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	03/12/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, staff interviews and policy review, the facility failed to provide notification to the physician or family for a newly identified pressure ulcer. This affected one (#10) of three reviewed for pressure ulcers. care. The facility census was 56. Findings include: Review of medical record for Resident #10 revealed admitted [DATE]. The resident was hospitalized [DATE] and did not return. The resident was admitted with diagnoses including bilateral osteoarthritis, type two diabetes mellitus and hypertension. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She required was independent for eating, moderate assistance for bed mobility, toileting hygiene and transfers were not attempted. Documentation revealed no pressure ulcers upon admission to the facility. Record review of the 02/06/25 skin assessment documented a nine centimeter (cm) by (x) 11.0 centimeter unstageable sacral pressure wound. The notification section of the document had no indicating marks the physician or family had been updated. Interview on 03/12/25 at 12:33 P.M. with the Director of Nursing verified the physician nor the family had been informed of Resident #10's pressure ulcer upon its discovery on 02/06/25. Review of the facility policy, Change in a Resident's Condition or Status revised 09/24 revealed the facility would notify the physician and resident representative in changes of a resident's medical condition. This deficiency represents non-compliance investigated under Complaint Number OH00163062.

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: 366302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review and staff interviews, the facility failed to provide assistance with personal hygiene and Activities of Daily Living (ADL). This affected one (#10) of three residents reviewed for ADL care. The facility census was 56. Findings include: Review of medical record for Resident #10 revealed admitted [DATE]. The resident was hospitalized [DATE] and did not return. The resident was admitted with diagnoses including bilateral osteoarthritis, type two diabetes mellitus and hypertension. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She required was independent for eating, moderate assistance for bed mobility, toileting hygiene and transfers were not attempted. She required moderate assistance with showering and bathing. A care plan revealed alterations in bladder elimination related to incontinence with interventions to assist with toileting needs and incontinence care on routine rounds and as needed. A plan for impaired function related to the requirement for assistance in performing ADL's revealed interventions which included assistance with toileting needs and incontinence care on routine rounds and as needed to change incontinence products and assist with bath or shower. Record review of the shower documentation for Resident #10 documented one bed bath from 02/02/25 until her 02/21/25 hospitalization . Record review of the physical therapy note dated 02/18/25 documented several attempts/checks were made of nursing staff to ensure Resident #10 was getting cleaned up and ready for transfer. Nursing aides were not timely and unable to be located to complete session. Interview on 03/12/25 at 12:33 P.M. with the Director of Nursing (DON) confirmed Resident #10 had one bed bath during her stay at the facility. The DON confirmed there were no shower sheets or further documentation to verify additional showers had been provided for Resident #10. Interview on 03/12/25 at 9:42 A.M. with Physical Therapist #29 revealed on 02/18/25 the plan for therapy was to get Resident #10 up via mechanical lift and into a wheelchair. Upon arrival Resident #10 was found to be saturated the chux pad and onto the bottom sheet. She encouraged Resident #10 to put on the call light to have the Certified Nursing Assistance (CNA's) get her cleaned up. She stated she gathered the lift pad, wheelchair and foot pedals in preparation for the session. She was unable to locate CNA's by the end of her 30 minute allotted time. She did report her concern to her manager but was unsure what transpired. She shared there were two to three times she found Resident #10 saturated when she came for therapy. She stated she was not confident Resident #10 was aware of her incontinence episodes, in order to call staff. This deficiency represents non-compliance investigated under Complaint Numbers OH00163301 and OH00163062.

