

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  12/24/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of statements, staff interview and policy review, the facility failed to ensure residents were free from resident to resident abuse. This affected one (Resident #108) out of three residents reviewed for abuse. The facility census was 100. Based on medical record review, review of statements, staff interview and policy review, the facility failed to ensure residents were free from resident to resident abuse. This affected one (Resident #108) out of three residents reviewed for abuse. The facility census was 100. Findings Include:1. Review of the medical record revealed Resident #107 was admitted on [DATE] and discharged on 11/11/25. Diagnoses included Parkinson's disease, epilepsy, and intellectual disabilities. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #107 was severely cognitively impaired. Resident #107 required setup or clean-up assistance for meals. Resident #107 was substantial to maximal assistance for oral care, toileting hygiene, personal hygiene, bathing, and dressing upper body. Resident #107 was dependent for placing shoes on and off feet and dressing his lower body. Review of the plan of care dated 08/25/25 revealed Resident #107 had problematic behaviors characterized by wandering, verbal and or physical abuse, throwing objects at others, calling out making disruptive noises, and rejection of care related to his intellectual disability. Interventions included approaching the resident slowly and from the front, be cognizant of not invading resident's personal space, be sure you have the resident's attention before speaking or touching, do not ask the resident to make decisions or ask what was wrong, focus on feelings rather than cause. Do not make unrealistic demands of resident, document summary of each episode, note cause and successful interventions, include frequency and duration, if aggressive try and remove from recreational program, provide individualized program, if strategies are not working, reapproach resident at a later time, initiate psychiatric consult as needed, involve family, encourage resident to call upon them and other support, medication as ordered, reapproach resident at a later time when care was rejected, remove resident from public area when behavior was disruptive, talk with resident in a low pitch, calm voice to decrease and eliminate undesired behavior, and provide diversional activity. Review of a progress note dated 08/16/25 written by Licensed Practical Nurse (LPN) #248 documented Resident #107 was very combative and throwing items at staff and other residents. Resident #107 was redirected but continued to throw items at the staff and other residents. Review of a progress note dated 08/16/25 written by Registered Nurse (RN) #260 who documented Resident #107 was aggressive towards residents and staff this morning. Resident #107 took medication appropriately and remained agitated and yelling at staff and residents. Review of a progress note dated 08/17/25 written by RN #260 who documented Resident #107 yelled throughout the morning in the common area, became aggressive with staff and residents. Review of a progress note dated 08/17/25 written by LPN #253 who documented Resident #107 was hitting numerous residents and staff. Resident #107 also yelled and threw magazines at staff. Resident #107 was unable to be redirected. Resident #107 was given toy cars and was unable to be redirected. Resident #107 was given numerous items to assist with behavior. None were effective. Review of a progress note dated 08/18/25 written by Unit Manager #215 who documented Resident #107 attempted to hit residents and staff with magazines. Resident #215 was redirected multiple times, was still showing aggression toward others. Staff notified family, brother started trying and put him to bed. Resident #107 was unable to be redirected. Review of a progress note dated 08/19/25 written by LPN #251 documented while doing the medication pass, continued to redirect Resident #107. Resident #107 was swinging and yelling at all the residents down the hall. Resident #107 came to the front common area with the nurse and continued to yell and raise his hands at staff and residents. When redirected he became very angry and rammed his wheelchair into the back of another resident and when the nurse and multiple aides tried to move Resident #107, he continued to push harder into the other resident. Once separated Resident #107 then took his shirt off and threw it on the ground. He kept picking up the shirt and threw it and kicked it across the floor. The nurse took the shirt to his room. The nurse walked with Resident #107 to his room he kept yelling, he wanted a shirt and he threw the shirt again. Review of a psychiatric note dated 08/22/25 written by Nurse Practitioner #243 who documented Resident #107 was admitted to the facility for respite care which transitioned into long term care. Prior to admission Resident #107 lived at home his entire life. Resident #107 had severe intellectual disability with a mental age of less than two years old. Since 08/14/25 there have been almost daily reports of physical and verbal aggression including yelling hitting staff and</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of statements, staff interview, review of the Self-Reported Incidents and policy review, the facility failed to ensure allegations of resident to resident abuse were thoroughly investigated and reported to the State Agency when Resident #107 verbally assaulted one resident and had physical aggression towards another unknown resident. This affected one (#108) out of three residents reviewed for abuse. The facility census was 100. Based on medical record review, review of statements, staff interview, review of the Self-Reported Incidents and policy review, the facility failed to ensure allegations of resident to resident abuse were thoroughly investigated and reported to the State Agency when Resident #107 verbally assaulted one resident and had physical aggression towards another unknown resident. This affected one (#108) out of three residents reviewed for abuse. The facility census was 100. Findings Include:1. Review of the medical record revealed Resident #107 was admitted on [DATE] and discharged on 11/11/25. Diagnoses included Parkinson's disease, epilepsy, and intellectual disabilities.