

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  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Aventura at Oakwood Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1500 Villa Road 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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record reviews, observations and staff interviews, the facility failed to ensure the medication error rate did not exceed five percent (%). Three errors occurred within 27 opportunities for an error rate of 11.11%. This affected two (#20 and #21) of two residents reviewed for medication administration. The facility census was 108. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of 11/13/25. Diagnoses included chronic kidney disease and atrial fibrillation. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had intact cognition. Review of the physician's orders dated 11/14/25 revealed an order for oxybutynin (treats overactive bladder) 10 milligrams (mg) extended release. Give one tablet daily until 11/17/25. Observation on 11/18/25 at 8:56 A.M. of medication administration revealed Licensed Practical Nurse (LPN) #100 was administering medications to Resident #20. LPN #100 administered oxybutynin chloride extended release (overactive bladder) 10 milligrams (mg) to Resident #20. Interview on 11/18/25 at 11:42 A.M. with LPN #100 verified the Oxybutynin order was no longer active. 2. Review of the medical record for Resident #21 revealed an admission date of 03/05/25. Diagnoses included stroke, autistic disorder and peripheral vascular disorder. Review of the physician orders dated 11/02/25 revealed an order for Vitamin B6 (vitamin) one tablet by mouth daily and there was no documented dosage. A second order was for Tylenol 1,000 milligrams (mg) by mouth every six hours as needed for pain. Observation on 11/18/25 at 9:27 A.M. of medication administration revealed Licensed Practical Nurse (LPN) #101 administered medications to Resident #21. LPN #101 administered Vitamin B6 100 mg and one Tylenol 325 mg tablet to Resident #21. Interview on 11/18/25 at 11:28 A.M. with LPN #101 verified there was no dosage prescribed for the Vitamin B6 supplement and acknowledged the physician should be called to clarify the order. LPN #101 also verified she had administered one 325 mg Tylenol table when the order was for 1,000 mg. This deficiency represents non-compliance investigated under Complaint Number 2666022.</p>

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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