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	12/12/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 22445 Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure staff followed the policy to check placement of the resident's gastrostomy tube (G-tube) before medication was administered. This affected one (#62) of four residents observed for medication administration. The facility census was 60. Findings included: Review of an admission medical record for Resident #62 revealed an admission on 12/04/24. Diagnoses for Resident #62 included: moderate protein-calorie malnutrition and dysphagia (difficulty swallowing foods or liquids) in the oral phase. Review of the admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/11/24, revealed Resident #62 had severe cognitive impairment. The MDS indicated Resident #62 was dependent on staff for completion of all activities of daily living (ADLs). The MDS also revealed Resident #62 received 51% or more of their total calories and fluid intake through their feeding tube. Review of Resident #62's care plan dated 12/10/24, included a focus area, for at nutritional and dehydration risk related to dependence on a G-tube and the need for a therapeutic formula. The care plan directed staff to provide tube feeding and check residuals per orders. Review of Resident #62's Physician Order Summary Report for active physician orders as of 12/11/24, revealed an order dated 12/04/24, to check the residual volume, hold the tube feeding, and notify the physician if the residual was over 60 milliliters. The Physician Order Summary Report also revealed an order dated 12/09/24, to check the resident's G-tube placement every shift. Observation on 12/11/24 at 8:40 A.M., during the medication administration, Registered Nurse (RN) #3 prepared medication to administer to Resident #62 by way of the G-tube. After preparation, at 9:10 A.M., RN #3 placed the G-tube feeding pump on hold, flushed the tube with water, and then pulled back on the syringe to check residual, which was clear with tan colored particles. The observation revealed RN #3 proceeded to administer Resident #62's medications. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/24 at 9:20 A.M., with RN #3 stated she instilled water by way of a syringe to check the placement of Resident #62's G-tube. RN #3 stated she should not have used water to check placement because there was a danger that water could have gone into the wrong place (somewhere other than the resident's stomach). Interviewed on 12/12/24 at 2:16 P.M., with the Director of Nursing (DON) stated nurses should not use water to check G-tube placement because if the tube was not in the correct location, the installation of water could cause harm to the resident. Interview on 12/12/24 at 2:20 P.M., the Administrator stated she expected the nurses to use the facility policy when they checked G-tube placement. Review of the policy titled, Confirming Placement of Feeding Tubes, revised November 2018, indicated, the purpose of this procedure is to ensure proper placement of an existing feeding tube prior to administering enteral feedings or medication. According to the policy, To confirm placement of an existing feeding tube at the bedside: 1. Test whether the tube is properly positioned: a. Observe for symptoms of elevated gastric residual volume (GRV): (1) A sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach. (2) Little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus. b. Observe and check the pH [potential of hydrogen] of aspirate: (1) Fasting stomach contents will have a clear and colorless or grassy green and brown appearance. (2) Fluids from the pleural space [lungs] may have a pale yellow, serous appearance. (3) Post-pyloric/small bowel contents can be bile-stained, light to dark yellow or greenish-brown. (4) Fasting stomach acid will have a pH of 5 or less. (5) Fluid from the pleural space will have a pH of 7 or higher. (6) A pH of 5 or less suggests that the tube is placed in the stomach. However, a pH of 6 or greater is not definitive of placement outside the stomach. 2. If the above suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. When correct tube placement has been verified, flush tubing with at least 30 mL [milliliters] warm water (or prescribed amount).

