STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Aventura at Assumption Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 9800 Market Street North Lima, OH 44452	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record review, interviews and review of the facility policy, the facility failed to notify the physician/nurse practitioner and resident representative of a significant weight change. This affected one resident (Resident #70) out of three residents reviewed for nutrition. The facility census was 94. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE]. Pertinent diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, dysphagia following cerebral infarction, vascular dementia, lymphedema, and obesity. Review of Resident #70's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 12/12/24, revealed the resident was severely impaired cognitively, had no behaviors or rejection of care, had a significant unplanned weight loss, was on a therapeutic diet, and was receiving 51 percent (%) or more of proportion of calories from a feeding tube, and 501 cubic centimeters (cc) or more of average fluid intake from intravenously or from a tube feeding. Review of Resident #70's weights from 06/07/24 to 12/06/24 revealed on 10/09/24 the resident weighed 235. 8 pounds and on 11/11/24 weighed 213.8 pounds, which was a significant weight loss of 9.3 % weight loss between 10/09/24 and 11/11/24. Review of the nutritional risk assessment dated [DATE] and authored by Dietitian #500 confirmed Resident #70 had an unplanned weight loss of 9.3% weight loss between 10/09/24 and 11/11/24. Further review of Resident #70's medical record revealed there was no documented evidence the physician/nurse practitioner or resident representative were notified of the significant weight loss. Interviews on 12/18/24 at 9:57 A.M. and at 11:31 A.M. with Dietitian #500 confirmed the significant weight loss for Resident #70 and stated she had not gotten a hold of Resident #70's resident representatives about the significant loss because they worked during the day, and she thought she verbally told the nurse practitioner of the weight loss but confirmed there was no documented evidence in the medical record that the nurse practitioner was notified of the significant weight loss. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Assumption Village		STREET ADDRESS, CITY, STATE, ZIP CODE 9800 Market Street North Lima, OH 44452	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/19/24 at 12:12 P.M. with Nurse Practitioner #506 stated if she had been made aware of the weight loss there would have been a written notification of the weight loss in the chart, or she would have put it in her notes. Review of the facility policy Weight Assessment and Intervention, revised August 2022, revealed residents would be monitored for undesirable weight loss or gain, and the dietitian would notify the physician and resident representative of any weight change of five percent or more.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, review of the medical record and review of the facility policy, the facility failed to ensure residents received the required level of assistance for meals. This affected one resident (Resident #36) of two residents reviewed for activities of daily living (ADL). The facility census was 94. Findings include: Review of the medical record revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including cerebral ischemia, dementia, hemiplegia or hemiparesis following cerebral infarction affecting the left non-dominant side, difficulty in walking, major depressive disorder, osteoporosis, anxiety, glaucoma, hearing loss, dysphagia, psychophysical visual disturbances, atrial fibrillation, and muscle weakness. Review of the care plan dated 08/23/24 revealed Resident #36 had an ADL self-care deficit related to decreased mobility, difficulty walking, generalized muscle weakness, left-sided weakness, and glaucoma. Interventions included staff setup and cleanup for eating. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 10/01/24 revealed Resident #36 had intact cognition and an upper extremity range of motion impairment on one side. Further review of the MDS revealed Resident #36 required setup assistance for eating. Interview on 12/16/24 at 9:24 A.M. with the daughter of Resident #36 revealed concern that staff were not assisting her mother with setting up her meals, removing lids from cups and bowls, or cutting her food for her. Observation and interview on 12/16/24 from 10:05 A.M. to 10:15 A.M. revealed a meal tray on Resident #36's bedside table with lids/covers intact. When family lifted the dome lid to check to see what was on the plate, it revealed a sausage patty, a piece of French toast, and dry toast cut in half. The sausage and French toast were not cut up and there was a lid on the bowl of dry rice Krispies with unopened milk. Interview with Resident #36 confirmed she was unable to see what was on the plate when staff brought it to her room earlier that morning and if she had been shown what was on the plate and had assistance cutting her food, she would have liked to have at least eaten the sausage patty with cereal. Observation on 12/17/24 at 4:28 P.M. revealed the light was not on in Resident #36's side of room, a meal tray was left on bedside table (a wheelchair was partially situated between the chair where Resident #36 was seated and the bedside table), all foods were covered, and Resident #36 stated she was unable to see well and did not know what food was there. Resident #36 confirmed the girl just left it and did not turn on the light, tell her what was for dinner, or ask if she needed help. When informed what foods were listed on her meal ticket, Resident #36 stated she would need help opening packages and cutting chicken if she was going to be able to eat. Interview on 12/17/24 at 4:33 P.M. with Licensed Practical Nurse (LPN) #445 confirmed Resident #36 required assistance with setup for all meals. (continued on next page)

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	365783	A. Building B. Wing	12/19/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 4:36 P.M. with Certified Nurse Aide (CNA) #426 stated no, we usually just leave the tray in here when asked if Resident #36 received any type of meal support from staff. CNA #426 then entered the resident's room and confirmed Resident #36 needed assistance cutting up her chicken to eat it. Observation on 12/19/24 at 8:16 A.M. revealed Resident #36 had dry cereal spilled on her floor on the right side of her bed as she struggled to open a carton of milk. At the time of this observation, Resident #36 stated she could not open the milk herself and asked for assistance. Review of the Point of Care aide documentation in the electronic medical record from the past thirty days revealed staff marked no setup or physical help from staff was provided to Resident #36 for eating support on 11/26/24 for lunch, 11/29/24 for breakfast or lunch, 12/06/24 for breakfast, 12/10/24 for breakfast and lunch, and 12/13/24 for lunch. There was no documentation regarding the level of eating support provided to Resident #36 on 11/20/24 through 11/24/24, 11/30/24, 12/02/24, 12/04/24, 12/05/24, 12/07/24/ through 12/09/24, 12/12/24, and 12/14/24 through breakfast on 12/19/24. Interview on 12/19/24 at 8:19 A.M. with CNA #446 confirmed the carton of milk should have been opened for Resident #36 because it was part of tray set-up, which she also confirmed Resident #36 needed. Interview on 12/19/24 at 9:59 A.M. with LPN #322 confirmed Resident #36 required setup level of assistance for eating. Further interview with LPN #322 confirmed setup consisted of opening all the foods, removing lids, cutting up foods, and making sure plates, bowls, and silverware were accessible to the resident. Review of the policy titled Activities of Daily Living (ADL), Supporting revised August 2022, revealed appropriate care and services would be provided for residents who were unable to carry out their own ADL independently, including appropriate support and assistance with meals and snacks.

