 2025, residents described the soup as too salty and vendor food quality as horrible and disgusting. In April 2025, residents reported meals were overly salty.This deficiency represents non-compliance investigated under Complaint Number 2724006.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on review of dietary staff schedules and staff interviews, the facility failed to provide sufficient support personnel to meet the needs of the dietary service program. This deficient practice had the potential to affect all residents who received food prepared by the kitchen. The facility identified three residents (Residents #9, #42, and #70) as receiving nothing by mouth. The facility census was 107.Findings include:During the Resident Council meeting held on 05/06/26 at 3:00 P.M., with the Administrator present, Residents #8, #14, #17, #20, #23, #44, #48, #49, #50, #93, #102, and #122 reported multiple concerns, including:-Frequent closure of the dining room-The kitchen running out of food items-Menus being incorrect-Poor food qualityResidents stated they repeatedly reported these concerns to staff, but the issues were not resolved.An interview on 05/07/26 at 8:58 A.M. with Dietary Manager #764 revealed they had been instructed by the regional team to reduce kitchen staffing hours.An interview on 05/07/26 at 12:05 P.M. with Licensed Practical Nurse (LPN) #648 revealed the dining room had been closed a couple of times a week due to dietary staffing shortages. LPN #648 stated residents complained each time the dining room was closed and that administrative staff had not taken action to resolve the issue.An interview on 05/07/26 at 12:10 P.M. with Certified Nursing Assistant (CNA) #532 revealed the dining room was closed for both lunch and dinner multiple times weekly due to dietary staffing issues. CNA #532 stated residents were unhappy about this and typically were not informed of closures until mealtime, when dietary staff instructed them to return to their rooms.An interview on 05/07/26 at 12:15 P.M. Dietary Aide #681 reported the dining room was closed most days at lunch and dinner, that five dietary workers left in March 2026 and were not replaced, and staffing cuts were ordered.An interview on 05/07/26 at 9:43 A.M. with the Administrator revealed she does not determine dietary staffing hours because the department is contracted to a thirdˆparty vendor that makes staffing decisions prior to notifying her.An interview with Dietary Manager #764 on 05/11/26 at 8:24 .A.M further revealed dinner was typically not served in the dining room due to frequent callˆoffs by kitchen staff.A record review of the kitchen staffing schedule from 04/26/26 through 05/21/26 revealed repeated shortages and callˆoffs, including:-No morning cook scheduled on 04/27/26.-Afternoon cook and morning dietary aide callˆoffs on 04/28/26.-Morning dietary aide callˆoff on 04/29/26.-Afternoon dietary aide callˆoff on 05/01/26.-No morning cook scheduled on 05/02/26 and 05/03/26.-Afternoon cook callˆoff on 05/05/26.-Morning and afternoon dietary aide callˆoffs on 05/06/26.-No morning cook scheduled on 05/08/26.-Afternoon dietary aide callˆoff on 05/09/26.-Morning and afternoon dietary aide callˆoffs on 05/12/26.This deficiency represents non-compliance investigated under Complaint Number 2993517.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, personnel file review, job description review, emergency medical services (EMS) and hospital document review, policy review, and interviews, the facility failed to be administered in a manner that ensured resources were used effectively and efficiently to maintain the highest practicable wellˆbeing of residents. The facility failed to ensure timely recognition and response to changes in condition, failed to follow physician orders, failed to ensure proper care planning practices, failed to maintain resident rights including privacy and confidentiality, failed to maintain safe and sanitary practices across multiple departments, failed to ensure adequate staffing and required positions, failed to maintain accurate and complete medical records, failed to meet food service and nutrition requirements, and failed to maintain an effective infection control program. These failures resulted in Immediate Jeopardy, Actual Harm, and the potential for harm to all 107 residents in the facility.Findings include:During the annual, complaint, and extended survey, observations, record reviews and interviews resulted in concerns including but not limited:1. Failure to recognize and respond to an acute change in condition (Resident #108). The facility failed to monitor, reassess, and obtain timely medical intervention for a resident experiencing respiratory distress beginning 03/09/26 at 1:38 A.M. No monitoring occurred until 6:14 A.M. despite oxygen saturations of 84%. EMS was not contacted until 7:58 A.M., and the resident died at the hospital the same day. This resulted in Immediate Jeopardy and Actual Harm.Resident #108, who had multiple chronic conditions and a Do Not Resuscitate Comfort Care (DNR-CC) directive, remained clinically stable through early March 2026 with no documented decline. On the night of March 