

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Aventura at Shiloh Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Shiloh Springs Road Trotwood, OH 45426	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on record review, resident and staff interviews, review of the facility's self-reported incident (SRI) and investigation, and policy review, the facility failed to prevent resident-to-resident physical abuse when a resident struck another resident with a cane, and a third resident came up behind the resident and struck the same resident. This affected one (Resident #19) of three residents reviewed for abuse. The facility census was 51.</p> <p>Findings include:</p> <p>Review of the facility's SRI dated 07/09/24 revealed Resident #19 reported an allegation of physical abuse by two other residents to Licensed Practical Nurse (LPN) #287. Resident #19 reported that Resident #41 struck him across the face while outside in the courtyard and Resident #52 used his hand to hit the back of his head. No injuries noted at time of incident.</p> <p>Review of the investigative notes dated 07/09/24 revealed Resident #41 and #52 denied the allegations. On 07/10/24, Resident #52 confirmed he came up behind Resident #19, swung, hitting him in the face.</p> <p>Review of the addendum to the SRI dated 07/17/24 revealed on 07/16/24, Resident #41 and #52 appeared in the Municipal Court of [NAME] County and the case was set for pretrial. During the course of the investigation conducted by the Parole Officer on 07/17/24, Resident #41 was interviewed and admitted that, in response to Resident #19 pulling on his Hoyer pad, he hit Resident #19 in the face with a cane. When asked why Resident #41 had not disclosed this fact during prior interviews, he said he was done with the matter.</p> <p>1. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including combined systolic (congestive) and diastolic (congestive) heart failure, type II diabetes mellitus with hyperglycemia, and acquired absence of left leg above knee.</p> <p>Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had moderate cognitive impairment, required supervision with wheelchair mobility, required substantial staff assistance for bed mobility, and was dependent on staff assistance for toileting hygiene, bathing, dressing, and transfers.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366302
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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>Review of the care plan dated 06/24/24 revealed Resident #19 had behavior problems, was disruptive to others, resisted care, verbally abusive, wandering. was drug seeking, wandering and was disruptive to other resident's activities of daily living.</p> <p>Review of Resident #19's progress notes revealed on 07/10/24 at 1:15 P.M., the resident was sent to the hospital with complaints of seeing black dots after previous head trauma. Resident #19 returned back to the facility the same with no new diagnosis.</p> <p>Interview on 08/02/24 at 9:58 A.M. with Resident #19 confirmed Resident #41 hit Resident #19 across the face with a metal cane and Resident #52 hit Resident #19 in the head from behind.</p> <p>2. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including major depressive disorder and behavioral and emotional disorders with onset usually occurring in childhood and adolescence.</p> <p>Review of the Discharge Return Anticipated MDS assessment dated [DATE] revealed Resident #41 was independent with decision making skills, was independent with wheelchair mobility, and was dependent on staff assistance with toileting hygiene, bathing, dressing, personal hygiene, bed mobility, and transfers.</p> <p>Review of the care plan dated 06/07/24 revealed Resident #41 had behavior problems, was socially inappropriate, verbally abusive, combative, swung at others, and trying to hit staff. Interventions included psych services, provide calm reassurance, redirection or distractions and assess effectiveness. Provide positive reinforcement for appropriate behavior. Confront gently and respectfully when behavior is inappropriate.</p> <p>Review of Resident #41's progress note dated 07/10/24 at 1:10 A.M. revealed a head-to-toe assessment was completed and there were no negative clinical or psychosocial effects. Resident #41 was sent to the hospital with a pink slip.</p> <p>Interview on 08/02/24 at 10:20 A.M. with Resident #41 confirmed he hit Resident #19 across the face with a cane.</p> <p>3. Review of the medical record for Resident #52 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses of multiple sclerosis and depression.</p> <p>Review of the Discharge Return Not Anticipated MDS assessment dated [DATE] revealed Resident #52 was independent with daily decision making, was independent with wheelchair mobility, and required supervision with bathing, toileting hygiene, dressing, bed mobility, transfers, and ambulating 50 feet.</p> <p>Review of the care plan dated 02/21/24 revealed Resident #52 had behavior problems of wandering and had abusive language towards staff. Interventions included the resident's behavior will not cause harm to self or others, provide calm reassurance, redirection or distractions and assess effectiveness. Provide positive reinforcement for appropriate behavior. Confront gently and respectfully when behavior is inappropriate and set limits.</p> <p>(continued on next page)</p>		

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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>Review of the progress note dated 07/10/24 at 1:12 A.M. revealed Resident #52 was in an alleged altercation with another resident, head-to-toe assessment completed, no visible signs or symptoms of injuries noted, and no negative clinical or psychosocial effects. Resident #52 was sent to the hospital with a pink slip, and Resident #52 remained supervised by staff, medics arrived at 12:40 A.M., and the resident left facility at 12:50 A.M.</p> <p>Interview on 08/02/24 at 1:53 P.M. with the Director of Nursing (DON) confirmed Resident #41 hit Resident #19 across the face with a metal cane. The DON confirmed Resident #52 hit Resident #19 in the head from behind.</p> <p>Review of the policy titled The Elder Justice Act and Reporting Suspected Crimes Against Residents, dated 08/2022, revealed it was the purpose to facilitate efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation and to protect elders with diminished capacity while maximizing their autonomy and their right to be free of abuse, neglect, and exploitation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155727.</p>