

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  05/20/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, staff and resident interviews and policy review, facility failed to ensure a resident was afforded dignity during a meal when staff did not stand while providing feeding assistance. This affected one (#25) of three residents reviewed for dignity. Facility census was 104.</p> <p>Findings include:</p> <p>Review of the medical record of Resident #25 revealed an admission date of 04/20/22. Diagnoses included parkinsonism and moderate protein-calorie malnutrition.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident #25 had intact cognition. Resident #25 was dependent on staff for all activities of daily living.</p> <p>Observation on 05/14/25 at 12:38 P.M. revealed Certified Nursing Assistant (CNA) #252 delivered a lunch tray to Resident #25, who was resting in bed. CNA #252 set up Resident #25's tray and began to feed her, while standing over her.</p> <p>Observation on 05/14/25 at 12:39 P.M., Resident #25 asked CNA #252 if she was going to sit down. CNA #252 was not observed to respond or acknowledge Resident #25's question and continued to feed Resident #25 while standing. Further observation at the same time revealed there was a chair located behind CNA #252, approximately six feet away.</p> <p>Continued observation on 05/14/25 between 12:40 P.M. and 12:53 P.M. revealed CNA #252 continued to stand over Resident #25 to feed her.</p> <p>Interview on 05/14/25 at 12:54 P.M., CNA #252 verified she stood over Resident #25 during the entire time she fed her lunch.</p> <p>Interview on 05/14/25 at 1:00 P.M., Resident #25 verified she asked CNA #252 to sit down while she was feeding her.</p> <p>Review of the facility policy titled, Resident Rights Policy and Procedure, dated 2025, revealed all staff and associates must treat residents with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview, and policy review, the facility failed to notify resident responsible party/power of attorney (POA) of significant weight loss. This affected one (#37) of three residents reviewed for weight loss. The facility census was 104.</p> <p>Findings include:</p> <p>Review of the medical record of Resident #37 revealed an admission date of 09/18/20. The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]. Diagnoses included aspiration pneumonia, chronic obstructive pulmonary disease, prostate cancer, type 2 diabetes mellitus, moderate protein-calorie malnutrition, and dementia with behavioral disturbance.</p> <p>Review of the 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required set-up/clean-up assistance for eating, substantial/maximal assistance with bed mobility, and was dependent on staff for toileting, bathing, dressing, and transfers.</p> <p>Review of weights revealed, on 10/08/24, Resident #37 weighed 146.4 pounds. On 11/06/24, Resident #37 weighed 144.1 pounds. On 01/06/25, Resident #37 weighed 145.4 pounds. On 03/17/25, Resident #37 weighed 146.2 pounds. On 04/07/25, Resident #37 weighed 129.8 pounds. On 04/19/25, Resident #37 weighed 109 pounds. On 05/05/25, Resident #37 weighed 118 pounds.</p> <p>Review of the medical record revealed Resident #37's son was listed as Resident #37's medical POA.</p> <p>Review of the medical record revealed no evidence of the resident's medical POA being notified of Resident #37's weight changes on 04/07/25 (10.9% loss within 1 month), 04/19/25 (25% loss for 1 month), and 05/05/25 (9.2% loss for 1 month, 18% loss for 6 months).</p> <p>Interview on 05/14/25 at 2:49 P.M., Registered Dietitian (RD) #116 verified he had not notified Resident #37's POA of Resident #37's weight changes. RD #116 stated he last spoke with Resident #37's POA during the care conference on 03/28/25 and further verified the resident had not experienced a documented weight change at that time.</p> <p>Review of the facility policy titled, Weight Assessment and Intervention, dated 08/2022, revealed the POA would be notified of any change of 5% or more from the last weight. Severe weight loss was defined as greater than 5% for 1 month and 10% for 6 months.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview and policy review, the facility failed to ensure a resident was free from unnecessary medications by ensuring as needed psychotropic medications were limited to 14 days. This affected one (#61) of five reviewed for unnecessary medications. Facility census was 104.</p> <p>Findings include</p> <p>Review of the medical record for Resident #61 revealed an admission date of 11/01/23. Diagnoses included cerebrovascular disease, hemiplegia and hemiparesis, malnutrition, vascular dementia and unspecified psychosis.</p> <p>Review of the plan of care dated 03/19/24 revealed resident had a history of becoming aggressive and resisting care with interventions to administer medications as ordered and monitor behaviors. The care plan revealed resident used psychotropic medications related to anxiety and depression with interventions to give medications as ordered and monitor for side effects. The care plan also stated residents used antipsychotic's with interventions to consult with pharmacy, give medications as ordered and monitor symptoms.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was cognitively impaired with a Brief Interview for Mental Status (BIMS) of three out of 15.</p> <p>Review of Resident #61's physician order for 04/25/25 for Ativan oral tablet 0.5 milligrams (MG) with instructions to give one tablet by mouth every four hours as needed for anxiety/dyspnea.</p> <p>Interview on 05/15/25 at 2:00 P.M. with Director of Nursing (DON) confirmed Resident #61 had an order for Ativan PRN from 04/25/25. The DON confirmed the order should have had a stop date and should not be ordered for over 14 days.</p> <p>Review of facility policy titled Medication Management - Psychotropic dated 03/24/25, revealed GDR ' s shall be completed unless contraindicated and psychotropic medications ordered in PRN (as needed) status are limited to 14 days.