8-9, she developed acute symptoms including severe hypoxia, lethargy, poor appetite, abdominal discomfort, and critically low blood glucose. Staff failed to promptly reassess her, notify her physician appropriately, or contact her family, resulting in several hours of delay before she was finally sent to the emergency room. EMS and emergency room (ER) findings showed severe acidosis, hypoglycemia, and suspected mesenteric ischemia, indicating a life-threatening deterioration. After discussions with her family, she was transitioned to hospice care and died later that day. Interviews revealed that staff did not follow facility policy regarding timely communication and appropriate escalation for significant changes in condition.2. Failure to follow physician orders and report significant changes (Resident #53). The facility failed to obtain a physicianˆordered C. diff stool specimen, failed to notify the physician when unable to do so, and failed to report worsening necrotic abdominal wound changes. The resident required hospitalization for sepsis and abdominal abscess. This resulted in Actual Harm.Resident #53, admitted on [DATE] with multiple chronic conditions and a recent digestive surgery, was identified as being at risk for bowel complications and required ongoing wound care. Although early documentation showed her abdominal wound was healing, facility records reveal critical lapses in care beginning 04/24/26, when staff noted the wound had become odorous with more than 60% necrotic tissue yet failed to notify the physician or wound nurse practitioner. At the same time, a stool sample ordered to rule out C. diff was never collected, nor was the missed collection communicated to a provider. By 04/26/26, Resident #53 exhibited acute confusion and her wound produced foul-smelling drainage, prompting a delayed transfer to the hospital, where she was diagnosed with sepsis and an abdominal wall abscess. Interviews confirmed multiple breakdowns in communication, documentation, and adherence to facility policy regarding significant condition changes.3. Failure to facility failed to provide the necessary care and services to prevent the development, worsening, and to promote the healing of a facilityˆacquired pressure ulcer for Resident #14 resulting in Actual [NAME].The facility failed to provide adequate care to prevent the development and worsening of a facilityˆacquired pressure ulcer for Resident #14, whose Stage II coccyx ulcer progressed to a Stage III wound due to inconsistent assessments, missed or altered treatments, improper woundˆcare practices, and lapses in documentation. Despite multiple (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	physicianˆordered treatment changes from October 2025 through early 2026, the Treatment Administration Record contained numerous unsigned dates suggesting treatments were not completed, and staff interviews revealed improper product use, failure to follow orders, and attempts to retroactively date dressings. Observations also showed inadequate pressureˆrelief practices, and wound care was performed with breaches in sterile technique. The Wound Care Nurse Practitioner repeatedly documented concerns that the wound was stalled due to staff not following proper procedures. 4. Failure to ensure informed consent and careˆplanning participation for psychotropic medication management (Resident #31). The facility failed to ensure the resident was informed of risks and benefits and meaningfully engaged in care planning.Resident #31, admitted with multiple chronic conditions including traumatic ischemia, depression, anxiety, hypothyroidism, atrial fibrillation, and hypertension, was cognitively intact and independent in daily activities. The resident was prescribed three psychotropic medications-Citalopram, Xanax, and Buspirone, each requiring ongoing monitoring for adverse effects. Review of documentation revealed that although the psychiatric nurse practitioner had educated the resident on medication side effects and interactions, there was no evidence that the required discussion of risks and benefits had been completed. Interviews with the resident confirmed that this information had never been reviewed with him, and the Director of Nursing (DON) acknowledged the absence of a care plan or orders for nonˆpharmacological interventions, as well as missing documentation regarding risks and benefits.5. Failure to address and resolve resident council concerns. Repeated concerns from 05/02/25 through 04/03/26 were not effectively addressed or resolved, affecting all 107 residents.Resident council minutes from May 2025 through April 2026 showed persistent, recurring concerns about basic care, communication, housekeeping, laundry processes, staff behavior, equipment cleanliness, and disruptions to services such as showers and dining. Despite residents reporting the same issues month after month, documentation repeatedly marked many concerns as satisfied without evidence of actual resolution or sustained corrective action. Meeting records lacked essential detail, including which issues were raised, who was affected, what actions were taken, and whether followˆup occurred. During