STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365917	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Oakwood Village	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of facility investigation reports, review of staff witness statements, staff interview, and review of the facility policy, the facility failed to ensure residents were free from unnecessary physical restraints. This affected one (Resident#110) of one resident reviewed for physical restraints. The facility census was 109 residents.Findings include:Review of the medical record for Resident #110 revealed an admission date of 11/06/24 with diagnoses including cirrhosis of the liver with ascites, diabetes mellitus, chronic obstructive pulmonary disease, and depression and a discharge date of 02/20/26. Review of the Minimum Data Set (MDS) assessment for Resident #110 dated 02/05/26 revealed the resident had intact cognition and required partial assistance with activity of daily living (ADLs), supervision with transfers and was independent with bed mobility. Review of the care plan for Resident #110 revealed the resident had the need for restful sleep. Interventions included the following: keep the room quiet, dim lights, offer the resident a back rub, offer a snack. Further review of the care plan revealed the resident was at risk for falls. Interventions included placing a fall mattress on the floor to the side of bed for the resident to be place on a perimeter defining mattress. Review of the nurse progress note for Resident #110 dated 02/15/26 at 11:55 P.M. per Licensed Practical Nurse (LPN) #501 revealed staff called her to Resident #110's room and noted the resident was agitated, restless, combative, was trying to toss herself to the floor, and was yelling for her son. The hospice nurse arrived and assessed Resident #110 and obtained a new order for Ativan every four hours. Resident #110 became calm after Ativan was administered. Review of the facility SRI involving Resident #110 initiated on 02/16/26 revealed on 02/16/26 staff found a mattress against Resident #110's bed with a chair positioned on the other side of the mattress holding the mattress against the resident's bed while the resident was sleeping in the bed. The facility did not substantiate abuse had occurred but did reeducate staff regarding restraint use. Review of the facility investigation report of the incident involving Resident #110 dated 02/16/26 completed per Former Unit Manger (FUM)#500 revealed Resident #110 was combative and agitated during the night hours. Day shift aides reported finding a mattress which had been placed at the side of the resident's bed with two chairs against the bed and a sheet tucked under the mattress to prevent the resident from falling out of bed. Day shift staff removed the sheet, removed the mattress and removed chairs from the bedside. Resident #110 sustained no injuries related to the incident. The facility suspended the staff suspected of having placed the mattress against Resident #110's bed and filed a SRI. Review of the witness statement per Certified Nursing Assistant (CNA) #206 revealed Resident #110 was up in her chair at the beginning of the 11:00 P.M. shift on 02/15/26. The resident was grabbing at the air and not responding to direction from CNA #206, was restless and attempted to throw herself out of the chair. At 5:45 A.M on 02/17/26 CNA #206 transferred Resident #110 into the bed and placed a mattress against the bed which was held in placed with the resident's chair. Review of the witness statement per CNA #203 revealed when she arrived at work on 02/16/26 at 7:15 A.M Resident #110 was in bed with a mattress against one side of the bed with a chair holding up the mattress and the other side of the bed was against the wall. There was a sheet tucked over the resident making it impossible for the resident to (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit the bed. There were also two pillows tucked in such way to prevent Resident #110 from exiting the bed. Review of the witness statement per CNA # 217 revealed on 02/16/26 at 7:30 A.M. she observed FR #110 had a mattress against the bed a specialized positioning chair against it. Review of the witness statement per LPN #501 revealed the last time she was in Resident #110's room on 02/16/26 was at 5:15 A.M. and she did not see a mattress against the resident's bed at that time. Review of LPN #501's statement revealed she had no knowledge that staff had placed a mattress against Resident #110's bed. Interview on 03/05/26 at 1:55 P.M. with CNA #217 verified on 02/16/26 at 7:30 A.M. she observed Resident #110 in bed with a mattress against the bed secured by a locked chair against it. CNA #217 stated she had not observed a sheet over the resident. The resident was asleep and had no visible signs of skin injury or discomfort. Interview on 03/05/26 at 2:05 P.M. with the Director of Nursing, (DON) confirmed the facility had verified CNA #206 had restrained Resident #110 in bed on 02/16/26 at approximately 5:45 A.M. when the