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, staff interviews and record review, facility failed to ensure the activity careplan had appropriate and resident centered interventions. This affected one Resident (#49) of one reviewed for activities. Facility census was 104.</p> <p>Findings include</p> <p>Review of the medical record for Resident #49 revealed an admission date of 07/03/18. Diagnoses included senile degeneration of the brain, unspecified psychosis, anxiety, and spinal stenosis.</p> <p>Review of the activity assessment dated [DATE] revealed resident was alert and oriented with come confusion. Resident reported she was religious (Catholic) and enjoyed baking/cooking, country music, and television, movies and dogs.</p> <p>Review of the plan of care dated 03/03/23 revealed Resident #49 was at risk for alteration in activities with interventions for one on one activities.</p> <p>Review of the activity assessment dated [DATE] revealed resident had unchanged preferences and the preferences were for one to one activity participation.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively impaired with a BIMS of 00 and was rarely if ever understood.</p> <p>Review of the activity participation revealed resident was only offered three one on one visits in 04/2025 and only two visits in 05/2025 with no visits in the previous 10 days.</p> <p>Review of the calendar dated 04/2025 revealed activities ended at 1:30 P.M. for the day except four days that ended at 2:00 P.M.</p> <p>Review of the calendar dated 05/2025 revealed activities ended at 3:00 P.M. with no evening activities planned.</p> <p>Observations on 05/12/25 at 9:20 A.M. and 4:50 P.M. revealed Resident #49 was sitting in her room without any lights on, no television or music was playing and resident was laying in bed staring up at the ceiling. Resident had not been out of bed or to any activities this date.</p> <p>Observations on 05/13/25 from 10:00 A.M. and 3:00 P.M. revealed Resident #49 was sitting in her room without any lights on, no television or music was playing. Resident had not been out of bed or to any activities this date. Staff did not invite or encourage activity attendance prior to any activities this date.</p> <p>Interviews on 05/15/25 at 11:55 A.M. with Activity Coordinator #100 and Activity Aide #101 confirmed the activity care plans were not updated to reflect interests and did not include activity options for a resident with cognitive impairment and decline in health.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Activity Evaluation, dated 06/2018 revealed the activity careplan shall include resident needs and allow resident to participate in activities of their interest.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, staff interviews and policy review, the facility failed to ensure facility offered a resident activities of interest. This affected one (#49) of one resident reviewed for activities. The facility census was 104.</p> <p>Findings include</p> <p>Review of the medical record for Resident #49 revealed an admission date of 07/03/18. Diagnoses included senile degeneration of the brain, unspecified psychosis, anxiety, and spinal stenosis.</p> <p>Review of the activity assessment dated [DATE] revealed resident was alert and oriented with come confusion. Resident reported she was religious (Catholic) and enjoyed baking/cooking, country music, and television, movies and dogs.</p> <p>Review of the plan of care dated 03/03/23 revealed Resident #49 was at risk for alteration in activities with interventions for one on one activities.</p> <p>Review of the activity assessment dated [DATE] revealed resident had unchanged preferences and the preferences were for one to one activity participation.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively impaired with a BIMS of 00 and was rarely if ever understood.</p> <p>Review of the activity participation revealed resident was only offered three one on one visits in 04/2025 and only two visits in 05/2025 with no visits in the previous 10 days.</p> <p>Review of the calendar dated 04/2025 revealed activities ended at 1:30 P.M. for the day except four days that ended at 2:00 P.M.</p> <p>Review of the calendar dated 05/2025 revealed activities ended at 3:00 P.M. with no evening activities planned.</p> <p>Observations on 05/12/25 at 9:20 A.M. and 4:50 P.M. revealed Resident #49 was sitting in her room without any lights on, no television or music was playing and resident was laying in bed staring up at the ceiling. Resident had not been out of bed or to any activities this date.</p> <p>Observations on 05/13/25 from 10:00 A.M. and 3:00 P.M. revealed Resident #49 was sitting in her room without any lights on, no television or music was playing. Resident had not been out of bed or to any activities this date. Staff did not invite or encourage activity attendance prior to any activities this date.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews on 05/15/25 at 11:55 A.M. with Activity Coordinator #100 and Activity Aide #101 revealed facility shall complete activity assessments upon admission, quarterly and annually that would include residents abilities and interests. Activity Aide #101 confirmed staff will be assigned a group of residents for one on one visits and residents should be seen at least weekly four about 10 to 20 minutes. They confirmed Resident #49 only had three visits in 04/2025 and two 05/2025 with no visits in the previous 10 days. They confirmed Resident #49's previous activity assessments when resident was more alert and confirmed facility could have a television or music playing for Resident #49.</p> <p>Review of facility policy titled Activity Evaluation, dated 06/2018 revealed the activity evaluation shall be conducted to reflect interest of the residents. Resident ' s lifelong interests, spirituality, needs and preferences were to be included in the evaluation. The activity care plan shall include resident needs and allow resident to participate in activities of their interest.</p>		