the 05/06/26 Resident Council meeting, multiple residents reported ongoing problems with the dining room repeatedly closing, food shortages, inaccurate menus, and unavailable medications, stating that staff were informed but the issues were never fixed. Staff interviews on 05/07/26 confirmed frequent dining room closures due to staffing shortages, chronic food shortages, failure to restock supplies, and limited menu availability, with some workers reporting administrative decisions that reduced staffing. Administrator and DON interviews acknowledged these concerns but provided no evidence of effective or sustained corrective measures, demonstrating a systemic failure to respond to and resolve resident grievances6. Failure to maintain resident privacy and confidentiality. Staff used unsecured text messaging apps (WhatsApp) to transmit resident information, and residentˆidentifiable documents were found unsecured in hallways. This had the potential to affect all residents.Facility staff were repeatedly observed using an unsecure textˆmessaging application, WhatsApp, to transmit residentˆspecific information to physicians and other providers, despite facility expectations that staff contact providers by phone. Leadership, including the Administrator, confirmed this practice was not permitted and had not been authorized. Multiple observations across 05/06/26 through 05/13/26 showed nurses and other staff routinely using WhatsApp to communicate protected health information (PHI), revealing a widespread, unchecked practice. Additionally, several residentˆidentifiable STNA Report documents containing sensitive information were found discarded on the floor in a resident hallway, accessible to individuals other than authorized staff. Interviews confirmed that WhatsApp was used facilityˆwide to transmit PHI to physicians, pharmacy, management, and clinical supervisors. Facility policy discouraged transmitting patient information from personal devices and directed staff to use phone communication instead. The observations and interviews collectively demonstrate systemic failures to protect PHI and maintain compliance with Health Insurance Portability and Accountability Act (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(HIPAA) privacy and security expectations.7. Failure to ensure accurate, complete, and truthful documentation.Nursing documentation lacked accuracy and completeness for Residents #4 and #14, affecting potential care for all residents.The facility demonstrated multiple instances of improper and inaccurate documentation practices involving Residents #4 and #14, including staff being instructed to add or alter dates on wound dressings and medicationˆrelated documents, as well as concerns about backdating a Gradual Dose Reduction form. Staff interviews confirmed that nurses felt pressured or were directly asked to inaccurately document care, while leadership denied knowledge of these requests.8. Failure to ensure appropriate bathing and grooming (Resident #119). The facility did not provide personal care according to assessed needs and preferences. Resident #119, admitted on [DATE], required extensive assistance with activities of daily living, including twiceˆweekly showers with twoˆstaff help. Despite this, the resident was observed on 05/05/26 wearing soiled clothing and reported not receiving a single shower since admission. Shower documentation confirmed no showers or bed baths were provided during the first five days of the stay. Staff interviews verified that scheduled shower days were assigned but not carried out. 9. Failure to ensure timely labs, monitoring, and followˆup for a urinary tract infection (UTI) (Resident #11). The facility failed to meet professional standards for diagnostic followˆup.Resident #11 experienced significant delays and gaps in care related to urinary symptoms, including a urinalysis collected on 10/22/25 that was not resulted for 16 days and received no followˆup despite highly abnormal findings. Throughout late October and early November, documentation showed repeated complaints of pain, burning, and bloody urine, yet providers were not promptly notified, contaminated results were not reˆcollected, and abnormal findings were not addressed. When the resident's condition worsened on 11/11/25, with altered speech and vomiting, she was sent to the ER and diagnosed with a UTI and strokeˆlike symptoms. Interviews confirmed staff did not follow expected procedures for timely reporting, reassessment, or escalation of abnormal urinary findings, contrary to facility policy requiring prompt evaluation and intervention for suspected UTIs.10. Failure to provide adequate nutrition care and timely physician notification (Resident #27). The facility failed to act on nutritional decline and implement recommended medication changes.Resident #27 experienced a delay in receiving appropriate nutritional intervention after the dietitian recommended discontinuing Marinol and starting Remeron on 03/17/25, due to noted nutritional decline. Although the resident had documented weight loss greater than 5% and was cognitively intact, the recommended medication change was not implemented