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 03/12/2025
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, observations, interviews with staff and Wound Physician and policy review, the facility failed to provide appropriate care and services to pressure ulcers. This affected two (#10 and #11) of three reviewed for pressure wounds. The facility census was 56. Findings include: 1. Review of medical record for Resident #10 revealed admitted [DATE]. The resident was hospitalized [DATE] and did not return. The resident was admitted with diagnoses including bilateral osteoarthritis, type two diabetes mellitus and hypertension. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She required was independent for eating, moderate assistance for bed mobility, toileting hygiene and transfers were not attempted. Documentation revealed no pressure ulcers upon admission to the facility. Record review of the 02/06/25 skin assessment documented a nine centimeter (cm) by (x) 11.0 centimeter unstageable sacral pressure wound. There was no further description or assessment of the wound or surrounding area. Record review of Resident #10's medical record including the progress notes and physician orders revealed no notification or treatments were ordered to the pressure ulcer on the residents sacral area until 02/09/25. Record review of the 02/13/25 wound physician note revealed Resident #10 had an unstageable sacral pressure wound, 100 percent (%) slough (non-viable tissue) measuring 9.5 cm x 11.0 cm. The peri wound was macerated (soft, soggy) no exudate (drainage) with odor noted. An order to cleanse the wound with normal saline or sterile water, pat dry apply wound gel to wound bed and cover with clean dry dressing once a day. Review of Resident #10's physician orders and treatment administration record (TAR) revealed an order to cleanse the wound with normal saline or sterile water, pat dry apply wound gel to wound bed and cover with silicone border (Mepilex) gauze two times a day with a start date of 02/13/25. Interview on 03/12/25 at 12:33 P.M. with the Director of Nursing (DON) confirmed Resident #10's pressure ulcer to the sacral area was found on 02/06/25 but a treatment was not started until 02/09/25. The DON confirmed the Wound Physician #24 order the dressing to be changed daily on 02/13/25 but the order was written for twice daily. The DON also confirmed Wound Physician #24 ordered a clean dry dressing but the facility ordered a Mepilex dressing. Interview on 03/13/25 at 9:50 A.M. with Wound Physician #24 revealed the incorrect frequency and dressing would not have attributed to a decline in Resident #10's wound. Wound Physician #24 stated his bigger concern was his order had not been followed as written. (continued on next page)

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 03/12/2025
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record for Resident #11 revealed admitted [DATE]. The resident was admitted with diagnoses including chronic obstructive pulmonary disease (COPD), depression, and anxiety. The resident remained in the facility. The quarterly MDS dated [DATE] revealed Resident #11 had a Brief Interview Mental Status (BIMS) score of six indicating impaired cognition. He required set up for eating, dependent for toileting hygiene, maximum assistance with bed mobility and transfers were not applicable. A care plan revealed potential for impaired skin integrity with interventions to elevate heels and moon boots in bed as tolerated. A readmission skin assessment on 03/05/25 revealed an unstageable pressure wound to his bilateral heels. There were no measurements or further description or assessment of the wounds. Review of the physician orders revealed orders for skin prep on bilateral heels and moon boots while in bed as tolerated no treatment orders were not entered until 03/07/25. Record review of the 03/10/25 skin assessment revealed there were no skin issues documented. An additional skin assessment for 03/10/25 was documented and signed on 03/11/25 which indicated Resident #11's right heel pressure wound, no staging was documented. No measurements, descriptions or measurements were documented. There was no documentation for any other skin areas of concern. Observation and interview on 03/11/25 at 11:07 A.M. with the DON revealed Resident #11 was laying in bed with his bilateral feet in moon boots and elevated on pillows. The DON removed the left moon boot and lifted his leg to reveal an approximate 3.0 cm x 3.0 cm unstageable pressure area. She then removed the right moon boot and lifted his right leg to reveal and approximate 2.0 cm x 2.0 cm unstageable wound to his right heel. This was verified with the DON at the time of the observation. Immediately following the wound observation on 03/11/25 at 11:11 A.M. the 03/10/25 skin assessment was reviewed with the DON. She verified the documentation did not indicate any areas of skin concern. Interview on 03/12/25 at 12:33 P.M. with the DON verified there were no measurements or description/assessment of Resident #11's unstageable wounds on the 03/05/25 skin assessment. She also verified a treatment was initiated until 03/07/25. She verified there had been no measurements, or further description of the wounds documented at the time of the interview. The DON shared wounds and the documentation of them would be addressed. Review of the facility policy, Pressure Ulcers/Skin breakdown revised 04/18 revealed a full assessment of pressure sore including location, stage, length, width and depth. Presence of exudate (drainage) or necrotic tissue. This deficiency represents non-compliance investigated under Complaint Numbers OH00163301, OH00163062 and OH00162988.

