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	10/21/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on medical record review, observation, staff interview, and review of policy, the facility failed to ensure medications were not left unattended in resident rooms. This affected one (Resident #15) of two residents observed for medication administration. The facility census was 63 residents. Findings include: Review of the medical record for Resident #15 revealed an admission date of 04/08/25 with diagnoses including atrial fibrillation, malignant prostate cancer, and pneumonia. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 07/15/25 revealed the resident had intact cognition and required moderate staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #15 dated October 2025 revealed there was no order for the resident to self-administer medications. Observation on 10/20/25 at 10:01 A.M. with License Practical Nurse (LPN) #30 revealed the nurse entered Resident #15's room with an ampule of albuterol, an inhalant medication to assist with breathing. LPN #30 placed the contents of the ampule into the nebulizer and told the resident the medication was there for him whenever he was ready to use. The nurse then left the room. Interview on 10/20/25 at 10:03 A.M. with LPN #30 confirmed Resident #15 did not have a physician's order to self-administer albuterol. Review of facility policy titled Administering Medications dated April 2019 revealed residents may self-administer medications only if the attending physician and interdisciplinary care team had determined the resident had the decision-making capacity to do so safely. This deficiency represents noncompliance investigated under Complaint Number 2640037.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff administered blood pressure medications according to physician-ordered parameters. This affected one (Resident #15) of two residents observed for medication administration. The facility census was 63 residents. Findings include: Review of the medical record for Resident #15 revealed an admission date of 04/08/25 with diagnoses including atrial fibrillation, malignant prostate cancer, and pneumonia. Review a physician's order for Resident #15 revealed an order dated 04/09/25 for Diltiazem 120 milligram (mg) once daily with parameters to hold the medication if the resident's systolic blood pressure was less than 110.Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 07/15/25 revealed the resident had intact cognition and required moderate staff assistance with activities of daily living (ADLs.)Observation on 10/20/25 at 10:05 A.M. with Licensed Practical Nurse (LPN) #30 revealed the nurse withheld Resident #15's dose of Diltiazem because the resident's blood pressure was 104/66 with the systolic blood pressure reading as lower than 110. LPN #30 then disposed of the medication in the sharps container. Review of Medication Administration Record (MAR) for Resident #15 dated 10/20/25 LPN #30 signed off administration of the dose of Diltiazem at 1:03 P.M. The MAR did not include a recheck of Resident #15's blood pressure. Interview on 10/21/25 at 4:30 P.M. with the Director of Nursing (DON) confirmed LPN #30 signed off administration of Diltiazem for Resident #15 on 10/20/25 at 1:03 P.M. and the MAR did not include a recheck of Resident #15's blood pressure. The DON confirmed Resident #15's Diltiazem order included physician-ordered parameters to withhold the medication if the systolic blood pressure was lower than 110. The DON stated she called LPN #30 and got confirmation the nurse had administered Resident #15's dose of Diltiazem on 10/20/25 at 1:03 P.M. along with other medications ordered for 1:00 P.M. Review of facility policy titled Administering Medications dated April 2019 revealed medications should be administered as ordered by the physician. This deficiency represents noncompliance investigated under Complaint Number 2640037.

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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 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. Based on medical record review, review of the facility menu, observation, staff interview, and review of the facility policy, the facility failed to prepare pureed foods in a method that conserved nutritive value, flavor and appearance. This affected four (Residents #7, #13, #21,and #35) of four residents with orders for pureed diets. The facility census was 63 residents. Findings include: Review of the medical records for Residents #7, #13, #21,and #35 revealed the residents had physician orders to receive a pureed diet. Review of the puree diet menu for 10/20/25 revealed the following items were on the lunch menu: beef burgundy, vegetable rice pilaf, green peas, mandarin oranges, dinner roll, chocolate chip cookie. Review of the substitution log revealed beef stew was substituted for beef burgundy on 10/20/25. Observation on 10/20/25 at 11:07 A.M. revealed [NAME] #14 prepared pureed peas. [NAME] #14 added 10 ounces (oz) of peas, one cup of water, and three scoops of thickener to a food processer and blended the peas. [NAME] #14 then prepared pureed beef stew by adding 12 oz. stew, one cup of water and two scoops of thickener to the food processor. Interview on 10/20/25 at 11:18 A.M. with [NAME] #14 verified that she used water as a thinning agent when making pureed foods.Review of the facility policy titled Summary of House Diets dated August 1015 revealed fruit or vegetable juices, meat broths, or milk should be used to thin pureed food to the appropriate consistency. This deficiency represents noncompliance investigated under Complaint Number 2640037.