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<p>F 0689</p> <p>Level of Harm - 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> 3. Review of medical record for Resident #32 revealed admission date of 11/12/24 with vascular dementia, chronic obstructive pulmonary disease, hypertension, diabetes mellitus.</p> <p>Review of the quarterly MDS dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. MDS revealed Resident #32 was dependent on staff for toileting, showering, dressing, and personal hygiene.</p> <p>Review of the care plan dated 11/13/24, revised 02/25/25, revealed Resident #32 had a potential for falls related to impaired cognition and weakness, interventions included evaluate medication regimen, fall risk assessment per protocol, hospice to supply Bariatric shower chair, keep environment clutter free, keep room well lighted, nonskid footwear at all times, perimeter mattress, and place resident on get up list.</p> <p>Observation on 05/13/25 at 8:49 A.M. of Resident #32 in her room identified she was sitting on the edge of her bed eating breakfast. Resident #32 did not have a perimeter mattress.</p> <p>Interview with CNA #208 confirmed Resident #32 ate breakfast on the side of her bed, had not been out of bed for the day, and did not have her morning cares completed.</p> <p>Observation on 05/15/25 at 10:25 A.M. of Resident #32's bed revealed a bariatric mattress on the bed, no perimeter mattress was observed on the bed or in the room.</p> <p>Interview on 05/15/25 at 10:29 A.M. with CNA #223 confirmed Resident #32's bed had a bariatric mattress and she has had it for a few months.</p> <p>2. Review of the medical record for Resident #57 revealed an admission date of 04/19/22. Diagnoses included unspecified dementia, heart disease, spinal stenosis, muscle weakness and unspecified psychosis.</p> <p>Review of the plan of care dated 05/09/22 revealed resident was at risk of falls due to decreased mobility with interventions to keep bed in lowest position and two mattresses to right side of the bed.</p> <p>Review progress notes dated 01/09/25 and 04/29/25 revealed resident had a fall from the bed.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively impaired with a BIMS of 00 and was rarely if ever understood.</p> <p>Observation on 05/13/25 at 8:52 A.M. Resident #57 was calling out saying, I want to get up, help, and I need the toilet. It was observed that Resident #57's bed was in high position and both fall mats were leaning up against residents recliner several feet from residents bed tilted up on their side. No staff were observed to be monitoring resident and no staff were present at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Continuous observation on 05/13/25 from 8:52 A.M. to 9:21 A.M. with Resident #57 revealed no staff were present and floor mats remained against the recliner.</p> <p>Interview on 05/13/25 at 9:21 A.M. with Licensed Practical Nurse (LPN) #161 confirmed Resident #57's floor mats were not against the bed as per the care plan.</p> <p>Observation and interview on 05/14/25 at 5:15 P.M. with Registered Nurse (RN) #186 revealed the floor mats should be down at all times unless staff are with Resident #57 providing care such as assisting with feeding her. RN #186 also acknowledged staff were disgruntled regarding the double floor mat and were upset about it being in place as they cannot move it easily. RN #186 acknowledged the floor mats were not in place at the time of the observation and meals had not yet been passed out. RN #186 also verified the bed was not in low or lowest position as per the care plan.</p> <p>4. Review of the medical record of Resident #75 revealed an admission date of 05/02/24. Diagnoses included cerebral atherosclerosis, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, atrial fibrillation, type 2 diabetes mellitus, anxiety, insomnia, major depressive disorder, and dementia.</p> <p>Review of the plan of care dated 05/12/25 revealed Resident #75 had a potential for falls and frequently attempted to transfer herself in and out of bed. Interventions included an air mattress with bolsters, dycem to broda chair, educate dietary staff not to move residents out of the dining room, recline broda chair after finished eating meals, encourage resident to lay down after meals, fall mats times two to the right side of the bed, increase rounding, left side of mattress against the wall, encourage to be in common area when up.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. Resident #75 was dependent on staff for all activities of daily living.</p> <p>Review of the Morse Fall Scale dated 04/28/25 revealed the resident was at high risk for falling. Further review of all Morse Fall Scale assessments dated 08/20/24 through 04/28/25 revealed the resident was at high risk for falls.</p> <p>Review of the fall investigation dated 08/19/24 revealed the resident sustained an unwitnessed fall at 12:27 P. M. The resident was found laying on the floor next to the bed. The bed was in low position and there were fall mats noted on the floor. The resident was asked if she hit her head and the resident said she did not. The resident was noted with a dark purple bruise to the right forehead. The resident denied pain. The resident was believed to have been attempting to transfer herself. The intervention was to provide a perimeter mattress. The fall investigation was silent for neurochecks being initiated.</p> <p>Review of the fall investigation dated 10/20/24 revealed the resident sustained an unwitnessed fall at 1:00 A. M. The resident was found sitting on her fall mat next to the bed. The bed was in low position. The resident was not able to say how she rolled onto the mat. The resident denied pain. No injuries were noted. The resident was believed to be attempted to transfer herself. The fall investigation did not address whether the perimeter mattress was in place at the time of the fall. The intervention was to provide a perimeter mattress. The fall investigation was silent for neurochecks being initiated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the fall investigation dated 11/01/24 revealed the resident sustained an unwitnessed fall at 12:42 P. M. The resident was found on the floor on the fall mat next to the bed. The bed was in low position. The resident denied hitting her head. The resident did not have any injuries. Neurochecks were noted to be initiated. The investigation did not indicate if the perimeter mattress was in place at the time of the fall. There were no interventions noted to be put into place following the fall.