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on observation, staff interview, medical record review, and policy review, the facility failed to maintain a medication error rate of less than five percent (%). There were 3 medication errors of 38 medication opportunities, which resulted in a medication error rate of 7.89%. This affected two (#62 and #111) of four residents observed for medication administration. The facility census was 60. Findings included: 1. Review of an admission medical record for Resident #111 revealed an admitted [DATE]. Diagnoses for Resident #111 included: hypertensive urgency, hypertensive chronic kidney disease, atherosclerotic heard disease, and essential hypertension. Observation on 12/10/24 beginning at 8:14 A.M., during medication administration, Licensed Practical Nurse (LPN) #1 prepared one vitamin B12, 500 micrograms (mcg) and one enteric coated aspirin, 81 milligrams (mg). The medications were administered to Resident #111. Review of Resident #111's physician Order Summary Report for active orders as of 12/11/24, revealed orders dated 12/05/24, for one chewable aspirin (not enteric coated), 81 mg in the morning for stroke prevention and for cyanocobalamin (vitamin B12) 2000 mcg, one tablet every morning related to a vitamin B12 deficiency. Interview on 12/12/24 at 10:50 A.M., with LPN #1 stated she had only seen 81 mg on the aspirin bottle and did not read that the order was for a chewable aspirin. LPN #1 stated she was unable to remember giving vitamin B-12 to Resident #111, but remembered the surveyor looked at the medications and counted the number of pills placed in the resident's medication cup. Interview on 12/12/24 at 1:56 P.M., with the DON stated before medications are administered, she expected the nurse to check the resident's medication administration record (MAR), pull the medication, and check the medication against the MAR to make sure it was the right medication, right time, right route of administration, right dose, and the right resident. The DON stated if LPN #1 gave Resident #111 enteric coated aspirin and did not give the correct vitamin B-12 dosage, those were medication errors because the medications given did not match the physician's order. Interview on 12/12/24 at 2:05 P.M., with the Administrator stated before medications were administered, she expected the nurse to check the dose and to make sure it was the correct medication and the right time for the medication. 2. Review of an admission medical record for Resident #62 revealed an admission on 12/04/24. Diagnoses for Resident #62 included: moderate protein-calorie malnutrition and dysphagia (difficulty swallowing foods or liquids) in the oral phase and epilepsy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/11/24 at 8:40 A.M., during medication administration, Registered Nurse (RN) #3 prepared levetiracetam (an anti-seizure medication) 100 milligrams/milliliter (mg/ml) oral solution for Resident #62. RN #3 poured 10 ml of levetiracetam solution into a medication cup and administered the medication to the resident by way of the resident's gastrostomy tube (G-tube). Review of Resident #62's Physician Order Summary Report, with active orders as of 12/11/24, revealed an order dated 12/04/24, for levetiracetam 500 mg/5 ml oral solution, give 5 ml per G-tube twice a day. Interview on 12/11/24 at 12:33 P.M., with RN #3 stated she could have sworn the order for the levetiracetam was for 10 ml. RN #3 reviewed Resident #62's medication administration record (MAR) and stated the order for the resident's levetiracetam was to give 5 ml. RN #3 stated she made an error and looked at the wrong entry on the MAR. RN #3 stated if a resident received too much levetiracetam, it could cause levetiracetam toxicity, and she would notify the physician about the medication error. Interview on 12/12/24 at 2:16 P.M., with the Director of Nursing (DON) stated she expected the nurse to administer the right dose of medication to the right resident. The DON stated the danger of getting too much levetiracetam could be an elevated level of the medication. Review of the policy titled, Administering Medications, revised August 2024, indicated, Medications are administered in accordance with prescriber orders, including any required time frame. The policy specified, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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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** 22445 Based on observation, resident interview, staff interview, medical record review, and policy review, the facility failed to ensure medications were not left unattended at the bedside. This affected one (#45) of three sampled residents reviewed for potential accidents. The facility census was 60. Findings included: Review of the admission medical record for Resident #45 revealed an admitted [DATE]. Diagnoses for Resident #45 included: neurocognitive disorder with Lewy bodies (a neurological brain disorder with symptoms of Alzheimer's disease) and aphasia (the inability to verbally express ideas and thoughts). Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 09/20/24, revealed Resident #45 had severe cognitive impairment. Review of Resident #45's care plan, revised 03/20/23, included a focus area indicating the resident had impaired decision-making ability and impaired memory. The care plan indicated Resident #45 would be assisted in decision making and care. Observation on 12/09/24 at 10:28 A.M., revealed on the top of Resident #45's nightstand, there were two bottles of saline nasal spray and in the top drawer of the nightstand, there was an opened bottle of Dulcolax (a laxative medication) and two bottles of digestive aid. Review of Resident #45's Physician Order Summary Report with active orders as of 12/10/24, revealed the resident did not have a physician's orders for saline nasal spray, Dulcolax, or a digestive aid. Observation on 12/10/24 at 10:03 A.M., revealed on the top of Resident #45's nightstand were two bottles of saline nasal spray and in the top drawer of the nightstand, there was an opened bottle of Dulcolax and two bottles of a digestive aid. A Certified Nursing Assistant (CNA) was observed in the resident's room to assist the resident with dressing. The CNA did not remove the medications. Observation on 12/10/24 at 3:10 P.M., revealed on the top of Resident #45's nightstand were two bottles of saline nasal spray and in the top drawer of the nightstand, there was an opened bottle of Dulcolax and two bottles of a digestive aid. Observation on 12/10/24 at 12:56 P.M., revealed on the top of Resident #45's nightstand were two bottles of saline nasal spray and in the top drawer of the nightstand, there was an opened bottle of Dulcolax and two bottles of a digestive aid. Interview with Resident #45, at the time of the observation, revealed the resident was able to identify one medication as nasal spray but was unable to recall who had given the medication to them. Resident #45 was unable to verbalize when to use the medications or how to use the medications that were at their bedside, including the nasal spray, Dulcolax, and the digestive aid. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/24 at 12:59 P.M., with CNA #5 stated she worked the hall on which Resident #45 resided and usually was assigned to care for Resident #45. CNA #5 stated if she found medications at the bedside, she reported to the nurse on the hall and then to the supervisor. CNA #5 stated she had been in Resident #45's room earlier in the day and had not seen the medications in the resident's room. Interview on 12/11/24 at 1:18 P.M., with Licensed Practical Nurse (LPN) #6 acknowledged he was assigned to care for Resident #45. LPN #6 stated if he went into a resident's room and observed over-the-counter medications, he would explain to the resident that they could not have the medications at the bedside. LPN #6 stated he would also remove the medications from the room and notify the Director of Nursing (DON) and the physician. LPN #6 stated he had not found any medications at a resident's bedside during his shift. During the interview, LPN #6 went into Resident #45's room and observed the medications and stated he did not see the medications that day when he gave Resident #45 their medications. Interview on 12/11/24 at 1:28 P.M., with the Director of Nursing (DON) stated with Resident #45's having impaired cognition, the resident was not capable of self-administration of medications. The DON stated prior to any resident being able to self-administer medications there had to be a physician's order for self-administration and an assessment to determine the resident's ability. The DON stated the danger of having medications in a resident's room would be the resident could overdose or someone else could potentially get the medications. Interview on 12/12/24 at 1:51 P.M., with the Administrator, stated she expected medications from any source not to be left at a resident's bedside. The Administrator stated she expected staff to remove medications from a resident's room when the staff member left the room. Review of the policy titled, Self-Administration of Medications, revised December 2016, indicated, staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 22445 Based on observation, staff interview, and policy review, the facility failed to maintain infection control procedures when administering medications. This affected one (#111) of four residents observed for medication administration. The facility census was 60. Findings included: Observations on 12/10/24 at 8:14 A.M., during the medication administration, in the presence of Registered Nurse (RN) #2, Licensed Practical Nurse (LPN) #1 removed the following medications from the medication package and place the medications in her bare hands: amlodipine (a high blood pressure medication), Plavix (a medication to help prevent blood clots), Lexapro (an antidepressant medication), Microzide (a blood pressure medication), and Lopressor (a blood pressure medication). Interview on 12/10/24 at 8:23 A.M., with LPN #1 stated she had not been taught anything about touching medication, but stated touching the medication with her hands could contaminate the medication. Interview on 12/10/24 at 8:24 A.M., with RN #2 stated she planned to speak with LPN #1 about touching medications with her hands and had no explanation why she had not immediately stopped LPN #1 from touching the medication and educated her. Interview on 12/12/24 at 12:08 P.M., with the Infection Preventionist (IP) stated she would have expected RN #2 to stop the LPN immediately if the RN observed the LPN touching medications. The IP stated nurses were not allowed to touch medications with their bare hands because that could contaminate the medication. Interview on 12/12/2024 at 1:56 P.M., with the Director of Nursing (DON) stated she did not expect nurses to touch medications with their bare hands due to infection control issues. The DON stated if a mentor (RN #2) watched the medication pass she expected RN #2 to stop the nurse and provide education on why they should not touch the medications with their bare hands. Review of the policy titled, Administering Medications, revised August 2024, revealed Medications are administered in a safe and timely manner, and as prescribed. The policy specified, Staff follows established facility infection control procedures for the administration of medications, as applicable.