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	365783	A. Building B. Wing	12/19/2024

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, medical record review and facility policy review, the facility failed to ensure Resident #70's weekly weights were obtained as ordered and failed to monitor and follow Resident #57's fluid restriction. This affected two residents (#57 and #70) out of three residents reviewed for nutrition. The facility census was 94. Findings include: 1. Review of the medical record for Resident #70 revealed an admitted [DATE]. Pertinent diagnoses included hemiplegia (total or nearly complete paralysis on one side of the body) and hemiparesis (weakness of one entire side of the body) following nontraumatic intracerebral hemorrhage (bleeding in the brain) affecting left non-dominant side, dysphagia (difficulty swallowing) following cerebral infarction (stroke), vascular dementia, lymphedema (swelling in various areas of the body), and obesity. Review of the care plan dated 06/15/24 revealed Resident #70 had a nutritional problem related to advanced age, receiving nothing by mouth with the need for a tube feeding, lymphedema, and significant weight loss related to illness. Interventions included providing enteral feedings as ordered, dietitian to evaluate and make enteral feeding change recommendations as needed, and monitor/document/report to physician any signs or symptoms of dehydration which included sudden weight loss. Review of the dietary progress note, dated 09/18/24 and authored by Dietitian #500, revealed Resident #70 had a history of weight variations; however, how clothing fit and visualization of the resident had not changed and there had been no change in her tube feeding product or rate, which was meeting her needs. It was determined the resident would be weighed weekly to follow trends. Review of Resident #70's physician orders revealed an order dated 09/25/24 for a weekly weight one time every seven days for weight maintenance. Review of Resident #70's quarterly Minimum Data Set (MDS) assessment, dated 12/12/24, revealed the resident was severely impaired cognitively, had no behaviors or rejection of care, had a significant unplanned weight loss, was on a therapeutic diet, and was receiving 51 percent (%) or more of proportion of calories from a feeding tube, and 501 cubic centimeters (cc) or more of average fluid intake from intravenously or from a tube feeding. Review of Resident #70's October and November 2024 Treatment Administration Records (TARs) where the facility was recording the weekly weights revealed a weekly weight was to be obtained on Wednesdays. On 10/02/24 there was no weekly weight obtained. On 10/09/24, the resident's weight was 235.8 pounds. On 10/16/24, 10/23/24, and 10/30/24 there were no weekly weights obtained. On 11/06/24 a weight was not obtained since the resident was in the hospital. On 11/13/24 there was no weight obtained. On 11/20/24 the resident's weekly weight was 217 pounds, and on 11/27/24 the resident's weekly weight was 220 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/18/24 at 9:38 A.M. with Licensed Practical Nurse (LPN) Manager #312 revealed for weekly weights, the weekly weights are scheduled and put in the TAR for the nurses to type in the weights. The dietitian was to follow up to make sure the weekly weights were being done and if a weight was not obtained, the dietitian would either send an email or tell her of the missing weight and a weight would then be obtained that day. LPN #312, after reviewing Resident #70's weights in the medical record, confirmed weekly weights had been missed and could not give an explanation as to why. Interview on 12/18/24 at 9:57 A.M. with Dietitian #500 revealed she was the one who monitored if weekly weights were being done. If she saw a weekly weight had not been obtained, she would either email the Director of Nursing (DON) or the Unit Managers, give a handwritten note to nursing staff on the respected units, or would verbally tell staff on the units or during morning meeting if a weekly weight needed to be obtained. After looking at the weekly weights for Resident #70, Dietitian #500 confirmed the missing weekly weights and stated she didn't know why those weekly weights were missed. Dietitian #500 stated she was not sure of the reason for the weight variance for Resident #70 but was questioning the accuracy of the weights. Interview on 12/19/24 at 12:12 P.M. with Nurse Practitioner (NP) #506 revealed after reviewing her notes, Resident #70 had been sick for a while, and there were no concerns with her labs. She went on to state that Resident #70 looked the same and was questioning the accuracy of the weights. Review of the facility policy Weight Assessment and Intervention, revised August 2022, revealed residents would be monitored for undesirable weight loss or gain. Residents would be weighed upon admission and at intervals established by the interdisciplinary team and weights would be recorded in the individual's medical record. 2. Review of the medical record for Resident #57 revealed an admitted [DATE]. Pertinent diagnoses included end stage renal disease (ESRD), hyperkalemia (high levels of potassium in the blood), hypertensive chronic kidney disease with stage one through stage four chronic kidney disease, congestive heart failure (CHF), anemia in chronic kidney disease, and dependence on renal dialysis. Review of the care plan, dated 03/14/24, revealed Resident #57 had a nutritional problem related to ESRD with dialysis and being on a fluid restriction. Interventions included continue education and encouragement offered of the importance of fluid restriction, provide diet as ordered, monitor intake and record every meal, monitor fluid intake, and provide the resident with personal preferences. Review of Resident #57's physician's orders revealed an order dated 05/21/24 for a regular diet, regular texture, 1000 milliliter (ml) fluid restriction. Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #57 was cognitively intact, had no behaviors or rejection of care, required set up or clean-up assistance for eating, supervision or touch assistance for walking up to 150 feet, was on a therapeutic diet, and received dialysis. Review of Resident #57's November and December 2024 TARs revealed the resident was on a 1000 ml fluid restriction with dietary providing 640 ml and nursing 360 ml (120 ml an eight-hour shift). Nursing was marking a checkmark that they were aware of the fluid restriction, but there was no place to document how much fluids were provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility document Fluid Restriction Worksheet, undated, for Resident #57 revealed he was on a 1000 milliliter (ml) fluid restriction and dietary would provide 640 ml, and nursing would provide 360 ml (120 each 8-hour shift) amount provided for each meal: breakfast 120 ml or half a cup beverage of choice lunch 120 ml or half a cup of beverage of choice 120 ml or half a cup of beverage of choice For a total of 240 ml for lunch dinner 120 ml or half a cup of beverage of choice 120 ml or half cup of beverage of choice For a total of 240 ml at dinner Interview on 12/16/24 at 4:52 P.M. with Resident #57 revealed he knew he was on a fluid restriction but was unaware of how much he was allowed to drink or what was considered a fluid. Observation of Resident #57's breakfast tray on 12/18/24 at 7:41 A.M. revealed there was one eight-ounce (240 ml) carton of two percent milk sitting on the tray. On the tray was a dietary ticket which had a water mark on it indicating the resident was on a fluid restriction, and the ticket indicated the resident should receive four ounces of two percent milk. Certified Nursing Assistant (CNA) #340 at the time of observation confirmed the eight-ounce carton of milk on the resident's tray (according to the fluid restriction worksheet, the resident should have been provided four ounces of fluid). Interview on 12/18/24 at 11:16 A.M. LPN #422 revealed Resident #57 was on a fluid restriction, and she gave him about 300 ml of fluids with his pills throughout her 12-hour day shift (according to the fluid restriction worksheet, nursing for a 12-hour shift was allowed 180 ml). She stated they do not record how much they give him and went on to state, nursing just places a checkmark in the TAR indicating he was on a fluid restriction. She stated the facility really didn't know how much fluids he was consuming. She stated he ate in the main dining room for lunch and dinner, and no one was tracking how much he was consuming there. Observation on 12/18/24 at 11:25 A.M. revealed Resident #57 was in the main dining room with one eight-ounce (240 ml) glass of iced tea and one six-ounce bowl (180ml) bowl of soup. At the time of observation, Dietary Aide #508 confirmed the resident had an eight-ounce glass of iced tea and one six-ounce bowl of soup (according to the fluid restriction worksheet, the resident should have been provided eight ounces of fluid). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/18/24 at 11:35 A.M. with Dietitian #500 stated Resident #57 was on a 1000 ml fluid restriction, and dietary was providing 640 ml, and nursing was to provide 360 ml (120 ml each eight-hour shift). She confirmed the resident was to receive 120 ml at breakfast and two 120 ml beverages at both lunch and dinner from dietary. Dietitian #500 stated she didn't think the resident understood what a fluid restriction was and how it was divided. She stated she had never broken the fluid restriction down step-by-step for the resident, and the facility was responsible for following the fluid restriction. Interview on 12/18/24 at 2:16 P.M. with Dietary Manager #327 revealed when there was a person on a fluid restriction, the dietitian would give her a fluid restriction worksheet which she would use to identify on the dietary slips how much fluids dietary would provide for each meal. She stated the dietary tickets have a water mark on them indicating if a resident was on a fluid restriction, which was how the staff knew if a person was on a fluid restriction. Observation on 12/18/24 at 5:00 P.M. revealed Resident #57 had one eight glass of cranberry juice (240 ml) and one four-ounce container of sherbet (120 ml) in front of him. At the time of observation, Dietary Aide #501 confirmed the eight-ounce beverage and four-ounce orange sherbet (according to the fluid restriction worksheet the resident should have been provided eight ounces of fluid). Review of the undated facility policy Food and Nutrition and Dietary Services Policy and Procedure revealed each resident of the facility would be provided with a nourishing, palatable, well-balanced diet that met his/her daily nutritional and special dietary needs taking into consideration the preferences of each resident.

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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** 46195 Based on medical record review, staff interviews and review of communication forms from dialysis center, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for Resident #57. This affected one resident (#57) of one resident reviewed for dialysis but had the potential to affect two additional residents (#15 and #77) identified by the facility as receiving dialysis. The facility census was 94. Findings include: Review of the medical record for Resident #57 revealed an admitted [DATE]. Pertinent diagnoses included end stage renal disease, hypertensive chronic kidney disease with stage one through four chronic kidney disease or unspecified chronic kidney disease, anemia in chronic kidney disease, and dependence on renal dialysis. Review of Resident #57's physician's orders revealed an order dated 09/09/24 for dialysis every Tuesday, Thursday, and Saturday with a chair time of 11:15 A.M. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/16/24, revealed Resident #57 was cognitively intact, exhibited no behaviors or rejection of care, and received dialysis. Further review of Resident #57's medical record revealed communication sheets from the dialysis center dated 08/01/24, 09/26/24, 10/01/24, 10/10/24, 10/26/24, 10/29/24, 12/14/24, and 12/17/24. There were no communication sheets from the dialysis facility between 08/03/24 to 09/24/24, 10/03/24 to 10/08/24, 10/12/24 to 10/24/24, and 10/31/24 to 12/12/24, and there was no documented evidence the facility had been communicating with the dialysis center on dialysis days. Interview on 12/18/24 at 11:10 A.M. with Resident #57 revealed he does not take any paperwork with him to dialysis from the facility, but he does bring back paperwork from the dialysis facility and gives it to a facility nurse when he returns. Interview on 12/18/24 at 11:16 A.M. with Licensed Practical Nurse (LPN) #422 revealed she would take vital signs prior to Resident #57 leaving for dialysis, would call dialysis if there were concerns, and confirmed the dialysis facility was sending forms back with the resident. Interview on 12/18/24 at 4:27 P.M. with LPN Manager #312 confirmed the facility did not send communication forms with the resident, but the resident did bring back communication forms from the dialysis facility, which should be put in the medical chart. LPN #312 confirmed there were missing communication forms and if the nurse doesn't have communication from dialysis, they should be calling the dialysis center. Interview on 12/19/24 at 8:37 A.M. with Renal Registered Nurse (RN) #505 from the dialysis facility stated she had never seen the facility send forms with Resident #57, but the staff at the dialysis center filled out a form while he was at dialysis and would send it back with him every time.