</p> <p>Review of the fall investigation dated 12/06/24 revealed the resident sustained an unwitnessed fall at 1:30 P. M. Resident #75's chair was noted tilted over The resident appeared to have tried to climb out of her geri chair and fell to the floor. The resident complained of pain to her right shoulder and the area was bruised and swollen. Neurochecks were initiated.</p> <p>Review of the fall investigation dated 01/05/25 revealed the resident sustained an unwitnessed fall at 12:00 P. M. The resident was found on the floor on the fall mat next to the bed. The bed was in low position. The resident was believed to have slid out of bed. Neurochecks were initiated. The investigation did not indicate if the perimeter mattress was in place at the time of the fall.</p> <p>Review of a progress note dated 01/05/25 at 1:00 P.M. revealed the hospice nurse visited the resident and received a new order from the hospice physician for haldol 1 milligram every four hours as needed for terminal agitation.</p> <p>Review of the fall follow-up note dated 01/07/25 revealed an intervention of hospice evaluation of medications</p> <p>Review of the fall investigation dated 01/28/25 revealed the resident sustained an unwitnessed fall at 10:15 A. M. The resident was found on the floor in front of her broda chair, which was noted in an upright position. The broda chair was sitting straight up because the resident had been eating breakfast and the resident slid from the broda chair. The resident complained of pain to the right knee and coccyx. Tylenol was administered with positive outcome. The nurse practitioner examined the resident and stated, if pain continued, to send for an x-ray. The investigation did not indicate if the dycem was in place at the time of the fall. The fall investigation was silent for neurochecks being initiated. The intervention was to educate staff to recline broda chair after meals.</p> <p>Review of the fall investigation dated 02/04/25 revealed the resident sustained an unwitnessed fall at 3:15 P. M. The resident as found on the floor at her bedside with her back against the bed. The resident was noted to be looking for her husband who had passed away years ago. The resident was believed to have been trying to get out of bed and slid to the floor onto the mat. Fall mats were noted in place and the bed was in low position. The resident did not have any injuries. Neurochecks were initiated. The intervention was for hospice to evaluate for possible medication changes for anxiety. The investigation did not indicate if the perimeter mattress was in place at the time of the fall.</p> <p>Review of physician orders revealed an order dated 02/08/25 for lorazepam (anti-anxiety medication 0.5 milligrams every 4 hours was ordered as needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the fall investigation dated 02/15/25 revealed the resident sustained an unwitnessed fall at 3:25 P. M. The resident was found on the floor, laying on her left side, between the bed and the window. The bed was in low position and fall mats were in place. The resident denied hitting her head and did not have any injuries. The resident had last been seen 25 minutes prior. The resident was unable to answer what she was doing at the time of the fall and believed to have rolled out of bed. The investigation did not indicate if the perimeter mattress was in place at the time of the fall. The fall investigation was silent for neurochecks being initiated following the fall. The intervention was to increase rounding.</p> <p>Review of progress notes dated 02/15/25 at 5:50 P.M. and 5:55 P.M. revealed a loud crash was heard in the common area and the resident was found lying on the floor on her left side. The resident had a protruding hematoma measuring 4 centimeters (cm) in length by 3 cm in width by 2 cm in depth.</p> <p>Review of the fall investigation dated 02/15/25 revealed the resident sustained an unwitnessed fall in the common area at 5:50 P.M. The resident was laying on her left side on the floor in front of her broda chair. The resident had last been seen five minutes prior in the dining room for dinner. The resident had a large skin tear noted to her left elbow/forearm and a large, raised bruised area to her left temple. The resident complained of right shoulder pain and was guarding her right arm. The resident was sent to the hospital for evaluation. The intervention was to educate dietary staff to not move the resident from the dining room. The investigation did not indicate if the dycem was in place at the time of the fall.</p> <p>Interview on 05/15/25 at 11:51 A.M. RN #185 stated she was walking toward Resident #75 while she was sitting in the common area and saw her trying to get out of the chair and saw her tip forward and the entire chair tipped forward. RN #185 stated the chair was positioned at a 45 degree angle. RN #185 stated she observed the resident hit her head and one of her arms. RN #185 stated the Resident #75 had a dycem in the wheelchair and the wheelchair was locked.</p> <p>Review of the fall investigation dated 03/10/25 revealed the resident sustained an unwitnessed fall at 4:53 P. M. The resident was found sitting at her bedside on the floor mat. The resident was last seen at 4:30 P.M. The bed was noted in low position. The resident did not have any injuries. The intervention was to place the left side of the bed against the wall. The investigation did not indicate if the perimeter mattress was in place at the time of the fall. The fall investigation was silent for neurochecks being initiated following the fall.