STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366302	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Shiloh Springs	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, medical record review, resident and staff interview, and facility policy review, the facility failed to maintain and clean and sanitary environment. This affected two (#13 and #34) of six resident's rooms observed for environmental cleanliness. The facility census was 59. Findings Included: 1. Review of the medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included chronic diastolic heart failure, cognitive communication deficit, atrial flutter, and hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was assessed with severely impaired cognition. Observation on 01/22/25 at 11:01 A.M. of Resident #34's room revealed the floor to the left side of the bed had 25 circular brownish-black marks approximately two to three inches in diameter scattered on the floor. The floor was also noted to be dirty and stained, and the wall edges in the room were covered with black, hard dirt from approximately two to three inches from the wall into the room. Interview on 01/22/25 at 11:05 A.M. with Housekeeping Aide (HA) #236 confirmed Resident #34's floor was stained, had circular brownish-black marks, and there was hard, black dirt around the wall base approximately two to three inches from the wall into the room. HA #236 confirmed it was hard to get the substance up with a regular mop, and it was possible there was old floor wax present. Interview on 01/22/25 at 11:20 A.M. with Resident #34 verified his floor was dirty and stained. 2. Review of the medical record revealed Resident #13 had an admitted [DATE]. Diagnoses included type two diabetes, alcohol dependence, bipolar disorder, major depressive disorder, acute kidney failure, and hypertension. Review of the admission MDS assessment dated [DATE] revealed Resident #13 was assessed as cognitively intact. was cognitively intact. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/21/25 at 12:00 P.M. with Housekeeping Director (HD) #300 confirmed Resident #13's floor was very dirty, all the wall edges had black, hard dirt around them, there was dirt scattered on floor in the room, and there were large circular wear patterns which were approximately two to three feet in diameter on the floor. HD #300 also confirmed Resident #13's bathroom sink was dripping underneath on to brown paper towels soaking up the water. The dripping was observed to be one drip at a time and was continuous. Review of the facility policy titled, Quality of Life-Homelike Environment, dated 05/2017, revealed residents are provided with a safe, clean, comfortable, and homelike environment, and encourage to use their personal belongings to the extent possible. This deficiency represents non-compliance investigated under Complaint Number OH00161139.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to provide timely care and services when answering call lights. This affected one (#29) of three residents reviewed for call light response. The facility census was 59. Findings Included: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included bipolar disorder, type two diabetes, morbid obesity, anxiety, and major depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was assessed with intact cognition, required partial to moderate assistance with bathing, toileting hygiene, personal hygiene, dressing the lower body, placing shoes on and off the feet, and required a walker to ambulate. Review of a plan of care dated 12/31/24 revealed Resident #29 was at risk for impaired activities of daily living (ADLs) related to requiring assistance to perform and complete ADLs, weakness, asthma, diabetes, and respiratory failure. Interventions included to assist with toileting needs, provide set up and clean up assistance with personal hygiene, observe the resident's ability and performance, offer and honor the resident's choices, and provide positive feedback and encouragement. Observation on 01/22/25 at 8:35 A.M. revealed Resident #29's call light was activated. Continued observation revealed Certified Nurse Aide (CNA) #278 answered the resident's call light at 8:55 A.M. Interview on 01/22/25 at 8:57 A.M. with CNA #278 verified she just answered Resident #29's call light. CNA #278 stated the reason for the delay in answering the call light was because the illuminated call light could not be seen behind the opened fire door on the hall. CNA #278 stated the fire door was unlatched for a while. Observation on 01/22/25 at 8:59 A.M. of the fire door near Resident #29's room revealed the door to the right of the hall obscured the view of Resident #29's call light. Interview on 01/22/25 at 9:55 A.M. with Resident #29 verified he was in the bathroom earlier that morning when he activated his call light because he needed assistance. Resident #29 stated it took the staff a long period of time to come assist him. Interview on 01/22/25 at 3:00 P.M. with the Director of Nursing (DON) stated staff should answer call lights within 15 minutes. Interview on 01/22/25 at 3:05 P.M. with Regional Administrator #284 stated he did not know the fire door near Resident #29's room was broken and unable to attached to the magnetic hold open device on the wall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Answering the Call Light, dated 08/02/24, revealed when answering from the call light station staff should turn off the signal light. If the resident needs assistance, indicate the appropriate time it will take to respond. If assistance was needed when staff enter the room, the staff should summon help by using the call signal. This deficiency represents non-compliance investigated under Complaint Number OH00161139.