aide admitted to placing a mattress against the open side of the resident's bed. The DON further confirmed CNAs # 203 and #217 found Resident #110 at 7:30 A.M. in bed with a mattress against the side of the bed held with a locked positioning chair, and other side of the bed against the wall. The resident was unable to exit the bed. Interview on 03/11/26 at 2:25 P.M. with CNA #203 verified on 02/16/26 at 7:15 A.M. she observed Resident #110 in bed asleep with a sheet and blanket over top of the resident and tucked under the mattress. There was a mattress against the bed with a locked chair holding it in place. CNA #203 confirmed Resident #110 would not have been able to exit the bed, as the other side of the bed was against the wall. Interview on 03/11/26 at 3:18 P.M. with CNA #206 verified Resident #110 had been restless and was trying to throw herself out of a positioning chair about 11:00 P.M. on 02/15/26 according to LPN #501. CNA #206 stated at 5:45 A.M. on 02/16/26 she transferred the resident to bed, covered the resident with a bedsheet but denied the sheet was tucked in under the mattress. CNA #206 verified she put a mattress up against the side of the bed held with the locked chair, and the other side of the bed was against the wall. CNA #206 confirmed she checked on Resident #110 prior to leaving the shift at 7:00 A.M. and the mattress was still in place, and the resident was in no distress and not trying to move in the bed. CNA #206 stated she was trying to keep Resident #110 from falling out of bed and stated she should have lowered the bed and put the mattress on the floor, allowing the resident to move on her own. Review of facility policy titled Physical Constraint Consent dated March 2025 revealed the facility would ensure the residents' right to be free from physical restraints. If a physical restraint was ordered the facility would use the least restrictive restraint for the least amount of time and provide ongoing reevaluation of the need for the physical restraint. This deficiency represents non-compliance investigated under Complaint Number 2787363.

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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. Based on medical record review, observation, and staff interview, the facility failed to ensure a medication error rate below five percent (%). The facility had 28 medication opportunities with two medication errors for an error rate of seven This affected one (Resident #39) of six residents observed for medication administration. The facility census was 109 residents.Findings include:Review of the medical record for Resident #39 revealed an admission date of 12/22/25 with diagnoses including type two diabetes mellitus, hypothyroidism, and hypertension. Review of the physician's orders for Resident #39 dated March 2025 revealed orders Synthroid 50 microgram (mcg) one table and glipizide 10 milligrams (mg) every morning. Observation of medication administration for Resident #39 on 03/05/26 at 7:52 A.M. per Registered Nurse (RN) #115 revealed Synthroid was not available in the medication cart or the emergency box for the resident. RN #115 pulled the card of glipizide for Resident #39 from the medication drawer but did not remove the dose before returning the card to the drawer. Prior to administering Resident #39's morning medication the Surveyor intervened and asked RN #115 if she had removed the glipizide from the card for the resident before returning the card to the cart. RN #115 verified she had not dispensed the dose of glipizide for Resident #39 and returned to the cart and retrieved the medication for administration to Resident #39 Interview on 03/05/26 at 8:00 A.M. with RN #115 confirmed Resident #39's Synthroid was not available for administration. RN #115 further confirmed she administered Resident #39's glipizide after the Surveyor intervened and pointed out the nurse had not removed the dose of glipizide from the drawer. Interview on 03/05/26 at 9:45 A.M. with the Director of Nursing (DON) confirmed understanding of the facility's medication error rate for the med pass completed on 03/05/26. The DON confirmed understanding that there were 28 medication opportunities with two medication omission errors (Synthroid and glipizide) for Resident #39 which gave the facility a medication error rate of seven %. This deficiency represents non-compliance investigated under Complaint Number 2737965.