for 17 days. Leadership acknowledged the delay was inappropriate and that such recommendations should not remain unaddressed for weeks.11. Failure to administer oxygen as ordered (Residents #12 and #22).Residents did not receive oxygen per physician orders.The facility failed to ensure proper oxygen administration and documentation for Residents #12 and #22. Resident #12, who required continuous oxygen at 2 liters per minute (L/min), was observed without oxygen in place, and although staff claimed she frequently refused it, no refusals were documented in the medical record. Resident #22, ordered continuous oxygen at 4 L/min with weekly tubing changes, was found receiving only 3 L/min with undated tubing, and staff were unsure whether the setting was correct. These findings show nonˆcompliance with physician orders and facility oxygenˆadministration policy, which requires verifying orders, documenting refusals, and ensuring accurate oxygen delivery.12. Failure to complete required preˆ and postˆdialysis assessments (Resident #14). Assessments were incomplete or missing.Resident #14, who required ongoing dialysis management due to multiple serious conditions including endˆstage renal disease and MRSA infection, did not receive consistent required preˆ and postˆdialysis assessments. Review of records showed entire months, such as January with no preˆdialysis assessments and January through February with no postˆdialysis assessments, along with numerous incomplete or missing entries throughout March, April, and May 2026. Interviews revealed the facility failed to send required communication materials to the dialysis provider and that the resident missed three dialysis appointments due to transportation issues. Leadership confirmed staff were responsible for (continued on next page)

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Aventura at Assumption Village	9800 Market Street North Lima, OH 44452

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	agencies, participation in surveys and inspections, and ensuring proper handling of protected health information. The Administrator must be licensed, experienced in supervisory healthcare roles, knowledgeable of relevant regulations and reimbursement systems, and capable of making independent decisions while maintaining a professional, supportive, and residentˆcentered environment.Review of the Director of Nursing Services (DON) job description signed on 01/05/26 revealed the DON oversees all operations of the Nursing Department to ensure residents consistently receive highˆquality, regulatoryˆcompliant care. Responsibilities include planning, developing, and evaluating nursing policies and procedures; supervising staffing levels, recruitment, training, and performance; coordinating nursing care with other departments; participating in surveys, quality assurance programs, and care planning; and ensuring compliance with safety, infection control, and residentˆrights standards. The DON manages budgets, monitors clinical documentation, maintains secure handling of protected health information, and ensures that nursing practices follow state and federal guidelines. The role requires an active RN license, supervisory experience in healthcare, strong leadership and decisionˆmaking skills, and the ability to work collaboratively while maintaining a supportive, residentˆcentered environment.During an interview on 05/13/26 at 10:19 A.M., the DON and the Administrator stated that the Quality Assurance and Performance Improvement (QAPI) team met quarterly with the full group and monthly with a smaller subset of members, and that they were currently investigating falls and an issue related to physician notes, noting that any staff member could bring concerns to QAPI; they also reported they were new to the facility. They further explained that the kitchen department had been QAPI'd in the fourth quarter of 2025, which led to consideration of outsourcing kitchen operations beginning in February 2026 to provide what they described as an extra layer of support, and reported that this work was still in progress. Despite these QAPI activities, the DON and Administrator confirmed the facility had not identified multiple systemic issues prior to the survey and had not initiated QAPI investigations or performance improvement activities for these areas.This deficiency represents non-compliance investigated under Complaint Number 2993517.