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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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to maintain kitchen equipment and furnishings in a clean and sanitary manner. This had the potential to affect all of the residents residing in the facility with the exception of three facility-identified residents who did not consume food by mouth. The facility census was 63 residents.Findings include:1.Observation on 10/20/25 at 9:24 A.M. revealed there were plastic containers on the clean dish rack which had been stacked while wet and were nesting. Interview on 10/20/25 at 9:25 A. M. with Dietary Manager (DM) #21 verified that the containers were wet and were being stored nested together so they couldn't dry properly. 2.Observation on 10/20/25 at 9:28 A.M. revealed the knife storage rack above the prep table contained two knives each with several missing metal chips along the blades and three knives with residue on the blade. Interview on 10/20/25 at 9:28 A.M. with DM #21 verified that the two knives had missing metal chips along the blades and the three knives were unclean. 3. Observation on 10/20/25 at 9:29 A.M. revealed there was a metal plate warmer with food debris stored on the clean dish drying rack. Interview on 10/20/25 at 9:29 A.M. with DM #21 verified that the plate warmer was dirty. 4. Observation on 10/20/25 at 9:30 A.M. revealed the can opener attached to the prep table had dried food debris on the blade. Interview on 10/20/25 at 9:30 A.M. with DM #21 verified that the can opener was unclean. 5. Observation on 10/20/25 at 9:33 A.M. revealed there was a build up of debris at the bottom of the steam table wells. Interview on 10/20/25 at 9:33 A.M. with DM #21 verified the steam table wells were dirty. 6. Observation on 10/20/25 at 9:35 A.M. revealed there was a build-up of ice on the vinyl strip curtains and floor in the walk-in freezer.Interview on 10/20/25 at 9:35 A.M> with DM #21 verified the walk-in freezer had a build-up of ice on the vinyl strip curtains and on the floor. 7. Observation on 10/20/25 at 9:37 A.M. revealed the walk-in cooler metal floors and walls were rusted with the metal flooring separating. Further observation revealed the condenser was leaking with a bucket below it containing gray stagnant water and water on the floor. Interview on 10/20/25 at 9:37 A.M. with DM #21 confirmed the cooler had been leaking for a while and the maintenance department had placed the bucket below the condenser. This deficiency represents noncompliance investigated under Complaint Number 2640037.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure staff donned appropriate personal protective equipment (PPE) for residents on enhanced barrier precautions. This affected three (Residents #61, #21, #14) of three residents observed for care. The facility also failed to ensure staff practiced proper hand hygiene. This affected one (Resident #21) of three residents observed for care and one (Resident #15) of two residents observed for medication administration. The facility census was 63 residents.Findings include:1.Review of the medical record for Resident #61 revealed an admission date of 09/23/25 with diagnoses including cerebral atherosclerosis, tracheostomy, and gastrostomy. Review of the physician's orders for Resident #61 revealed an order dated 09/24/25 for the resident to be on enhanced barrier precautions Observation on 10/21/25 at 8:27 A.M. revealed Licensed Practical Nurse (LPN) #30 was in Resident #61's room providing care without a gown. Interview on 10/21/25 at 8:29 P.M. with LPN #30 confirmed Resident #61 had an order for enhanced barrier precautions and the nurse had been caring for the resident's gastrostomy tube, but had not donned a gown prior to entering the room. 2.Review of the medical record for Resident #15 revealed an admission date of 04/08/25 with a diagnosis of pneumonia. Observation on 10/20/25 at 10:01 A.M. revealed LPN #30 entered Resident #15's room to check the resident's blood pressure and to administer medications and donned gloves. LPN #30 used a reusable wrist blood pressure (BP) monitor to take BP, administered medications, doffed gloves, and returned to the medication cart and began to pull medication for Resident #11. LPN #30 then administered medications to Resident #11 without performing hand hygiene between residents. Interview on 10/20/25 at 10:40 A.M. with LPN #30 confirmed she had not performed hand hygiene after administering medication to Resident #15 and prior to administering medication to Resident #11. 3. Review of the medical record for Resident #21 revealed an admission date of 01/15/24 with diagnoses including cerebral palsy, stage three pressure ulcer, severe protein malnutrition, and dysphagia. Observation on 10/21/25 at 2:14 P.M. revealed Resident #21 had a sign outside his door indicating he was on EBP. Observation of wound care for Resident #21 per LPN #10 assisted by Certified Nursing Assistant (CNAs) #14 and #64 revealed the staff did not don gowns prior to entering the room to perform care. LPN #10, CNA #14, and CNA #64 doffed gloves after performing care, but then exited Resident #21's room without performing hand hygiene. Interviews on 10/21/25 at 2:30 P.M. with LPN#10, CNA #14 and CNA #64 confirmed Resident #21 was on EBP and they should have donned gowns prior to entering the room to perform care and they had not performed hand hygiene after caring for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #14 revealed an admission date of 03/01/19 with diagnoses including hemiplegia and hemiparesis, cerebral infarction, diabetes, and stage three pressure ulcer. Observation on 10/21/25 at 2:41 P.M. revealed Resident #14 had a sign outside the door indicating the resident was on EBP. LPN #29 performed wound care for Resident #14 but did not don a gown. Interview on 10/21/25 at 2:55 P.M. with LPN #29 confirmed Resident #14 was on EBP, but she had not donned a gown for performing wound care for the resident. Review of facility policy titled Handwashing/Hand Hygiene dated October 2023 revealed hand hygiene was indicated immediately before touching a resident, after touching a resident, after touching a resident's environment and immediately after glove removal. Review of the facility policy titled Isolation-Categories of Transmission Based Precautions (TBP) dated 2001 revealed staff should consult with the nurse to determine what type of PPE should be donned prior to caring for a resident on TBP.