STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365876	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Carriage Inn	5040 Philadelphia Drive Dayton, OH 45415

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review and staff interview, the facility failed to develop a baseline care plan for a resident. This affected one (#76) of three residents reviewed who were new admissions. The census was 74. Findings include: Review of Resident #76's closed medical record revealed an admitted [DATE]. Diagnoses listed included osteoarthritis, restless leg syndrome, type two diabetes mellitus, and morbid obesity. Resident #76 was discharged from the facility on 05/19/24. Further review of Resident #76's closed medical record revealed no documentation of baseline careplan being developed. During an interview on 06/05/24 at 10:50 A.M. The Director of Nursing (DON) confirmed a baseline careplan had not been completed for Resident #76. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review and staff interview, the facility failed to update a resident's comprehensive care plan for suicide risk/suicidal ideation. This affected one (#59) of three residents reviewed for comprehensive care plans. The census was 74. Findings include: Review of Resident #59's medical record revealed an admitted d of 01/31/23. Diagnoses listed include hypertensive kidney disease, major depressive disorder, bradycardia, impulsiveness, dementia, and congestive heart failure. Review of quarterly Minimum Data Set (MDS) assessment revealed Resident #59 was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of a possible 15. Review of progress notes revealed on 05/09/24 expressed thoughts of harming himself and having plan to do so by telling a state tested nursing assistant (STNA). Resident #59 was placed on one on one (1:1) supervision until a psychiatric evaluation on 05/10/24. On 05/20/24 Resident #59 was found with a call light wrapped around his neck after being found on the floor on his room. Resident #59's was discharged to a local hospital and pink slipped (emergency admitted) on 05/21/24 for psychiatric evaluation. Resident #59 returned to the facility on [DATE] was placed on 1:1 supervision until psychiatric evaluation on 05/24/24. Review of Resident #59's comprehensive care plan revealed no focus or related interventions interventions for suicide risk/suicidal ideation. During an interview on 06/05/24 at 1:25 P.M. the Director of Nursing (DON), Administrator, and Social Services Director (SSD) #150 confirmed Resident #59 had been evaluated for suicidal ideation on 05/10/24 and 05/24/24. The DON, Administrator, and SSD #150 confirmed Resident #59's comprehensive care plan should have been update to include interventions for suicide risk/suicidal ideation. This deficiency represents non-compliance investigated under Complaint Number OH00154118.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, and review of facility policy, the facility failed to provide urinary catheter care to a resident. This affected one (#76) of three residents reviewed for urinary catheters. The census was 74. Findings include: Review of Resident #76's closed medical record revealed an admitted [DATE]. Diagnoses listed included osteoarthritis, restless leg syndrome, type two diabetes mellitus, and morbid obesity. Resident #76 was discharged from the facility on 05/19/24. Review of a Nursing Administration Evaluation dated 05/16/24 revealed Resident #76 had an indwelling urinary catheter. Further review of Resident #76's closed medical record revealed no documentation of urinary catheter care being provided to Resident #76 from admission 05/16/24 to discharge 05/19/24. During an interview on 06/05/24 at 9:55 A.M. The Director of Nursing (DON) and Regional Nurse #100 confirmed urinary catheter care was not documented as being provided Resident #76. Urinary catheter care should be completed as least every shift (two times a day). Review of the facility's policy titled Catheter Care, Urinary dated revised September 2014 revealed a resident's urinary catheter care should be documented in the medical record. This documentation should include the date and the time that catheter care was given and the name and the title of the individual(s) giving the catheter care. This deficiency represents non-compliance investigated under Complaint Number OH00154127.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, review of facility policy, and review of medication information from Medscape, the facility failed to monitor a resident's blood glucose level before administering insulin. This affected one (#76) of three residents reviewed for insulin administration. The census was 74. Findings include: Review of Resident #76's closed medical record revealed an admitted [DATE]. Diagnoses listed included osteoarthritis, restless leg syndrome, type two diabetes mellitus, and morbid obesity. Resident #76 was discharged from the facility on 05/19/24. Review of physician orders revealed an order dated 05/16/24 to inject 60 units of insulin glargine subcutaneous solution 100 units per milliliter (unit/ml) subcutaneously (SQ) at bedtime for diabetes mellitus. Review of medication administration records (MAR) revealed 60 units of insulin glargine subcutaneous solution was administered to Resident #76 on 05/17/24 and 05/18/24. No documentation of blood glucose levels checks before administration was documented. Review of documented blood glucose level results revealed no documentation of results being obtained before administration of 60 units of insulin glargine subcutaneous solution to Resident #76 on 05/17/24 and 05/18/24. During an interview on 06/05/24 at 9:55 A.M. The Director of Nursing (DON) and Regional Nurse #100 confirmed Resident #76's blood glucose level was not checked prior to administration of 60 units of insulin glargine subcutaneous solution on 05/17/24 and 05/18/24. Both the DON and Regional Nurse #100 confirmed Resident #76 was admitted on [DATE] and the administration of insulin on 05/17/24 and 05/18/24 would have been the first time Resident #76 had received insulin at the facility. Both the DON and Regional Nurse #100 confirmed Resident #76's blood glucose levels should have been checked before being administered insulin on 05/17/24 and 05/18/24. Review of the facility's policy titled Insulin Administration dated revised September 2014 revealed step #2 in the insulin administration procedure was to check blood glucose per physician order or facility protocol. Documentation included the resident's blood glucose result. Review of Medscape at https://reference.medscape.com/drug/lantus-toujeo-insulin-glargine-999003#91 revealed blood glucose monitoring is essential in all patients receiving insulin therapy. Insulin glargine is a long acting insulin and while taking this insulin patients should monitor their blood sugar on a regular basis. This deficiency represents non-compliance investigated under Complaint Number OH00154127.