</p> <p>Review of the medical record revealed neurochecks were completed for the fall on 12/06/24. There was no evidence of neurochecks being completed at any other time.</p> <p>Interview on 05/15/25 at 1:45 P.M., the Director of Nursing (DON) verified its facility policy to complete neurochecks post fall if the fall is unwitnessed. The DON stated the documentation indicated neurochecks were initiated following most of Resident #75's falls and that sometimes neurochecks are done on paper. The DON confirmed she was not able to locate any neurochecks following Resident #75's falls other than the neurochecks dated 12/06/24. The DON further verified fall investigations did not address whether the perimeter mattress and dycem was in place as appropriate. The DON stated she was not sure if the perimeter mattress was in place at the time of the fall on 10/20/24, however since a perimeter mattress was ordered again, she felt it may not have been in place. The DON verified the fall investigations were not thorough as they did not contain information regarding what interventions were in place at the time of Resident #75's falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Neurological Assessment, dated 10/2010, revealed neurological assessments are indicated following an unwitnessed fall and following a fall involving head trauma.</p> <p>Review of the facility policy titled, Assessing Falls and Their Causes, dated 03/2018, revealed, when a resident falls information should be included in the medical record, including the condition in which the resident was found and interventions.</p> <p>Review of the facility policy titled, Managing Falls and Fall Risk, dated 07/08/24 revealed resident-specific interventions should be documented and placed in the care plan.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164621.</p> <p>Based on medical record review, review of facility investigation, staff interviews, and review of facility policy, the facility failed to ensure staff safely transferred a resident in accordance with the care plan. This resulted in Actual Harm when Certified Nurse Aide (CNA) #250 transferred Resident #149 from the bed to wheelchair on 04/10/25 without a mechanical lift (Hoyer) as care planned and the resident subsequently sustained a fall resulting in bilateral femur fractures. Additionally, the facility failed to ensure fall interventions were in place in accordance with Resident #57 and #32's care plan, failed to ensure Resident #75's falls were thoroughly investigated and failed to implement neurological checks (neurochecks) in accordance with facility policy following Resident #75's falls, which placed the resident's at risk for more than minimal harm. This affected four (#149, #32, #57, and #75) of seven residents reviewed for accidents. The facility census was 104.</p> <p>Findings include:</p> <p>1. Review of Resident #149's closed medical record revealed an admission date of 12/01/15. Diagnoses listed included hypertension, arthritis, hypothyroidism, dementia, psychotic mood disturbance, and chronic kidney disease.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #149 was totally dependent on staff for transfers, was receiving Hospice services, and was severely cognitively impaired.</p> <p>Review of care plan initiated 12/31/24 revealed Resident #149 was at risk for falls related to weakness, pain, decreased endurance, impaired judgement, and cognitive impairment. Resident #149 had a self-care deficit related to altered cognitive status, altered mobility, pain, weakness, and sensory deficit. Resident #149 required staff assistance with activities of daily living (ADL's) and required two staff members for transfers with a Hoyer.</p> <p>Review of progress notes dated 04/10/25 at 11:30 A.M. revealed Resident #149 was on the floor on her knees. CNA #250 stated she was trying to stand and pivot Resident #149 into the wheelchair. Resident #149 was non-ambulatory and was non-weight bearing. Resident #149 was returned to bed for an assessment and complained of pain in knees and legs. Both of Resident #149's feet were feet were edematous with purple areas. New orders were obtained for stat (as soon as possible) X-radiation (X-ray) of both hips and legs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of X-ray results dated 04/10/25 revealed acute fractures of Resident #149's left and right femur. Further review of Resident #149's medical record revealed the resident's bilateral femur fractures were not aggressively treated due to the resident's condition and the resident being on Hospice care.</p> <p>Review of a Fall Investigation revealed Resident #149 obtained fractures to the left and right femur when lowered to the ground by agency CNA #250. When told to get Resident #149's roommate out of bed agency CNA #250 instead attempted to get Resident #149 out of bed and dropped her to her knees. Resident #149 obtained left and right thigh fractures.</p> <p>Interview with the Director of Nursing (DON) on 05/14/25 at 2:33 P.M. confirmed Resident #149 was improperly transferred by Agency CNA #250 on 04/10/25. The DON confirmed Resident #149 was non-weight bearing and fell during transfer by CNA #250. CNA #250 made a mistake and was supposed to get up Resident #149's roommate. The DON confirmed Resident #149 fractured both femurs as a result of the fall.</p> <p>Interview with the DON on 05/15/25 at 10:04 A.M. confirmed CNA #149 did not use a Hoyer or assistance of another staff member when attempting to transfer Resident #149 on 04/10/25.</p> <p>Review of the facility's policy titled, Safe Lifting and Movement of Residents dated July 2017 revealed in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Review of medical record for Resident # 58 revealed admission date of 02/19/2024 with end stage renal disease, diabetes mellitus type 2, dependence on renal dialysis, heart failure, and chronic obstructive pulmonary disease.</p> <p>Review of the quarterly MDS dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition.</p> <p>Review of the care plan dated 03/27/25 revealed Resident #58 had renal insufficiency related to end stage chronic kidney disease stage 3 (CKD-3). Interventions included monitoring, documenting, and reporting to physician as needed the following signs and symptoms. Edema, weight gain of over two pounds a day, neck vein distension, difficulty breathing (dyspnea), increased heart rate (tachycardia), elevated blood pressure (hypertension), skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles.</p> <p>Review of the physician's orders revealed an order for daily weights one time a day for congestive heart failure (CHF) starting 02/27/24.</p> <p>Record review of the February, March, April, and May Medication Administration Record (MAR) revealed daily weights were scheduled for 5:00 A.M. Further review of the MAR for February, March, April, and May revealed weights were not obtained as ordered on 02/01/25, 02/05/25, 02/07/25, 02/12/25, 02/21/25, 02/22/25, 02/28/25, 03/01/25, 03/04/25, 03/05/25, 03/09/25, 03/10/25, 03/11/25, 03/15/25, 03/16/25, 03/17/25, 03/19/25, 03/24/25, 03/26/25, 03/31/25, 04/07/25, 04/09/25, 04/12/25, 04/13/25, 04/14/25, 04/20/25, 04/26/25, 04/28/25, 04/30/25, 05/03/25, and 05/04/25.</p> <p>Interview on 05/15/25 at 2:20 P.M. with the Director of Nursing verified daily weights were not obtained as ordered on 02/01/25, 02/05/25, 02/07/25, 02/12/25, 02/21/25, 02/22/25, 02/28/25, 03/01/25, 03/04/25, 03/05/25, 03/09/25, 03/10/25, 03/11/25, 03/15/25, 03/16/25, 03/17/25, 03/19/25, 03/24/25, 03/26/25, 03/31/25, 04/07/25, 04/09/25, 04/12/25, 04/13/25, 04/14/25, 04/20/25, 04/26/25, 04/28/25, 04/30/25, 05/03/25, and 05/04/25.</p> <p>Review of the facility policy titled Weight Assessment and Intervention dated 08/2022 revealed residents are weighed upon admission and at intervals established by the interdisciplinary team and weights are recorded in the individual's medical record.</p> <p>Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure weights were obtained in accordance with physician orders or the facility policy. This affected two (#25 and #58) of five residents reviewed for nutrition. The facility census was 104.</p> <p>Findings include:</p> <p>1. Review of the medical record of Resident #25 revealed an admission date of 04/20/22. Diagnoses included parkinsonism and moderate protein-calorie malnutrition.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for all activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed, on 11/07/24, Resident #25 weighed 128.2 pounds. On 12/07/25, Resident #25 weighed 128.3 pounds. On 01/07/25, Resident #25 weighed 135.6 pounds. On 03/07/25, Resident #25 weighed 135.7 pounds. On 04/07/25, Resident #25 weighed 130.6 pounds. On 05/05/25, Resident #25 weighed 116 pounds. There were no additional weights recorded after 05/05/25.</p> <p>Review of the medical record revealed no evidence of the dietitian acknowledging Resident #25's weight change.</p> <p>Interview on 05/12/25 at 9:50 A.M., Resident #25 stated the last time she had been weighed, the scale was beeping and she was told she had lost weight. Resident #25 stated she wanted to be reweighed, however she had not yet been weighed again.</p> <p>Interview on 05/14/25 at 11:03 A.M., Resident #25 stated she had not been reweighed since being weighed on 05/05/25 and nobody had offered to weigh her.</p> <p>Interview on 05/14/25 at 2:55 P.M., Registered Dietitian (RD) #116 stated he was aware of the 14 pound weight change (11.4% loss) between 04/07/25 and 05/05/25 and had requested for the resident to be reweighed during the prior week, however it had not yet been completed. RD #116 stated his expectation is for a reweight to be completed within 48 hours of his request and verified the reweight had not been completed in a timely manner.</p> <p>Review of the facility policy titled, Weight Assessment and Intervention, dated 08/2022, revealed any weight change of 5% or more since the last weight assessment should be evaluated the the dietitian. The dietitian will notify the nursing staff to obtain a reweight for confirmation.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff and resident interviews, and policy review, the facility failed to ensure medications were administered as physician ordered. This affected two (#91 and #58) of 12 residents reviewed for medication administration. The facility census was 104.</p> <p>Findings include:</p> <p>1. Review of medical record for Resident # 58 revealed admission date of 02/19/2024 with end stage renal disease, diabetes mellitus type 2, dependence on renal dialysis, heart failure, and chronic obstructive pulmonary disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition.</p> <p>Review of the physician orders revealed an order for Renvela (chronic kidney disease with dialysis) 800 milligrams (mg) once daily with a start date of 11/30/24.</p> <p>Record review of the January, February, March, April, and May Medication Administration Record (MAR) revealed Renvela was scheduled for administration at rising.</p> <p>Further review of the MAR for January, February, March, April, and May revealed Renvela was not administered as ordered on 01/10/25, 01/11/25, 01/13/25, 01/14/25, 01/15/25, 01/24/25, 01/25/25, 01/26/25, 01/27/25, 01/29/25, 02/01/25, 02/03/25, 02/05/25, 02/06/25, 02/07/25, 02/10/25, 02/12/25, 02/13/25, 02/14/25, 02/15/25, 02/17/25, 02/19/25, 02/23/25, 02/24/25, 02/27/25, 03/01/25, 03/2/25, 03/03/25, 03/04/25, 03/05/25, 03/08/25, 03/09/25, 03/13/25, 03/14/25, 03/17/25, 03/20/25, 03/23/25, 03/24/25, 03/26/25, 03/27/25, 03/31/25, 04/01/25, 04/03/25, 04/06/25, 04/09/25, 04/30/25, 05/03/25, 05/04/25, 05/06/25, 05/08/25, 05/13/25.</p> <p>Further record review of progress notes revealed Renvela was not available from the pharmacy for administration on the above dates.