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #107 was severely cognitively impaired. Resident #107 required setup or clean-up assistance for meals. 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Do not make unrealistic demands of resident, document summary of each episode, note cause and successful interventions, include frequency and duration, if aggressive try and remove from recreational program, provide individualized program, if strategies are not working, reapproach resident at a later time, initiate psychiatric consult as needed, involve family, encourage resident to call upon them and other support, medication as ordered, reapproach resident at a later time when care was rejected, remove resident from public area when behavior was disruptive, talk with resident in a low pitch, calm voice to decrease and eliminate undesired behavior, and provide diversional activity. Review of a progress note dated 08/16/25 written by Licensed Practical Nurse (LPN) #248 documented Resident #107 was very combative and throwing items at staff and other residents. Resident #107 was redirected but continued to throw items at the staff and other residents. 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The nurse walked with Resident #107 to his room he kept yelling, he wanted a shirt and he threw the shirt again Review of a psychiatric note dated 08/22/25 written by Nurse Practitioner #243 who documented</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure fall interventions were in place for a resident who was at high risk for falls. This affected one (#92) out of three residents reviewed for falls. The facility census was 100. Findings Included:Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure fall interventions were in place for a resident who was at high risk for falls. This affected one (#92) out of three residents reviewed for falls. The facility census was 100.Findings Included:Review of the medical record revealed Resident #92 admitted to the facility on [DATE]. Diagnoses included palliative care, Parkinson's disease, chronic obstructive pulmonary disease, and dementia.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #92 had an unfinished Brief Interview of Mental Status (BIMS) indicating severe cognitive impairment. Resident #92 required setup and clean-up for meals. Resident #92 was dependent for personal hygiene, placing on and off shoes, bathing, dressing lower body, and toileting hygiene. Resident #92 was substantial maximal assistance for oral hygiene and dressing upper body. Review of the plan of care dated 11/03/25 revealed Resident #92 had a potential for falls related to impulsivity or poor safety awareness. Interventions included assist the resident on and off the toilet, do not leave resident unattended in the bathroom, do not leave unattended in the dining room, a dycem mat in the wheelchair, evaluate medication regimen, fall matt to the left side of the bed, get resident up into wheelchair when restless, keep bed in lowest position, keep call bell within reach, encourage to use call bell, keep environment clutter free, keep room well lighted, make sure wearing proper footwear, and use a gait belt with transfer.Review of the Morse Fall Scale assessment dated [DATE] revealed Resident #92 was a fall risk with a high risk for falling score of 65.0. Resident #92 had fallen before, had more than one diagnoses in chart, had no ambulatory aids, had no intravenous apparatus, was weak, overestimates or forgets limits when alone. The Morse fall scoring was: low risk was 0-24, moderate risk was 25-44, and high risk was a score of 45 and higher.Review of the fall and incident log dated 07/01/25 to current revealed Resident #92 had falls on 07/10/25, 07/11/25, and 07/29/25. Observation on 12/23/25 at 9:30 A.M. Resident #92 had no call light, it was wrapped under the bed wheel. Interview on 12/23/25 at 9:30 A.M. with Certified Nursing Assistant (CNA) #225 verified Resident #92 had no call light in reach and the call light was under the bed wheel. Observation on 12/23/25 at 10:45 A. M. Resident #92 was in her bed that was in the high position. Resident #92's fall mat was located on the right side of the bed. No staff were observed in the room.Interview on 12/23/25 at 11:03 A.M. CNA #220 verified when entering the room Resident #92's bed was in the high position with no staff present in the room. CNA #220 verified that the fall mat was on the right side of her bed.Review of the facility policy titled Accidents and Incidents-Investigation and Reporting dated July 2017 revealed all accidents or incidents involving residents, employees, visitors, vendors, occurring on our property shall be investigated and reported to the administrator. This deficiency represents non-compliance investigated under Complaint Number 2620622 and 2566128.</p>		