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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** 48567 Based on observation, resident and staff interviews, medical record review and review of the facility policy, the facility failed to ensure medications were not left unattended. This affected two of four residents (#4 and Resident #27) who were observed with medications at the bedside and had the potential to affect 20 additional residents (#2, #6, #8, #9, #16, #19, #31, #32, #33, #38, #39, #40, #41, #43, #50, #54, #78, #80, #81 and #88) who received medications in the 1400 and 1600B hall. The facility census was 94. Findings include: 1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including non-traumatic intracerebral intraventricular hemorrhage, congestive heart failure (CHF), repeated falls, altered mental status, unspecified dementia, hypertension, hyperlipidemia, muscle weakness, major depressive disorder, muscle weakness, and the need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 12 04/24 revealed Resident #27 had moderate cognitive impairment. The MDS further revealed Resident #27 required moderate assistance with bathing and toileting hygiene, setup assistance for personal hygiene, and supervision or touching assistance with transfers. Review of the care plan last reviewed on 12/11/24 revealed Resident #27 had an alteration in cognitive function, neurological status, and was at risk for impaired thought processes secondary to dementia, altered mental status, and an intracerebral hemorrhage. Interventions included administration of medications as ordered, allowing him sufficient time to respond, and cueing and supervision as needed. There were no care plan interventions or assessments in the medical record indicating Resident #27 could self-administer his medications. Review of the physician orders and order scheduling details revealed the following medication orders: 01/15/24 - cyanocobalamin (Vitamin B12) 500 micrograms (mcg) by mouth daily as a supplement to be administered by a clinician. 01/18/24 - ferrous sulfate (iron) 325 milligrams (mg) by mouth daily to be administered by a clinician. 02/22/24 - folic acid 400 mg daily by mouth as a supplement to be administered by a clinician. Norvasc 5 mg by mouth once daily for hypertension to be administered by a clinician. Cetirizine hydrochloride (Zyrtec) 10 mg by mouth once daily for allergies to be administered by a clinician. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/16/24 at 10:53 A.M. of Resident #27 in his room revealed he was lying in bed and visible on his bedside table, which was located on the other side of the foot of his bed, was a medicine cup containing five pills sitting next to a cup of water. The pills included one black tablet, one pink tablet, one off-white tablet, one round white tablet, and one oblong tablet. An interview with Resident #27 at the time of the observation confirmed the nurse always left the medication cup on his table if he was asleep and he took them on his own when he woke up. Resident #27 further confirmed he had been unaware the pills were sitting there and would need to transfer himself to his wheelchair to get the medication since they were not within his reach. Interview at on 12/16/24 at 10:57 A.M. with Registered Nurse (RN) #343 confirmed the five tablets left at Resident #27's bedside included vitamin B12, iron, folic acid, Norvasc, and Zyrtec and that she had left them on his table during the morning medication pass. Interview on 12/16/24 at 4:20 P.M. with the Director of Nursing (DON) confirmed nurses were to remain with the resident while took take their medicine. Review of the policy titled Administering Medications, revised in August 2022, revealed residents were allowed to self-administer medications only if the prescriber or attending physician, in coordination with the interdisciplinary care planning team, had determined the resident could do so safely. Review of the policy further revealed medications were to be administered as prescribed and in a safe manner. 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including mononeuropathies of bilateral lower limbs, obstructive sleep apnea, atrial fibrillation, atherosclerotic heart disease, pulmonary hypertension, heart failure, cardiomyopathy, major depressive disorder, iron deficiency anemia, chronic pain, urinary retention, vitamin deficiency, and dependence on supplemental oxygen. Review of the medication orders revealed an order dated 06/13/23 for 40 milliequivalents (mEq) of potassium chloride extended release by mouth once daily for low potassium related to heart failure. Further review of the orders revealed an order dated 05/26/24 for Resident #4 to have a mechanical soft textured diet. Review of the care plan last reviewed on 12 06/24 revealed Resident #4 had a self-deficit in the performance of activities of daily living (ADL), demonstrated problematic behavior, such as resistance to care or treatment, and was at risk for impaired cognitive function. Interventions included administration of medication as ordered, supervise as needed, and providing cues during tasks to ensure completion. There were no care plan interventions and no assessments indicating Resident #4 was safe to self-administer medications. Review of the annual MDS 3.0 assessment completed on 12/09/24 revealed Resident #4 had intact cognition and was on a drug regimen that included antidepressant, anticoagulant, diuretic, opioid, and anticonvulsant medications. Further review of the MDS revealed Resident #4 was on a mechanically altered diet. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/16/24 at 11:00 A.M. revealed a medication cup was at Resident #4's bedside containing two potassium tablets, which was confirmed by RN #343 at 11:03 A.M. Further interview with RN #343 confirmed she had left a medicine cup with pills, including the two potassium pills, at Resident #4's bedside when she passed medications earlier that morning. RN #343 then left the room, broke the tablets in half, and returned to the resident's room where she supervised Resident #4 take the medication with vanilla pudding. Interview on 12/16/24 at 11:04 A.M. with Resident #4 confirmed RN #343 gave her a medicine cup containing her morning pills at approximately 8:30 A.M. that morning and left the room before Resident #4 took all her medication. Resident #4 further revealed she did not take the potassium because she was unable to swallow them, so she put them aside until someone came back to check on her and then she had planned to request some applesauce or some pudding to help her swallow the medication. During the interview, Resident #4 confirmed the facility nurses typically entered her room in the mornings, woke her up for morning medication administration, left the medication in her room, and then exited the room before she took the medication. Interview on 12/16/24 at 4:20 P.M. with the DON confirmed nurses should stay with the residents until they finish taking their medication. Review of the policy titled Administering Medications, revised August 2022, revealed residents were allowed to self-administer medications only if the prescriber or attending physician, in coordination with the interdisciplinary care planning team, had determined the resident could do so safely. Review of the policy further revealed medications were to be administered as prescribed and in a safe manner.