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interviews and record review, the facility failed to comply with applicable State and local licensure laws by allowing its food service license to lapse for over two months. This failure had the potential to affect all 107 residents residing in the facility, excluding Residents #9, #42, and #70, who consume nothing by mouth. Findings include:A tour of the kitchen on 05/04/26 at 8:20 A.M. revealed that no current food operating license was displayed. During an interview on 05/04/26 at 8:26 A.M., Dietary Aide #672 and [NAME] #672 stated they learned from local news that the facility's food operating license had expired in March 2026. A telephone interview on 05/07/26 with the Local Health Department #671 confirmed the facility's food service license expired on 02/28/26 and was not renewed until 05/04/26. During an interview on 05/13/26 at 10:19 A.M., the Director of Nursing (DON) and the Administrator stated that the kitchen had been identified as a Quality Assurance and Performance Improvement (QAPI) concern in late 2025, and that food services were outsourced to a thirdˆparty company in February 2026. The Administrator confirmed the kitchen operated without a valid food service license from 02/26/26 through 05/04/26 and described the kitchen as a work in progress. Review of the Administrator's job description (signed 11/23/25) showed that the Administrator is responsible for assisting department directors in developing and implementing departmental policies, procedures, and professional standards of practice. This deficiency represents noncompliance investigated under Complaint Numbers 3003067 and 2993517.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to ensure complete and accurate medical records were maintained for Residents #77, #20, #14, #111, and #9. Specifically, the facility failed to ensure physician orders and laboratory orders were entered into the electronic medical record (EMR) as required; failed to ensure communication with physicians and documentation of follow^up actions were recorded; failed to ensure staff did not alter documentation or apply inaccurate dates to resident treatments; failed to ensure residents with anticoagulation therapy had ordered laboratory monitoring of PT/INR; and failed to ensure required weekly weights for new admissions were completed and accurately recorded. This failure had the potential to negatively affect all residents. This affected five residents (#77, #20, #14, #111, and #9) of 44 sampled residents and had the potential to affect all residents residing in the facility. The facility census was 107.Findings include:1. Review of Resident #77 medical record revealed an admission date of 08/14/25. Diagnoses included atrial fibrillation, carpal left wrist fracture, protein-calorie malnutrition, hypertension, and mitral valve stenosis. Review of Resident #77's care plan dated 02/20/26 revealed Resident #77 had altered cardiovascular status related to atrial fibrillation, hypertension and valve stenosis. Staff were to administer medications as ordered, additionally Resident #77 was at risk for bleeding and bruising related to anticoagulant use. Staff were to monitor and report labs, administer medications as ordered, monitor for signs and symptoms of bleeding such as dark tarry stools, coffee ground emesis, hematuria, hypotension, decrease in pulse, dizziness, excessive bruising, petechiae and notify the physician as indicated.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 had intact cognition. She required set up assistance with eating, and oral hygiene, supervision with toileting, partial to moderate assistance with showers, dressing, personal hygiene, and bed mobility. Review of Resident #77's May 2026 physician's orders revealed an order for Warfarin Sodium Oral Tablet (anticoagulant) 5 milligram (mg) give one tablet by mouth one time a day for blood thinner; hold when PT/INR greater than 3.5, Monitor for signs and symptoms of bleeding every shift. Further review revealed there was no current order for a PT/INR. The last order for a PT/INR 03/30/26. 2. Review of Resident #20's medical record revealed and admission date of 04/08/24. Diagnoses included congestive heart failure, Parkinson's disease, hemiplegia following cerebral infarction, and atrial fibrillation. Review of the annual MDS 3.0 assessment dated [DATE] revealed intact cognition. Resident #20 required set up assistance with eating, supervision with oral hygiene, and partial to dependent assistance with toileting, showers, dressing, personal hygiene, and bed mobility. Review of the care plan dated 04/14/26 revealed Resident #20 was at risk for bleeding and bruising related to anticoagulation use secondary to atrial fibrillation. Staff were to administer medications as ordered, monitor and report labs, monitor for signs and symptoms of bleeding. Review of Resident #20's May 2026 physician's orders revealed there were no orders in for a PT/INR.During an interview on 05/05/26 at 2:20 P.M., Licensed Practical Nurse (LPN) #611 confirmed there were no lab orders put into electronic medical record (EMR) for PT/INR for Residents #20 and #77. LPN #611 stated the Unit Managers have just been putting them into the lab portal and not writing a physician's order for them.During an interview on 05/05/26 at 2:45 P.M., Registered Nurse (RN) Unit Manager #586 confirmed there were no PT/INR orders in the EMR and there should be for each lab drawn and then stated, I should probably do better audits then. She confirmed at this time there was no follow up documentation in the resident's progress notes related to dose increases or decreases or if the physician was notified of results.Review of the facility policy anticoagulation, revised November 2018, revealed the physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking hemoglobin/hematocrit, platelets, PT/INR, and stool for occult blood. If an individual on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.3. Review of the medical record for Resident #14 revealed an admission date of 10/05/25. Diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD), anxiety, kidney disease and heart failure.Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #14 was cognitively intact. He required supervision for oral care, set up help for eating, partial to moderate assistance for showering and personal hygiene and substantial to maximum assistance for toileting.During an interview on 05/13/26 at 9:10 A.M., LPN #556 stated she was asked by RN #586 to date a dressing on the resident's coccyx with the date 05/09/26, despite the dressing not originally having a date. She stated she did so but felt uncomfortable about the request.During an interview on 05/19/26 at 7:21 A.M., the Director of Nursing (DON) confirmed she had no knowledge of staff being asked to withhold documentation or incorrectly record dates regarding resident care.During an interview on 05/19/26 at 10:21 A.M., the Administrator confirmed she had no knowledge of staff being asked to withhold documentation or incorrectly record dates regarding resident care.4. Review of the medical record for Resident #111 revealed an 11/22/25 and discharge date of 12/01/25. Diagnoses included hypertension, heart failure, atrial fibrillation, and gastrointestinal hemorrhage.Review of the hospital after visit summary dated 11/22/25 revealed last PT/INR result was 2.1 and 20.6 on 11/21/25.Review of the Medicare five-day admission MDS 3.0 assessment dated [DATE] revealed Resident #111 had intact cognition. Resident #111 required partial to moderate assistance for all activities of daily living.Review of the nurse practitioner (NP) note dated 11/26/25 revealed a note stating for the facility to monitor PT/INR.Review of the care plan dated 11/26/25 revealed Resident #111 was at risk for bleeding related to warfarin use. Interventions included to monitor signs and symptoms of bleeding and to monitor and report laboratory results.Review of the physician's order dated 11/27/25 revealed an order for warfarin 2.5 mg to be administered every Tuesday, Thursday, Saturday, and Sunday evening and 5 milligrams to be administered every Monday, Wednesday, and Friday evening. No physician's orders to check PT/INR check to monitor coumadin levels were observed.Review of the nursing progress note dated 11/30/25 revealed the nurse was called to Resident #111's room with complaints of a nosebleed. Resident #111 had a few tissues with blood on them and the bleeding had subsided. Resident #111 reported she normally gets nose bleeds from dry air. Resident #111's oxygen concentrator was out of humidification and the bottle was replaced.During an interview on 05/06/26 at 9:22 A.M., the DON confirmed Resident #111 did not have an order for a PT/INR to be drawn and she confirmed she had a nosebleed while in the facility. Review of the facility policy anticoagulation, revised November 2018, revealed the physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking hemoglobin/hematocrit, platelets, PT/INR, and stool for occult blood. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. 5. Record review of Resident #9 revealed an admission date of 03/05/26 with diagnoses of aphasia following cerebral infarction, type II diabetes mellitus with diabetic polyneuropathy, and chronic obstructive pulmonary disease.Review of the MDS 3.0 assessment dated [DATE] revealed Resident #9 had a tube feed and was severely cognitively impaired.Record review of weights and vital signs on 03/06/26 revealed a weight of 197.0 pounds (lbs), on 03/14/26 revealed a weight of 197.0 lbs, on 03/29/26 revealed a weight of 177.0 lbs, on 03/31/26 revealed a weight of 179.9 lbs, on 04/04/26 revealed a weight of 178.2 lbs, and on 05/01/26 revealed a weight of 181.6 lbs.During an interview on 05/05/26 at 12:00 P.M., Certified Nursing Assistant (CNA) #636 stated new admissions were to be weighed weekly for 30 days.During an interview on 05/05/26 at 12:42 P.M., LPN #556 revealed new admissions got weighed weekly for four weeks and then monthly after that. LPN #556 confirmed Resident #9 was missing a weight around 03/21/26.During an interview on 05/06/26 at 9:10 A.M., RN Manager #522 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the first two weights were wrong and Resident #9 had been steady at 177 to 181 lbs. RN Manager #522 stated the resident's daughter-in-law said the initial weights were wrong; the resident had not lost any weight. RN Manager #522 confirmed Resident #9 was missing a weight on 03/21/26.During an interview on 05/12/26 at 9:27 A.M., Registered Dietitian (RD) #685 stated the weights of 197 lbs. were inaccurate, and the resident's family stated Resident #9 had not lost any weight.During an interview on 05/11/2026 8:19 A.M., Maintenance Director #659 explained the scale calibration process and confirmed scales are taken out of service when malfunctioning; documentation showed a scale was removed on 03/08/26 for a broken release.This deficiency represents non-compliance investigated under Master Complaint Number 3106164 and Complaint Number 2993517.