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, resident and staff interview, and medical record review, the facility failed to provide timely pain medication as ordered to effectively treat pain. This affected one (#3) of three residents reviewed for pain management. This facility census was 59. Findings Included: Review of the medical record for Resident #3 revealed a most recent admitted [DATE]. Diagnoses included cellulitis of the right lower limb, acute kidney failure, major depressive disorder, and hypertension. Review of the Minimum Data Set (MDS) assessment MDS dated [DATE] revealed Resident #3 was assessed with moderately impaired cognition. Review of a physician order dated 01/10/25 revealed Resident #3 had an order for the narcotic pain medication oxycodone immediate release (IR) five (5) milligrams (mg) to take one tablet by mouth every eight hours as needed for pain. Review of Resident #3's plan of care dated 01/11/25 revealed the resident received pain medication, received therapy, and had neuropathy. Interventions included to administer medications, ask physician to review medication if side effects persist, monitor respiratory rate, monitor for altered mental status, observe any adverse reactions and notify physician, and review for pain medication efficacy. Observation on 01/22/25 at 9:30 A.M. with Licensed Practical Nurse (LPN) #292 revealed Resident #3 asked the nurse for his oxycodone IR 5 mg. LPN #292 responded to Resident #3 she would have to contact the pharmacy to see where the medication was in delivery. Observation on 01/22/25 at 3:20 P.M. revealed Resident #3 was lying in bed and watching television with no distress noted. Interview on 01/22/25 at 3:22 P.M. with Resident #3 stated his pain level was a seven (7) on a 10-point pain scale, with 10 being the highest pain, and also stated he had not had his oxycodone IR 5 mg for two days. Observation and interview on 01/22/25 at 3:25 P.M. with LPN #292 verified Resident #3's oxycodone IR 5 mg was not in her medication cart. LPN #292 verified the medication room had the oxycodone IR 5 mg to pull, but stated she did not have a key to open the medication room narcotic locked cart for emergency drug kit. Observation and interview on 01/22/25 at 3:35 P.M. with the Director of Nursing (DON) revealed she opened the narcotic emergency drug kit to see oxycodone IR 5 mg was in the emergency supply. Further observation once the supply was unlocked revealed there were 12 pills available. The DON stated she was going to have the pain medication delivered to Resident #3 for pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 3:54 P.M. with LPN #228 confirmed LPN #292 should have pulled the oxycodone IR 5 mg from the emergency medication supply that morning if Resident #3 asked for the pain medication. LPN #228 stated she just received an authorization to pull the oxycodone IR 5 mg today at 3:51 P.M. Interview on 01/22/25 at 5:00 P.M. with the DON stated LPN #404 administered Resident #3's oxycodone IR 5 mg from the emergency medication supply. This deficiency represents non-compliance investigated under Complaint Number OH00161139.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, resident and staff interview, and medical record review, the facility failed to ensure blood glucose levels were adequately monitored as ordered to determine the need for sliding scale insulin. This affected one (#13) of three residents reviewed for insulin usage. The facility census was 59. Findings Included: Review of the medical record revealed Resident #13 had an admitted [DATE]. Diagnoses included type two diabetes, alcohol dependence, bipolar disorder, major depressive disorder, acute kidney failure, and hypertension. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was assessed as cognitively intact. Review of a plan of care dated 11/06/24 revealed Resident #13 had the potential for hypoglycemia or hyperglycemia related to diabetes. Interventions included to obtain blood glucose checks per physician order and as needed, administer medication as ordered, educate resident regarding signs and symptoms of hyperglycemia or hypoglycemia, and observe for and report signs and symptoms of hyperglycemia or hypoglycemia. Review of a physician order dated 11/20/24 revealed Resident #13 had a FreeStyle Libre 2 Sensor (a continuous glucose monitoring device worn on the skin) applied subcutaneously and to be changed every 14 days. Review of a physician order dated 01/14/25 revealed Resident #13 was ordered Humalog insulin 100 unit per milliliter (insulin lispro) with instructions to inject per sliding scale as follows: if the blood glucose level was between 200 milligrams per deciliter (mg/dL) and 250 mg/dL, give two units of insulin; if the blood glucose level was between 251 mg/dL and 300 mg/dL, give four units of insulin; if the blood glucose level was between 301 mg/dL and 350 mg/dL, give six units of insulin; if the blood glucose level was between 351 mg/dL and 400 mg/dL, give eight units of insulin; and if the blood glucose level was between 401 mg/dL and 450 mg/dL, give 10 units of insulin subcutaneously three times a day in the morning, evening, and night for type two diabetes. Further review of the order revealed to notify the physician for a blood glucose level over 451 mg/dL and hold the insulin if the blood glucose level was below 70 mg/dL. Review of Resident #13's January 2025 medication administration record (MAR) revealed Resident #13 was documented as refusing Humalog sliding scale insulin on 01/20/25 for the morning, afternoon, and evening doses with no documented evidence of blood glucose levels being obtained. Further review of the January 2025 MAR revealed on 01/21/25, it was documented the resident refused the morning and afternoon doses of sliding scale Humalog insulin with no evidence the resident's blood glucose level was checked. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/21/25 at 3:51 P.M. with Licensed Practical Nurse (LPN) #292 stated she poked her head into Resident #13's room that day and he refused his medication. LPN #292 stated she had not seen any blood glucose levels for Resident #13 and stated she did not know where the resident's FreeStyle Libre diabetic monitoring device was located on Resident #13's skin. LPN #292 stated she did not ask Resident #13 what his blood glucose level was for the afternoon to see if the resident needed sliding scale insulin. LPN #292 verified she documented Resident #13 refused even though she never asked for the resident's blood glucose level that afternoon. Observation and interview on 01/21/25 at 4:15 P.M. with Resident #13 stated LPN #292 never visited him on 01/21/25 for his sliding scale insulin or to check his blood glucose level. At that time, Resident #13's FreeStyle Libre monitor was noted on his abdomen with a blood glucose reading of 279 mg/dL. Interview on 01/21/25 at 4:35 P.M. with LPN #292 verified she did not know were Resident #13's FreeStyle Libre blood glucose monitor was located on the resident. LPN #292 verified she did not check the resident's blood glucose level or ask the resident what his blood glucose level was for the last two days to determine if the resident required sliding scale insulin. LPN #292 verified on the January 2025 MAR for 01/21/25 she documented the resident refused in the afternoon but the resident did not refuse. Interview on 01/22/25 at 4:30 P.M. with the Director of Nursing (DON) stated she was unaware staff were not checking Resident #13's blood glucose level as ordered, and verified it was not an acceptable practice of the facility. This deficiency represents non-compliance investigated under Complaint Number OH00161139.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, resident and staff interview, and medical record review, the facility failed to ensure medication administration records were accurately documented to reflect blood glucose monitoring. This affected one (#13) of three residents reviewed for insulin usage. The facility census was 59. Findings Included: Review of the medical record revealed Resident #13 had an admitted [DATE]. Diagnoses included type two diabetes, alcohol dependence, bipolar disorder, major depressive disorder, acute kidney failure, and hypertension. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was assessed as cognitively intact. Review of a plan of care dated 11/06/24 revealed Resident #13 had the potential for hypoglycemia or hyperglycemia related to diabetes. Interventions included to obtain blood glucose checks per physician order and as needed, administer medication as ordered, educate resident regarding signs and symptoms of hyperglycemia or hypoglycemia, and observe for and report signs and symptoms of hyperglycemia or hypoglycemia. Review of a physician order dated 11/20/24 revealed Resident #13 had a FreeStyle Libre 2 Sensor (a continuous glucose monitoring device worn on the skin) applied subcutaneously and to be changed every 14 days. Review of a physician order dated 01/14/25 revealed Resident #13 was ordered Humalog insulin 100 unit per milliliter (insulin lispro) with instructions to inject per sliding scale as follows: if the blood glucose level was between 200 milligrams per deciliter (mg/dL) and 250 mg/dL, give two units of insulin; if the blood glucose level was between 251 mg/dL and 300 mg/dL, give four units of insulin; if the blood glucose level was between 301 mg/dL and 350 mg/dL, give six units of insulin; if the blood glucose level was between 351 mg/dL and 400 mg/dL, give eight units of insulin; and if the blood glucose level was between 401 mg/dL and 450 mg/dL, give 10 units of insulin subcutaneously three times a day in the morning, evening, and night for type two diabetes. Further review of the order revealed to notify the physician for a blood glucose level over 451 mg/dL and hold the insulin if the blood glucose level was below 70 mg/dL. Review of Resident #13's January 2025 medication administration record (MAR) revealed Resident #13 was documented as refusing Humalog sliding scale insulin on 01/20/25 for the morning, afternoon, and evening doses with no documented evidence of blood glucose levels being obtained. Further review of the January 2025 MAR revealed on 01/21/25, it was documented the resident refused the morning and afternoon doses of sliding scale Humalog insulin with no evidence the resident's blood glucose level was checked. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/21/25 at 3:51 P.M. with Licensed Practical Nurse (LPN) #292 stated she poked her head into Resident #13's room that day and he refused his medication. LPN #292 stated she had not seen any blood glucose levels for Resident #13 and stated she did not know where the resident's FreeStyle Libre diabetic monitoring device was located on Resident #13's skin. LPN #292 stated she did not ask Resident #13 what his blood glucose level was for the afternoon to see if the resident needed sliding scale insulin. LPN #292 verified she documented Resident #13 refused even though she never asked for the resident's blood glucose level that afternoon. Observation and interview on 01/21/25 at 4:15 P.M. with Resident #13 stated LPN #292 never visited him on 01/21/25 for his sliding scale insulin or to check his blood glucose level. At that time, Resident #13's FreeStyle Libre monitor was noted on his abdomen with a blood glucose reading of 279 mg/dL. Interview on 01/21/25 at 4:35 P.M. with LPN #292 verified she did not know were Resident #13's FreeStyle Libre blood glucose monitor was located on the resident. LPN #292 verified she did not check the resident's blood glucose level or ask the resident what his blood glucose level was for the last two days to determine if the resident required sliding scale insulin. LPN #292 verified on the January 2025 MAR for 01/21/25 she documented the resident refused in the afternoon but the resident did not refuse. This deficiency represents an incidental finding discovered while investigating Complaint Number OH00161139.