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46195 Based on observation, interview, record review and review of facility policy, the facility failed to ensure weekly and always available menus were followed. This affected seven residents (#2, #18, #40, #50, #58, #66, #76) of 92 residents receiving meals from the kitchen, and had the potential to affect all residents except for two residents (#70 and #86) the facility identified as receiving nothing by mouth (NPO). The facility census was 94. Findings include: Review of the facility always available menu, dated 12/17/24, revealed deli sandwich, chef salad, pasta, peanut butter and jelly sandwich, baked lemon pepper fish, cottage cheese and fresh fruit plate, hot dog on bun, grilled cheese sandwich, house garden salad, oven baked chicken, cottage cheese, chicken noodle soup, and mashed potatoes were always available. Review of the facility menu for week three Tuesday dinner (12/17/24) revealed roasted chicken, bread stuffing, peas and carrots, and fruit cobbler was to be served. Review of monthly Dietary Meeting minutes held with residents revealed on 10/02/24 the residents indicated they would like to see meal items served match the menu without having to substitute items. Review of the facility menu substitution logs for October 2024 through December 2024 revealed on 10/26/24 cake was substituted for smore's bake because the food delivery truck was late, on 10/31/24 a variety of pudding was substituted for the butterscotch pudding since there were not enough cans of butterscotch pudding, on 11/06/24 chicken tenders were substituted for meatballs and Italian blend vegetables for oriental blend vegetables since the food vendor truck didn't come in on time, on 12/01/24 toast was substituted for a donut and four way mixed vegetable was substituted for cauliflower since the facility was out of both items, and on 12/14/24 turkey gumbo was substituted for chicken gumbo since the facility was out of chicken. Interview on 12/17/24 at 8:52 A.M. with Ombudsman #507 revealed he had seven open cases at the facility related to food concerns and systemically he felt there was a concern with food quality, food choices, and food temperatures. Interview on 12/17/24 at 10:45 A.M. with Dietary Manager (DM) #327 revealed she had a hard budget, and it was hard for her to get all the needed items she needed for the menu and the always available menu. She stated sometimes on Sunday (day before the order was to come in) they would run out of items, and there were times she couldn't order items since she couldn't fit it into her budget. Observation on 12/17/24 from 12:59 P.M. to 1:08 P.M. of supply of items in the facility for the always available menu with DM #327 revealed there was no lemon pepper fish, chicken noodle soup, or fresh fruit for the cottage cheese. At the time of the observation DM #327 confirmed the missing items and stated she couldn't fit the items into the food budget, and if a resident asked for those items, she would ask if they wanted something else. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/17/24 at 3:50 P.M. with Dietary Aide (DA) #317 of items on the steamtable revealed there was chicken, stuffing, green peas with no carrots, and fruit cobbler. On 12/17/24 at 4:10 P.M. DA #317 confirmed green peas, not green peas and carrots, were being served as the vegetable for dinner which did not match the menu. Interviews conducted with seven residents (#2, #18, #40, #50, #58, #66, and #76) who attended the resident council meeting held on 12/18/24 at 9:06 A.M. revealed the residents stated what was being served for meals didn't match the menu. When residents asked for something on the always available menu, items were not always available and as a result, they would be just be given whatever. When residents asked why those items were not available, they were told the truck has not come in. Interview on 12/18/24 at 11:25 A.M. with DA #508 confirmed there were times when the facility didn't have items on the always available menu. DA #508 revealed if a resident asked for one of the always available items the kitchen did not have, the resident would have to take something else. Interview on 12/18/24 at 2:26 P.M. with DM #327 revealed the food delivery for Monday morning was for Monday night dinner through Wednesday's dinner and the food delivery for Wednesday morning was for Thursday breakfast through Monday's lunch. She stated if the truck was late or if items came in frozen and couldn't be defrosted in time for the dinner meal, they would have to substitute items for the meal. She confirmed peas instead of peas and carrots had been served for dinner on 12/17/24 since she couldn't fit the peas and carrots into her budget. Review of facility policy Menu Substitutions, undated, revealed a substitute would only be provided when there was an uncontrollable situation, like an inventory emergency which made the item unavailable.