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, resident interview, staff interview, observation, and review of the facility policy, the facility failed to provide foods planned by the Registered Dietitian (RD) as listed on the dietary spreadsheet. This affected all of the residents in the facility who received food from the facility kitchen. The facility census was 109 residents. Findings Include: Review of the menu spreadsheets dated 02/28/26, 03/01/26 and 03/02/26 revealed residents on all types of diets should have received two ounces of scrambled eggs at breakfast. Residents on cardiac diets should receive an egg substitution product and no bacon. There was no notation on the spreadsheets of any food substitutions. Review of Temperature Guide dated 02/28/26 revealed no notation of any food substitutions. Review of Temperature Guide dated 03/01/26 revealed substitute eggs with sausage links. Review of Temperature Guide dated 03/02/26 revealed substituted toast for pancakes and waffles. There was no egg substitution listed. Interview on 03/05/26 at 8:05 A.M. with Resident #106 confirmed he had not received eggs on 02/28/26, 03/01/26 and 03/02/26. He stated he received one piece of toast and two slices of bacon and no scrambled eggs. Resident #106 stated the portion was not enough food and he wanted some type of protein. Interview on 03/05/26 at 8:30 A.M. with Resident #101 confirmed she had not received eggs on 02/28/26, 03/01/26 and 03/02/26. Resident #101 stated she received bacon and toast. Interview on 03/05/26 at 8:45 A.M. with Resident #98 confirmed he had not received eggs on 02/28/26, 03/01/26 and 03/02/26. Resident #98 stated he received bacon which he was not supposed to have because he was on a cardiac diet, and he should have received an egg substitution product on the days when eggs were on the menu. Interview on 03/05/26 at 8:30 A.M. with Certified Nursing Assistant (CNA) #216 stated he observed breakfast on 02/28/26 and 03/01/26 on the skilled unit, and the residents did not receive any eggs or egg products. CNA #216 confirmed the residents received a small portion of toast and bacon, and Resident #98 requested eggs which were not available. Interview on 03/05/26 at 8:35 A.M. with Housekeeper #35 stated the residents on the skilled unit were not served eggs or milk on 03/02/26 and Resident #98 had reported to her there was not enough food at breakfast over the weekend. Housekeeper #35 confirmed on 03/02/26 Resident #98 received two slices of toast and one piece of bacon, but there were no eggs or other protein on the breakfast tray. Interview on 03/05/26 at 9:50 A.M. with Diet Aide (DA) # 93 stated there were no eggs served on 03/02/26 for breakfast because there were no eggs in the kitchen to prepare. DA #93 confirmed staff instead served two slices of bacon to substitute for eggs. DA #93 stated only half of the facility residents received milk at breakfast on 03/02/26 because they ran out of milk in the kitchen. Interview on 03/05/26 at 10:05 A.M. with [NAME] #92 verified on 03/02/26 the kitchen substituted two slices of bacon for eggs and only half of the facility, the first two tray carts, received milk. [NAME] #92 verified eggs were to be served to all diets and stated he did not serve the meals from the spreadsheet of specialized diets and was unaware residents on cardiac diets were not to be served bacon or sausage as a substitute for the egg substitute product. [NAME] #92 stated he did not have a listing of protein substitutes and thought bacon was considered a protein substitute. Interview on 03/05/26 at 10:35 A.M. with Diet Manger (DM) # 90 verified the breakfast meals of 03/02/26 and 03/01/26 had bacon as a substitute for eggs. DM #90 stated he did not know bacon was not a protein substitute for eggs. DM #90 stated the substitutes documented on the temperature log were not recorded accurately and there was no separate substitution log for the listing of food substitutes. DM #90 verified the spreadsheet should be followed by the cooks to ensure specialized diets were provided as planned. Interview on 03/11/26 at 10:35 A.M. with [NAME] #77 verified she had assisted with preparation and service on 03/01/26, and there were no eggs to prepare for breakfast. She stated two slices of bacon were substituted for the egg portion. [NAME] #77 stated she did not know bacon was not a protein substitute for eggs and did not have a listing of appropriate substitute for eggs. She stated the spreadsheet was not used during meal service as a (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reference for specialized diets. Interview on 03/11/26 at 12:50 P.M. with RD #400 verified bacon was not a nutritionally equivalent substitution for egg protein. RD #400 stated the cooks should follow the approved spreadsheet for specialized diets to ensure residents with specialized diets receive the correct foods including residents on a cardiac diet. 2. Review of the menu spreadsheet dated 03/05/26 revealed all diets were to receive four ounces of mandarin oranges with the breakfast meal. There were no substitutions listed on the spreadsheet or the temperature sheet for mandarin oranges. Observation on 03/05/26 at the breakfast meal service at 8:00 A.M revealed there were no mandarin oranges served to all residents except for residents on pureed diets who were served applesauce. Interview on 03/05/26 at 9:10 A.M. with DA #96 verified mandarin oranges were listed to be served for all residents at breakfast on 03/05/26. DA #96 stated there were no mandarin oranges in the kitchen and there was no time to prepare another substitute. There was no food provided in