</p> <p>Interview on 05/15/25 at 2:15 P. M. with the Director of Nursing verified Renvela was not administered as prescribed on 01/10/25, 01/11/25, 01/13/25, 01/14/25, 01/15/25, 01/24/25, 01/25/25, 01/26/25, 01/27/25, 01/29/25, 02/01/25, 02/03/25, 02/05/25, 02/06/25, 02/07/25, 02/10/25, 02/12/25, 02/13/25, 02/14/25, 02/15/25, 02/17/25, 02/19/25, 02/23/25, 02/24/25, 02/27/25, 03/01/25, 03/2/25, 03/03/25, 03/04/25, 03/05/25, 03/08/25, 03/09/25, 03/13/25, 03/14/25, 03/17/25, 03/20/25, 03/23/25, 03/24/25, 03/26/25, 03/27/25, 03/31/25, 04/01/25, 04/03/25, 04/06/25, 04/09/25, 04/30/25, 05/03/25, 05/04/25, 05/06/25, 05/08/25, 05/13/25.</p> <p>Review of the facility policy titled Administering Medications dated 08/2024 revealed medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>2. Review of the medical record for Resident #91 revealed an admission date of 03/25/25 with diagnoses of unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medicare-5 Day MDS dated [DATE] revealed resident had moderate cognitive impairment.</p> <p>Review of the Care Plan, dated 04/15/25 revealed resident is at risk for altered Cardiovascular, has Seizure Disorder/Narcolepsy, uses antidepressant medications related to anxiety depression, and mood disorder, and is at risk for negative mood / behavior related to diagnosis of major depressive disorder. Interventions include administer medications as ordered.</p> <p>Review of the Medication Administration Record (MAR) dated 05/01/25 through 05/31/25 revealed the following medications were not administered on 05/07/25 Metoprolol Tartrate Oral Tablet 25 MG 0.5 tablet with the Code #16, see nurse note.</p> <p>The following medications were not administered on 05/08/25 Pramipexole Dihydrochloride Oral Tablet 1.5 MG 2 tablets and Doxepin HCl Oral Capsule 10 MG 1 capsule with the code #16, see nurse notes. The following medications were not administered on 05/10/25 Citalopram Hydrobromide Oral Tablet 20 MG 1 tablet, Pramipexole Dihydrochloride Oral Tablet 1.5 MG 2 tablets, Metoprolol Tartrate Oral Tablet 25 MG 0.5 tablet, Divalproex Sodium Oral Tablet Delayed Release 250 MG 1 tablet, Atorvastatin Calcium Oral Tablet 40 MG 1 tablet, Doxepin HCl Oral Capsule 10 MG 1 capsule, Apixaban Oral Tablet 5 MG 1 tablet with the code #16, see nurse notes.</p> <p>Review of the nurse's notes revealed on 05/07/25 at 8:44 P.M. Metoprolol Tartrate Oral Tablet 25 MG 0.5 tablet for hypertension was not administered due to await arrival from pharmacy.</p> <p>Review of the nurse's notes revealed on 05/08/25 at 10:08 P.M. Doxepin HCl Oral Capsule 10 MG 1 capsule for depression was not administered due to on order, not available.</p> <p>Review of the nurse's notes revealed on 05/08/25 at 10:09 P.M. Pramipexole Dihydrochloride Oral Tablet 1.5 MG 2 tablets for restless legs syndrome was not administered due to on order, not available.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:52 A.M. Apixaban Oral Tablet 5 MG 1 tablet for cardiovascular accident was not administered due to on order.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:52 A.M. Doxepin HCl Oral Capsule 10 MG 1 capsule for depression was not administered due to on order.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:53 A.M. Atorvastatin Calcium Oral Tablet 40 MG 1 tablet for hyperlipidemia was not administered due to on order.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:53 A.M. Divalproex Sodium Oral Tablet Delayed Release 250 MG 1 tablet for narcolepsy was not administered due to on order.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:54 A.M. Metoprolol Tartrate Oral Tablet 25 MG 0.5 tablet for hypertension was not administered due to on order.</p> <p>Review of the nurse's notes revealed on 05/10/25 at 1:55 A.M. Pramipexole Dihydrochloride Oral Tablet 1.5 MG 2 tablets for restless legs syndrome was not administered due to on order.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's notes revealed on 05/10/25 at 8:25 A.M. Citalopram Hydrobromide Oral Tablet 20 MG 1 tablet for depression was not administered due to awaiting pharmacy.</p> <p>Interview with Resident #91 on 05/12/25 at 11:02 A.M. confirmed she did not receive her medications over the weekend, specifically on night shift as ordered.</p> <p>Interview on 05/15/25 at 2:48 P.M. with the Director of Nursing confirmed Resident #91 did not received her medications on 05/07/25 at 8:44 P.M., 05/08/25 at 10:08 P.M., 05/08/25 at 10:09 P.M., 05/10/25 at 1:52 A.M., 05/10/25 at 1:53 A.M., 05/10/25 at 1:54 A.M., 05/10/25 at 1:55 A.M., and 05/10/25 at 8:25 A.M. due to not receiving from the pharmacy.</p> <p>Review of the Administering Medications policy, dated 08/2024 revealed it is the policy of the facility to administer medications in a timely and safe manner as prescribed.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of arbitration agreements and staff resident interviews, the facility failed to ensure a resident was capable of understanding an arbitration agreement before signing. This affected one (#90) of three residents reviewed for arbitration agreements. The facility census was 104.</p> <p>Findings include:</p> <p>Review of Resident #90's medical record revealed an admission date of 04/16/25. Diagnoses listed included emphysema, hypertension, malnutrition, and peripheral vascular disease.</p> <p>Review of an admission Minimum Data Set (MDS) dated [DATE] revealed Resident #90 had moderately impaired cognition.</p> <p>Review of progress noted dated 04/16/25 at 7:35 P.M. revealed Resident #90 was alert to self with some confusion.</p> <p>Review of a daily skilled summary dated 04/17/25 at 3:45 A.M. revealed Resident #90 was alert with both long term and short term memory deficits. Resident #90 could probably make limited decision that require simple understanding.</p> <p>Review of a form titled, RESIDENT AND FACILITY ARBITRATION AGREEMENT contained in the admission agreement revealed the parties understand by entering into this agreement, the parties are giving up there constitutional right to have any claim decided in a court before a judge and jury, as well as any appeal from decision or award of damages. Further review review Resident #90 signed the agreement on 04/22/25. A facility representative had not signed the arbitration agreement. Spaces for date and resident name at the top of the form were left blank.</p> <p>During an interview on 05/15/25 at 2:46 P.M. Resident #90 was unable to state the current month or year, how long he had been at the facility, or the name of the facility. Resident #90 was unable to explain what an arbitration agreement was and did not remember signing one at the facility.</p> <p>Interview with Regional Director of Clinical Operations (RDCO) #251 on 05/15/25 at 3:03 P.M. confirmed Resident #90 had impaired cognitional and had signed an arbitration agreement. RDCO #251 stated residents should be capable of understanding arbitration agreements before signing the document.</p>		