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	03/12/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, review of a hospital referral and interviews with staff, the facility failed to provide timely therapy services. This affected one (#10) of three residents reviewed for therapy services. The facility census was 56. Findings include: Review of medical record for Resident #10 revealed admitted [DATE]. The resident was hospitalized [DATE] and did not return. The resident was admitted with diagnoses including bilateral osteoarthritis, type two diabetes mellitus and hypertension. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She required was independent for eating, moderate assistance for bed mobility, toileting hygiene and transfers were not attempted. She required moderate assistance with showering and bathing. Review of the hospital referral for Resident #10 revealed orders for both Physical Therapy (PT) and Occupational Therapy (OT) services to continue at discharge. Review of the usual performance documentation for the Minimum Data Set (MDS) dated [DATE] through 02/01/25 revealed Resident #10 was independent for eating and oral hygiene, upper body dressing, rolling left to right and right to left, sit to lying and lying to sitting, she required moderate assistance for personal hygiene, lower body dressing and putting on shoes. Transfers and standing were not attempted due to medical condition. Review of Resident #10's medical record revealed the resident was not evaluated by PT until 02/04/25. Further record review revealed Resident #10 was never evaluated by OT. Interview on 03/10/25 at 3:05 P.M. with the Therapy Manager #20 revealed new referrals are usually discussed prior to a resident's admission to the facility. She did not recall the specifics of Resident #10's needs for services, looking at her chart or her admission orders. She stated there were many admissions during that time frame. Therapy Manager #20 confirmed PT did not evaluate Resident #10 until 02/04/25 and OT never evaluated the resident. Interview with the Administrator on 01/12/25 at 12:44 P.M. revealed it was the expectation of the facility a resident be screened for therapy services within the first 48 to 72 hours of admission. She acknowledged Resident #10 was admitted to the facility on [DATE] and did not receive a PT evaluation until 02/04/25. The Administrator confirmed Resident #10 was never evaluated by OT. This deficiency represents non-compliance investigated under Complaint Numbers OH00163323 and OH00162988.

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 03/12/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, observations, staff interviews and policy review, the facility failed to ensure proper infection control procedures were followed during resident care. This affected one (#12) out of three residents reviewed for infection control. The facility census was 56. Findings include: Review of medical record for Resident #12 revealed admitted [DATE] and admitted to hospice on 09/01/24. The resident was admitted with diagnoses including hemiplegia, diabetes mellitus, depression and gastronomy tube (g-tube). The resident remained in the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had significant impaired cognition. He was dependent for eating, bed mobility, transfers and toileting hygiene. He was documented as always incontinent of urine and bowel. Further review of Resident #12's medical record revealed the resident had a wound on the buttock that required treatments. Observation on 03/11/25 at 10:38 A.M. with Licensed Practical Nurse (LPN) #13 and the Director of Nursing revealed in preparation of wound care, Resident #12 was found to be incontinent. LPN #13 left the room to gather incontinence care supplies. Upon return to the room she washed her hands and was observed to ply multiple layers of gloves on each hand. Once the supplies were in place, the DON using the chux, turned Resident #12 onto his right side. The incontinence product was untaped and he was laid back onto his back. Peri care was provided with no concerns. Resident #12 was once again turned onto his right side. Resident #12 was observed to be incontinent of stool. LPN #12 proceeded to cleanse his buttocks with no concern. LPN #13 then removed the top layer of gloves. LPN #13 then removed the dressing and placed it into the soiled incontinence product. LPN #13 pulled the incontinence product from underneath Resident #12, wrapped it into a ball and disposed of it into the trash can. LPN #13 then removed an additional layer of gloves. LPN #13 cleansed the sacral wound with sterile water, patted dry with a four-by-four dressing. LPN #13 then placed calcium with silver to the wound bed and covered with a dry dressing. LPN #13 then removed another layer of gloves, exposing yet another set of gloves and picked the trash bag out of the trash can. LPN #13 stated she applied five sets of gloves prior providing care. LPN #13 acknowledged it was procedure to wash your hands upon removing gloves. LPN #13 confirmed hand hygiene was not performed during the observation or after removing multiple layers of gloves. Review of the facility policy, Wound Care revised 10/21 documented for staff to remove disposable gloves and discard and wash and dry hands thoroughly. This deficiency is based on incidental findings discovered during the course of this complaint investigation.