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46195 Based on observation, interview, record review and review of facility policy, the facility failed to ensure palatable food was served to all residents. This affected eight residents (#2, #4, #18, #40, #50, #58, #66 and #76) of 92 residents receiving meals from the kitchen, and had the potential to affect all 92 residents excluding two residents (# 70 and #86) who the facility identified as receiving nothing by mouth (NPO). The facility census was 94. Findings include: Review of the monthly Residents' Dietary Meeting minutes, dated 10/02/24, revealed the residents voiced they would like the food to be seasoned more and hotter. Interview on 12/16/24 at 11:05 A.M. with Resident #4 revealed the food was terrible, all of it' and stated she had people bring her food from the outside. Interview on 12/17/24 at 8:52 A.M. with Ombudsman #507 revealed he had seven open cases and systemically he felt there was a concern with food quality, food choices, and food temperatures. Observation on 12/17/24 at 5:05 P.M. to 5:25 P.M. of the dinner tray line and a test tray revealed at 5:08 P. M. the test tray was plated and placed on the food cart. At 5:11 P.M. the food cart was taken to the skilled unit. At 5:14 P.M. the food cart arrived on the skilled unit. At 5:15 P.M. the first tray was taken off the food cart to be passed. Three staff members were observed passing the meal trays. At 5:25 P.M. the last meal tray was taken off the food cart and Dietitian #500 took the test tray off the food cart and took the tray to an empty table in the unit dining room. Using the facility's digital thermometer, Dietitian #500 took the temperature of the food and beverage items which consisted of milk, cranberry juice, cobbler, chicken and peas. A concern was noted with the temperature of the peas being 109.5 degrees Fahrenheit (F). The peas tasted cold and had no flavor. Dietitian #500 also tasted the peas and confirmed they were cold and had no flavor. The other food items were found to be at acceptable temperature and flavor. Interviews conducted on 12/18/24 at 9:06 A.M. with Resident #2, #18, #40, #50, #58, #66 and #76 at the resident council meeting revealed all seven residents voiced the meals were terrible, had no good taste, and most of the time the hot foods were not hot but were cold. Review of the facility policy Food, Nutrition and Dietary Services Policy, undated, revealed menus would be followed and food would be palatable.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy the facility failed to ensure residents on mechanical soft diets received appropriate meal consistency. This affected one resident (Resident #6) of eight residents reviewed for food and nutrition. The facility identified 13 residents (#4, #6, #8, #11, #14, #30, #40, #46, #69, #73, #76 #86, and #146) who received a mechanical soft diet. The facility census was 94. Findings include: Review of the medical record for Resident #6 revealed an admitted [DATE]. Diagnoses included quadriplegia, dysphagia,, unspecified dementia, and macular degeneration. Review of Resident #6's annual Minimum Data Set (MDS) 3.0 assessment, dated 11/29/24, revealed the resident was cognitively intact, required setup and clean up assistance from staff for eating, and was on a mechanically altered diet. Review of Resident #6's physician orders revealed an order dated 11/13/24 for regular diet, mechanical soft texture, thin consistency. Review of Resident #6's care plan, dated 08/30/24, revealed the resident may be nutritionally at risk related to quadriplegia, dementia, and altered chewing ability. Interventions included provide diet as ordered. Review of the facility spread sheet Assumption Village Menu Extension for dinner week three (12/18/24) revealed the mechanical soft diets were to receive one number eight scoop (four ounces) of green beans instead of one number eight scoop (four ounces) of creamy coleslaw. Observation of Resident #6's meal tray on 12/18/24 at 4:55 P.M. revealed he had received coleslaw which consisted of shredded pieces of cabbage which were approximately 3/4 inch long. Review of the diet ticket on the meal tray revealed the resident was on a mechanical soft diet and was to receive green beans instead of coleslaw. At the time of observation Certified Nursing Assistant (CNA) #394 confirmed the resident had received coleslaw with shredded cabbage and had not received green beans. CNA #394 removed the coleslaw from the tray. Interview on 12/19/24 at 7:50 A.M. with Speech Therapy #361 revealed coleslaw was not appropriate for a mechanical soft diet. Review of the facility policy Food, Nutrition and Dietary Services Policy and Procedure, undated, revealed menus must be followed, and the facility must serve the food in a form designed to meet individual needs.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46195 Based on observation, record review, interview and review of facility policy, the facility did not ensure residents were offered a substantial snack in the evening when the time between dinner and breakfast exceeded 14 hours. This had potential to affect all 92 residents receiving meals from the kitchen except for two residents (#70 and #86) the facility identified as receiving nothing by mouth (NPO). The facility census was 94. Findings include: Observation on 12/17/24 from 4:00 P.M. to 5:11 P.M. of dinner meal delivery and on 12/18/24 from 7:18 A.M. to 8:14 A.M. of breakfast meal delivery revealed the following delivery times: Intermediate cart one dinner was delivered at 4:08 P.M. on 12/17/24 and breakfast on 12/18/24 was delivered at 7:18 A.M. (15 hours 10 minutes from dinner to breakfast) Intermediate cart two dinner was delivered at 4:17 P.M. on 12/17/24 and breakfast on 12/18/24 was delivered at 7:20 A.M. (15 hours three minutes from dinner to breakfast) Special Care cart one dinner was delivered at 4:30 P.M. on 12/17/24 and breakfast on 12/18/24 was delivered at 8:02 A.M. (15 hours 30 minutes from dinner to breakfast) Special Care cart two dinner was delivered at 4:55 P.M. on 12/17/24 and breakfast on 12/18/24 was delivered at 8:14 A.M. (15 hours 20 minutes from dinner to breakfast) Skilled unit cart dinner was delivered at 5:11 P.M. on 12/17/24 and breakfast on 12/18/24 was delivered at 7:53 A.M. (14 hours 42 minutes from dinner to breakfast) Review of the facility document Assumption Village Delivery Times, updated 02/13/24, revealed the following delivery times: Intermediate cart one dinner 4:10 P.M. and breakfast 7:10 A.M. (15 hours between dinner and breakfast) Intermediate cart two 4:20 P.M. and breakfast 7:20 A.M. (15 hours between dinner and breakfast) Special Care unit cart one dinner 4:35 P.M. and breakfast 8:15 A.M. (15 hours and 40 minutes between dinner and breakfast) Special Care unit cart two dinner 4:50 P.M. and breakfast 8:30 A.M. (15 hours and 40 minutes between dinner and breakfast) Skilled unit dinner 5:10 P.M. and 8:00 breakfast (14 hours and 50 minutes between dinner and breakfast). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews conducted during the Resident Council meeting on 12/18/24 at 9:06 A.M. with seven residents (#2, #18, #40, #50, #58, #66, #76) revealed the residents felt there was a long time between dinner and breakfast which was why the facility should be offering snacks. They stated staff don't come around to offer snacks in the evening. The residents stated some of them had snacks in their room that the family provided but other residents stated they didn't have family or money to purchase snacks. They stated they had never been asked if they agreed with the meal delivery times. Interview on 12/18/24 at 2:16 P.M. with Dietary Manager #327 revealed the meal times had been changed since the Special Care unit was complaining they were getting their trays last for dinner. She confirmed there were great than 14 hours between dinner and breakfast and a substantial snack was not being offered to everyone. Review of facility policy Food, Nutrition and Dietary Services Policy and Procedure, undated, revealed there must be no more than 14 hours between a substantial evening meal and breakfast except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agreed to this meal plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy, the facility failed to ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect all 92 residents who received food from the kitchen. The facility identified two residents (#70 and #86) as receiving nothing by mouth (NPO). The facility census was 94. Findings include: 1. Observations on [DATE] from 8:05 A.M. to 8:35 A.M. with Dietitian #500 and Dietary Supervisor (DS) #351 revealed the following concerns: In the dry storage area across from the walk-in coolers, there was one open and resealed half-full package of gluten-free dried macaroni not dated when opened, one open and resealed three fourth full package of gluten-free oats not dated when opened, and one package of gluten-free cookies half full open to air and not dated when opened. In the walk-in cooler, which was connected to the walk in freezer, there was one extra-large roll of sandwich bologna which had been opened and resealed with plastic wrap but was not dated when opened, five four-ounce clear plastic containers with lids of chocolate pudding dated [DATE], five four-ounce clear plastic containers with lids of lemon pudding dated [DATE], one half of a loaf of lunchmeat turkey opened and resealed with plastic wrap which had a large hole in it (which left the product exposed to air) and was undated. In the walk-in freezer, there was one box with a factory bag of three vegan burgers open to air and one box three-fourth full of vegan sausage patties open to air. The electric soup kettle sitting on a food service cart revealed on the outside of the unit there was an open area with evidence of corrosion related to rust. The meat slicer revealed it was uncovered and the blade of the slicer had dried food debris on its surface. Inside the single-door, reach-in cooler located to the left of the exhaust hood there were ten four-ounce clear plastic containers with lids of yogurt dated [DATE], three four-ounce clear containers with lids of applesauce dated [DATE], three four-ounce clear plastic containers with lids of applesauce dated [DATE], and one four-ounce clear container with a lid of vanilla pudding dated [DATE]. The mixer revealed it was not covered, and there was an accumulation of food splatter marks on the base and underside of the unit. The vents of the hood had a visible buildup of grease and dirt and the pipes of the fire suppression system had a heavy accumulation of visible dust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the single-door reach-in cooler to the right of the hood on the second shelf there was an opened container of liquid eggs which was sitting above the third shelf which had 3 slices of tomatoes wrapped in plastic wrap and a square clear container with approximately ten slices of ham sealed with plastic wrap. The container of ham had a date of [DATE]. Sitting on the top shelf, there was one half of a one pound stick of butter which was loosely wrapped in the factory paper with portions left to open air. In the dry storage area located by the ice machine, there was a build-up of debris around the perimeter of the room which included approximately 10 plastic lids on the floor, plastic tape from a box, and a small dried dark unidentifiable substance on the floor. The single-door reach-in beverage cooler located near the steam table contained three four-ounce plastic cups full of tea with lids dated [DATE] On the floor near the three compartment sink area there was a fan, which was running and pointed toward the tray line, with a buildup of dirt and dust on the blades. At the time of observation, Dietitian #500 and DS #351 confirmed areas of concern and stated items should be dated when opened and resealed, items should be thrown out after three days, and areas should be clean. 2. Observation on [DATE] from 11:47 A.M. to 12:17 P.M. of the Skilled and Intermediate unit refrigerators with Dietitian #500 revealed the following concerns: in the freezer compartment on the skilled unit there was a fast food bag containing a hot dog, a small oreo blizzard and chocolate pecan icecream with no name or date. In the refrigerator sections on both units there was a pitcher of red juice without a label or date, one large pitcher of thickened water without a date, boiled eggs, yogurt, fresh fruit in a container, chicken and rolls and a container of chicken and pasta with an offensive smell all without names or dates and multiple expired foods including sour cream with a use-by date of [DATE], pepperoni and cheese sandwiches dated [DATE], applesauce dated [DATE], chocolate pudding dated [DATE], [DATE] and [DATE], blue cheese crumbles with a use-by date of [DATE], string cheese with a use-by date of [DATE], and a bag of shredded cheddar cheese with a best by date of [DATE]. At the time of observation Dietitian #500 confirmed all unit refrigerators needed cleaned and all items should have a name and date and should be thrown out after three days or use by date. 3. Observation of tray line on [DATE] from 4:00 P.M. to 5:11 P.M. revealed throughout the tray line process Dietary Aide (DA) #414 was wiping off wet areas of dietary trays with a blue towel as they were placed on tray line and would then place the towel on the top of the three tier cart at the start of tray line which had a buildup of dirt and debris on each tier. DA #501 was observed wiping the wet areas of the dome lids off with a blue towel that was soiled with gravy on parts of the towel. Interview on [DATE] at 5:05 P.M. with DA #414 and DA #501 confirmed they were using their blue towels throughout the tray line to dry the trays and dome lids. Interview on [DATE] at 5:05 P.M. with Dietitian #500 confirmed the dirty towel and towels should not be used to dry off items in the kitchen and the three tier cart was dirty and needed cleaned. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's county health inspection report, dated [DATE], revealed the facility's kitchen was not in compliance for food in good condition, safe and unadulterated and food contact surfaces, cleaned and sanitized. Review of the facility policy Food Storage, reviewed [DATE], revealed left over food would be stored in covered containers or wrapped carefully and securely. Each item would be clearly labeled and dated and left over food would be used within three days or discarded. Raw animal products would be stored below raw fruits and vegetables and cooked items. All foods would be covered labeled and dated. Review of the facility policy Sanitation, dated [DATE], revealed all kitchen areas shall be kept clean. All equipment shall be kept clean and maintained in good repair, free of corrosion and open seams that may affect their use or proper cleaning. Kitchen surfaces shall be cleaned regularly and frequently enough to prevent an accumulation of grime. Review of the facility document Food Safety For Your Loved One, dated [DATE], revealed all food and beverages should be labeled with the resident's name and dated to monitor for food safety. Food in the original containers marked with manufacturer expiration dates and unopened did not need to be dated until opened. Once opened it needed to be thrown away after three days. Food and beverage items without a manufacturer's expiration date should be dated upon arrival and thrown away three days after the dated marked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Assumption Village		STREET ADDRESS, CITY, STATE, ZIP CODE 9800 Market Street North Lima, OH 44452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, and record review, the facility failed to maintain proper infection control procedures to prevent the spread of infection. This affected three residents (#68, #148 and #151) of three observed for isolation precautions. This had the potential to affect nineteen residents (#10, #15, #47, #51, #56, #60, #68, #71, #82, #83, #87, #89, #144, #145,#146 #147, #148, #150 and #151) residents residing on the 1100, 1200 and 1300 halls. The facility census was 94. Findings include: 1. Review of Resident #68's medical records revealed an admitted [DATE]. Diagnoses included stroke with right sided weakness and dementia. Review of the care plan dated 09/02/24 revealed Resident #68 required staff assistance for activities of daily living (ADL) care. Interventions included maintain isolation precautions during care. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 had impaired cognition. Resident #68 was dependent for toileting, bathing and personal hygiene. Resident #68 was incontinent of bowel and had a urinary catheter. Review of physician orders for December 2024 revealed Resident #68 was on enhanced barrier precautions (EBP) for catheter care related to extended-spectrum beta-lactamases (ESBL) (antibiotic resistant infection). Observation on 12/16/24 at 9:17 A.M. revealed Resident #68 was in bed yelling out for help. Resident #68 had a sign posted on his door that indicated Resident #68 was on EBP precautions and gown and gloves were required for high contact activities that included hygiene and catheter care. Further observation revealed Certified Nursing Assistant (CNA) #318 and CNA #326 had entered Resident #68's room without donning personal protective equipment (PPE). CNA #318 and CNA #326 had proceeded to provide Resident #68 with incontinence and catheter care and had not donned PPE during care. Interviews with CNA #318 and #326 at time of observation revealed they were not aware Resident #68 was on EBP and were required to wear PPE during care. 2. Review of Resident #148's medical records revealed an admitted [DATE]. Diagnoses included left femur fracture, muscle weakness, need for personal care assistance and urinary retention. Review of the care plan dated 12/10/24 revealed Resident #68 was at risk for infection related to a urinary catheter. Interventions included maintain EBP. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #148 had intact cognition. Resident #148 was dependent with toileting and required maximum assistance with bathing and personal hygiene. Resident #148 was incontinent of bowel and had a urinary catheter. Review of physician orders for December 2024 revealed Resident #148 was on EBP related to indwelling urinary catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/16/24 at 9:48 A.M. revealed Resident #148's door had a sign posted that indicated EBP and gown and gloves were required for high contact activities that included hygiene and catheter care. Further observation revealed CNA #318 entered Resident #148's room and had not donned PPE. CNA #318 proceeded to provide Resident #148 with incontinence care without wearing PPE. Interview with CNA #318 after completion of care revealed she was not aware Resident #148 was on EBP and she was required to wear PPE during care. 3. Review of Resident #151's medical record revealed an admitted [DATE]. Diagnoses included Covid-19 and dementia. Review of care plan dated 12/16/24 revealed Resident #151 had an infection related to covid-19. Interventions included maintain droplet precautions. Review of physician orders for December 2024 revealed Resident #151 was on droplet precautions. Observation on 12/16/24 at 11:22 A.M. revealed a sign posted on Resident #151's door that indicated droplet precautions and N95, gown, gloves and facesheild were to be worn upon entry and PPE should not be worn in common areas. Observation on 12/16/24 revealed CNA #318 had exited Resident #151's room and was wearing an N95 mask, gown and gloves. CNA #318 had proceeded to walk to the nurses station and asked Registered Nurse (RN) #313 for a drinking straw. CNA #318 had obtained the straw from RN #313 and had returned to Resident #151's room while still wearing the same PPE. Interview with RN #313 at time of observation confirmed Resident #151 was covid positive and RN #313 stated CNA #318 should have doffed the PPE prior to exiting Resident #151's room. Review of facility policy titled Enhanced Barrier Precautions updated 03/28/24 revealed PPE including gloves and gowns were to be worn during high contact activities that included hygiene and catheter care. Review of Coronavirus (Covid-19) revised 09/24 revealed staff were to wear an N95 mask, gown, gloves and facesheild prior to entering.