place of the mandarin oranges except for the residents with pureed consistency diets who received applesauce. Interview on 03/05/26 at 9:50 A.M. with DA # 93 verified no mandarin oranges were provided to any residents on 03/05/26 at breakfast and only the residents on pureed consistency diets received a substitute. Interview on 03/05/26 at 10:35 A.M. with DM # 90 verified there were no mandarin oranges served to any resident on 03/05/26 for breakfast. There had been no food substituted except for residents on puree diet. DM #90 stated there should have been a fruit substituted for the mandarin oranges and noted on a substitution log, as the item was not available for service. Review of the facility policy titled Menu Substitutions undated revealed menu changes shall be made when a menu item is not available for service. This deficiency represents noncompliance investigated under Complaint Number 2794532 and Complaint Number 2737965

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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. Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure staff performed appropriate hand hygiene during incontinence care and wound care. This affected one (Resident #31) of 88 facility-identified residents who required incontinence care and one (Resident #12) of 18 facility-identified residents with wounds that required a dressing change. The facility census was 109 residents. Findings include: 1.Review of the medical record for Resident #31 revealed an admission date of 01/02/2024 with diagnoses including chronic obstructive pulmonary disease, dementia, aphasia, atrial fibrillation and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 01/27/26 revealed the resident was dependent on staff with personal hygiene, bathing, upper body, and lower body dressing and was incontinent of bladder and bowel. Observation of incontinence care for Resident #31 on 03/05/26 at 9:56 A.M. per Certified Nursing Assistant (CNA) #225 revealed the CNA applied gloves prior to entering the resident's room and used prepackaged wipes to provide incontinence care. CNA #225 removed Resident #31's soiled brief, cleansed the resident's peri area and applied a clean brief. CNA #225 then doffed gloves and disposed of them in the trash and donned clean gloves without performing hand hygiene. CNA #225 then applied lotion to the resident's chest and then doffed the gloves, discarded of the gloves, and donned clean gloves without performing hand hygiene. CNA #225 then assisted Resident #31 with getting dressed. Interview on 03/05/26 at 10:06 A.M. with CNA #225 confirmed he should have performed hand hygiene after doffing gloves and prior to putting on clean gloves. Interview on 03/05/26 at 10:30 A.M. with the Director of Nursing (DON) confirmed staff should at minimum change gloves after performing incontinence care for a resident. 2. Review of the medical record for Resident #12 revealed an admission date of 03/05/18 with diagnoses including senile degeneration of brain, chronic obstructive pulmonary disease, chronic bronchitis, unspecified psychosis, dementia, and hypertension. Review of the MDS assessment for Resident #12 dated 12/04/25 revealed the resident was dependent on staff for activities of daily living (ADLs) and had a stage three pressure ulcer on her coccyx. Review of the physician's orders for Resident #12 revealed an order dated 03/12/26 for the staff change the dressing ot the resident's coccyx once daily which included cleansing the wound, pat dry, apply alginate to wound bed, and cover with dry clean dressing. Observation of wound care for Resident #12 on 03/05/26 at 10:17 A.M. per Licensed Practical Nurse (LPN) #102 revealed the nurse removed the resident's brief and the old wound dressing came off. LPN #102 then sprayed the wound with water, wiped the wound bed with a clean piece of gauze, applied calcium alginate to the wound dressing, applied the dressing to the resident, applied a clean brief to the resident, and repositioned the resident. LPN #102 then doffed the gloves, washed her hands and exited the room.Interview at 10:25 A.M. with LPN #102 confirmed she did not change gloves or perform hand hygiene between at any time during the wound care and dressing change. LPN #102 confirmed she should have doffed gloves and washed hands following the wound cleaning and then donned clean gloves prior to applying the wound dressing. Interview on 03/05/26 at 10:32 A.M. with the DON confirmed the staff were expected to follow handwashing/hand hygiene guidelines when providing wound care. Review of facility policy titled Handwashing/Hand Hygiene dated October 2023 revealed hand hygiene was indicated immediately before touching a resident, before performing a clean task, after contact with bodily fluids or contaminated surfaces, and after touching a resident. Staff were to wash hands with soap and water when hands were visibly soiled and staff should perform hand hygiene after contact with a resident, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal.