Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365917 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/31/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aventura at Oakwood Village | 1500 Villa Road<br>Springfield, OH 45503 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570<br><br>Based on record review, staff interview, and review of Self-Reported Incidents (SRIs), the facility failed to thoroughly investigate an allegation of resident-to-resident abuse. This affected two (Residents #4 and #21) of three residents reviewed for abuse. The facility census was 102.<br><br>Findings include:<br><br>Medical record review revealed Resident #4 admitted to the facility on [DATE] with diagnoses of dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively impaired. Resident required set-up assistance with eating, required supervision assistance with wheelchair mobility, required partial assistance with oral hygiene and bed mobility, and required substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, and transfers.<br><br>Review of the care plan dated 07/22/24 revealed Resident #4 was at risk for alteration in mood state due to dementia, anxiety, and history of psychotic disorder. Interventions included the facility will monitor/record/report to physician as needed (PRN) risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone.<br><br>Review of the nurses note dated 10/09/24 at 2:34 P.M. revealed Resident #4 was wandering around the facility in wheelchair, going into other resident's rooms, swatting and hitting staff, exit seeking, and not easily re-directable. PRN orders for Ativan were given, awaiting effectiveness, psych Nurse Practitioner (NP) in the facility and increased dose to 0.5 milliliters (ml).<br><br>Review of the nurses note for Resident #4 dated 10/09/24 at 3:56 P.M. revealed Resident #4 grabbed another resident by the throat and would not let go.<br><br>Review of the nurses note dated 10/10/24 at 10:53 A.M. revealed, Correction on previous note, Resident #4 did not grab another resident by the throat. Resident #4 put her hand towards another resident, her hand did touch the resident's neck, but no force nor grabbing motion occurred. Resident #4 was attempting to keep the other resident away from her. Both residents were redirected and taken to separate locations. The note was written by the Director of Nursing (DON).<br><br>(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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| NAME OF PROVIDER OR SUPPLIER: Aventura at Oakwood Village | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 Villa Road, Springfield, OH 45503 | |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the undated witness statement signed by Staffing Coordinator (SC) #570 revealed, on 10/10/24 around 3:30 P.M. to 4:30 P.M. SC #570 witnessed Resident #21 wheel herself up to Resident #4. It looked like a friendly conversation between the two residents, then Resident #4 pushed Resident #21 around the throat away from her. SC #570 immediately reported to Registered Nurse (RN) #550.<br><br>Review of the Oakwood Village Incident Log dated 08/01/24 through 10/27/24 revealed no documentation related to incident that occurred on 10/10/24.<br><br>Review of Self-Reported Incidents (SRIs) revealed no SRI had been completed for the incident on 10/10/24, indicating an investigation was not completed.<br><br>Interview on 10/29/24 at 2:40 P.M. with RN #550 confirmed she documented a nurses note on 10/09/24 regarding Resident #4 grabbing another resident by the neck and not letting go. RN #550 stated she did not witness the incident and charted based on what State tested Nurse Aide (STNA) #570 reported. RN #550 reported Resident #4 shoved the other resident back and away from her.<br><br>Interview on 10/31/24 at 3:26 P.M. with SC #570 confirmed she witnessed Resident #4 push Resident #21 around the neck, by using her whole hand to forcefully push Resident #21, causing Resident #21 head to push back. Interview confirmed she separated the residents, checked Resident #21's neck for injuries, and took Resident #4 in her wheelchair and reported incident to the nurse on duty. Interview also confirmed Resident #4 did not grab Resident #21 around the neck and refuse to let go.<br><br>Interview on 10/31/24 at 3:31 P.M. with the DON confirmed the incident between Resident #4 and Resident #21. The incident was not listed on the incident report or investigated because the DON did not feel the incident required an investigation. The DON verified SC #570's witness stated verified Resident #4 pushed Resident #21 around the throat.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00158828. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570<br><br>Based on record review and staff interview, the facility failed to communicate with the physician about family concerns related to the discontinuation of a medication. This affected one (Resident #4) out of four residents reviewed for medication changes. The facility census was 102.<br><br>Findings include:<br><br>Medical record review revealed Resident #4 admitted to the facility on [DATE] with diagnoses of dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively impaired. Resident required set-up assistance with eating, required supervision assistance with wheelchair mobility, required partial assistance with oral hygiene and bed mobility, and required substantial assistance with toileting hygiene, bathing, dressing, personal hygiene, and transfers.<br><br>Review of the medical record revealed Brexpiprazole (Rexulti) Oral Tablet 0.5 milligrams (mg) was ordered on 07/23/24 give 1 tablet by mouth one time a day for mood and discontinued on 07/25/24. On 07/25/24, Ativan Oral Tablet 0.5 mg was ordered give 0.5 mg by mouth every 6 hours as needed (PRN). On 07/30/24, Seroquel Oral Tablet 25 mg was ordered give 1 tablet by mouth two times a day for anxiety.<br><br>Review of the signed physician order dated 07/25/24 for Resident #4 revealed an order to discontinue Brexpiprazole (Rexulti) 0.5 mg every day.<br><br>Review of the nursing note dated 07/25/24 at 4:38 P.M. revealed a note stating, Husband and daughter notified of medication changes, family states concerns that resident may no longer be in a stable mind set. Husband states will bring paperwork into this facility from psych hospital that resident had came from prior to hospitalization .<br><br>Interview on 10/29/24 at 1:36 P.M. with Licensed Practical Nurse (LPN) #519 confirmed Rexalti was changed due to cost. If a resident comes in on an expensive medication, staff work with the physician to get it changed to a cheaper drug. Interview also confirmed she did not contact Nurse Practitioner (NP) #500 with Resident #4's family concerns related to the discontinuation of the medication.<br><br>Review of the Psychiatry Progress Note, from NP #500, dated 08/01/24 revealed no documentation of family concerns was communicated to NP.<br><br>Interview on 10/30/24 at 10:31 A.M. with NP #510 confirmed she was in the building every week day and is available for family questions or concerns. Interview also confirmed the facility was able to call her if she is not in the building to schedule a call with the families if they wish. NP #510 was not aware of any family concerns with medication changes related to Resident #4's Rexulti being discontinued.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/30/24 at 2:35 P.M. with Resident #4's spouse confirmed he has been okay with most of the residents care, except with her medication Rexulti being discontinued and there being no communication with the physician even though him and his daughter asked. He reported the resident did suffer a decline with an increase in behaviors right after the medication was discontinued.<br><br>Interview on 10/31/24 at 3:31 P.M. with the Director of Nursing (DON) confirmed there was no documentation of the physician or NP #500 being notified of Resident #4's family concerns when Rexulti being discontinued.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00158828. |