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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file reviews, job description review, and staff interviews, the facility failed to employ a full^time Licensed Social Worker (LSW) as required. This failure had the potential to affect all 107 residents in the facility.Findings include:Review of the personnel file for Social Services Director (SSD) #569 showed she was hired on 03/16/26. Her employment application and resume indicated she did not possess a degree in social services.During an interview on 05/06/26 at 11:02 A.M., SSD #569 confirmed she was not a Licensed Social Worker. She also reported that the facility had been without a full^time LSW for some time and confirmed she had been working at the facility since 03/16/26. (LSW #678's last day of employment was 02/13/26). Interview on 05/06/26 at 12:25 P.M., the Administrator confirmed the facility did not currently have a full^time LSW. She reported that LSW #678 had been employed full^time from 11/19/25 through 02/13/26. Since then, LSW #677 and LSW #679, both part^time employees from other facilities, have been covering social services duties, but did not fulfill the 40-hour requirement.SSD #569 was working toward obtaining her license.A review of the facility assessment dated [DATE] showed the facility required one full^time LSW.A review of the Social Services Director job description, signed by SSD #569 and the Administrator on 03/16/26, did not specify that the position required a social work license. The description indicated that registration with the Academy of Certified Social Workers (ACSW) was preferred but did not include language stating that a Licensed Social Worker was required when the census exceeded 120 residents, as required.This deficiency represents non-compliance investigated under Complaint Number 2724006.

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	05/20/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to ensure that Resident #12's tube feeding pump and pole were maintained in a clean and sanitary condition. This deficiency affected one resident (Resident #12) out of three reviewed for environmental concerns. The facility census was 107.Findings include:Record review for Resident #12 showed an admission date of 01/08/21. Her diagnoses included respiratory failure, asthma, malnutrition, heart disease, osteoporosis, sleep apnea, and epilepsy.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. She required supervision for eating and toileting, set up assistance for oral and personal hygiene and partial to moderate assistance for showering. She had no significant weight loss or gain in the past six months.Review of physician orders for May 2026 revealed that Resident #12 had an active order for nocturnal tube feeding from 7:00 p.m. to 7:00 a.m. daily, initiated on 04/01/26.During an observation and interview conducted on 05/07/26 at 8:08 A.M., Resident #12's tube feeding pump and pole were noted to have dried, crusted beige-to-light-brown debris on the pole, wheels, and display screen. Certified Nurse Aide (CNA) #502 confirmed that nursing staff were responsible for cleaning both the pole and the display each night when the tube feeding was connected. She further confirmed that based on the condition observed, the equipment had not been cleaned as expected.This deficiency represents non-compliance investigated under Complaint Number 2724006.

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	05/20/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident interview, review of pest control log, and review of facility policy, the facility failed to maintain an effective pest control program designed to provide a safe, sanitary, and comfortable environment for residents. This failure resulted in confirmed sightings of mice and ants in multiple areas throughout the facility, including resident rooms, dry storage areas, windowsills, the soiled linen area, and the special care unit. This affected two residents (#3 and #58) of three residents reviewed for pest concerns and had the potential to affect all 107 residents residing in the facility.Findings include:Interview on 05/12/26 at 9:20 AM with Maintenance Director #659 confirmed ongoing pest issues, including dead mice found in traps placed in multiple locations throughout the facility. He stated the pest control company sprays monthly, and maintenance sprays independently when pests are sighted.Interview on 05/12/26 at 9:32 A.M with Resident #58 reported carpenter ants in his room, crossing his floor and entering the bathroom; the room was inspected and sprayed by the exterminator.Interview on 05/12/26 at 9:50 A.M. with Resident #3 reported ants entering her room through the window and moving across the floor. Staff cleaned and sprayed the room the following day.Pest control logs documented multiple pest sightings, including:- 03/23/26: mouse spotted in dry storage area of the kitchen- 04/20/26: ants on windowsill in room [ROOM NUMBER]- - 04/27/26: mouse in the special care unit- 04/28/26: mouse in the special care unit- 04/28/26: ants on windowsill in room [ROOM NUMBER]- 04/30/26: ants in the soiled linen area- 05/07/26: ants crawling on the floor into the bathroom in room [ROOM NUMBER]Review of the undated facility policy titled, Resident Environmental Quality, states the facility is to be maintained in a safe, functional, sanitary, and comfortable condition; however, the facility did not implement or sustain an effective pest control system.This deficiency represents non-compliance investigated under Complaint Numbers 2993517 and 2724006.