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  05/20/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, staff review, and policy review, the facility failed to ensure an implement their water management policy to prevent the presence of microorganisms in their water system including legionella. This had the potential to affect all 104 residents residing in the facility. Additionally, the facility failed to ensure staff handled food in an appropriate manner while assisting a resident with a meal. This affected one (#25) out of three residents reviewed for infection control. The facility census was 104.</p> <p>Findings include:</p> <p>Review of the facility's Chlorine Check off Sheet for TCU (transitional care unit) for 01/12/24 through 04/17/25 revealed water flow rate had not been tested since 10/31/24 and hot water temperatures ranged 106-117 degrees Fahrenheit.</p> <p>Review of the facility's Chlorine Check off Sheet for the Care Center for 01/12/24 through 05/15/25 revealed water flow rate had not been tested since 10/31/24 and hot water temperatures ranged 102-120 degrees Fahrenheit.</p> <p>Review of the facility's Chlorine Check off Sheet for the basement for 01/04/24 through 03/31/25 revealed the water flow rate had not been tested since 09/30/24 and hot water temperatures ranged 112-120 degrees Fahrenheit.</p> <p>Interview on 05/15/25 at 12:35 P.M., Maintenance Director (MD) #153 verified the water flow rate had not been checked since 09/30/24 in the basement and 10/31/24 in TCU and the Care Center. MD #152 stated water flow rate should be checked quarterly per the facility policy. MD #153 verified none of the temperatures contained in all three of the Chlorine Check off Sheets were above 122 degrees Fahrenheit. MD #153 stated the water temperatures in resident areas was not to exceed 120 degrees Fahrenheit and was not sure how she could achieve a temperature greater than 122 degrees Fahrenheit. MD #153 verified the facility policy indicated water temperatures needed to be greater than 122 degrees Fahrenheit to prevent the growth of legionella.</p> <p>Review of the facility policy titled, Environmental Control Measures Guidelines, dated 08/03/21, revealed water flow rate should be checked at least quarterly at the change of seasons. Further review revealed water temperatures in the range of 68-122 degrees Fahrenheit encouraged the growth of legionella and other pathogens.</p> <p>2. Observation on 05/14/25 at 12:37 P.M., revealed Resident #25 was served a hamburger on a bun, cut in half prior to the tray being delivered, mashed potatoes, broccoli, pudding, and watermelon.</p> <p>Observation on 05/14/25 at 12:39 P.M. Certified Nursing Assistant (CNA) #252 removed the bun from the hamburger per Resident #25's request, and picked up the hamburger patty with her bare hand and handed the hamburger patty to the resident.</p> <p>Interview on 05/14/25 at 12:54 P.M., CNA #252 verified she handled the hamburger patty with her bare hand when handing it to Resident #25.</p>		

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  05/20/2025
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations, resident and staff interviews and policy review, the facility failed have an effective pest control program. This affected six (#9, #29, #30, #55, #60, and #81) out of six residents reviewed for effective pest control. The facility census was 104.</p> <p>Findings include:</p> <p>Interview on 05/13/25 at 7:37 A.M. revealed Resident #29 has had ants in the room. Ants had been on eyeglasses and on the bed. Resident #29 reported telling staff about the ant concern. Resident #29 had called the Administrator and left a message about ants.</p> <p>Observation of Resident #29's room during the interview on 05/13/25 at 7:37 A.M. revealed ants on the floor and on the bedside table.</p> <p>Interview with Certified Nurse Aide (CNA) #241 confirmed she had seen ants in Resident #29's room.</p> <p>During an interview on 05/13/25 at 7:50 A.M. the Administrator confirmed ants in Resident #29's room. The Administrator denied receiving a call from Resident #29. A local pest control company will be called to control the ants.</p> <p>Observation of Resident #9's room on 05/13/25 at 7:51 A.M. revealed ants crawling on the floor by an exterior wall.</p> <p>Observation of Resident #30's room on 05/13/25 at 7:58 A.M. revealed ants crawling on the floor by an exterior wall.</p> <p>Observation and interview with Maintenance Director #153 on 05/13/25 at 8:02 A.M. confirmed ants in Resident #9 and #30's rooms. Ants had been a concern due to recent wet weather.</p> <p>Interview with Resident #60 on 05/13/25 at 8:04 A.M. revealed ants have ben terrible. Resident #55 had been present for about two weeks. Resident #60 has had ants in his facial tissue box and on his wheelchair. Observation at the time of interview on 05/13/25 at 8:04 A.M. revealed ants on Resident #60's bedside table and multiple ant traps in the room on the floor and a window seal.</p> <p>Observation of Resident #81's room on 05/13/25 at 8:23 A.M. revealed ants crawling on the floor.</p> <p>Observation of Resident #55's room on 05/13/25 at 08:26 A.M. revealed ants crawling underneath the bed and on the bedside table.</p> <p>Review of the facility's policy titled, Pest Control dated revised may 2008 revealed the facility shall maintain an effective pest control program. The facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.</p>		