

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 09/03/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure residents were supervised while smoking and further failed to ensure residents smoked in designated areas per facility policy. Additionally, the facility failed to ensure residents utilized non-combustible containers to extinguish smoking materials. This affected two (#21 and #07) of two residents reviewed for smoking. The facility identified 15 (#07, #08, #13, #15, #16, #20, #21, #24, #26, #32, #34, #43, #48, #49, and #50) residents who smoked. The facility census was 50. Findings include: 1. Review of the medical record for Resident #21 revealed an admission date of 02/13/24 with medical diagnoses of chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), and tobacco use. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/11/25, revealed Resident #21 was cognitively intact and was independent with all activities of daily living (ADLs). Review of the current plan of care revealed Resident #21 was at risk for injury related to smoking. Interventions included nursing staff to maintain all smoking materials in the designated area and the resident was to be a supervised smoker. Review of the Smoking Safety Screen, dated 06/10/25, revealed Resident #21 was a smoker and preferred to smoke in the morning, afternoon, evenings, and nights. The screen indicated Resident #21 required supervision when smoking and the resident was aware that staff needed to store his lighter and cigarettes. Observation on 09/03/25 at 7:45 A.M. revealed Resident #21 exited the facility through the main entrance door, propelled himself in his wheelchair approximately three feet from the entrance, removed a cigarette and lighter from his pocket, lit a cigarette and proceeded to smoke. Further observation revealed a no smoking sign was posted on a pole near the entrance door. No facility staff were observed providing supervision for Resident #21. Concurrent interview with Resident #21 confirmed he was smoking on the sidewalk in front of the facility's main entrance. Interview on 09/03/25 at 7:50 A.M. with Housekeeper (HSK) #228 confirmed Resident #21 was smoking unsupervised, approximately three feet from the facility's main entrance door. HSK #228 stated residents who required supervision with smoking were to smoke in the designated smoking area at designated times. Interview on 09/03/25 at 8:25 A.M. with Resident #21 revealed the nursing staff kept his smoking supplies at the nurses' station and that he was provided with a cigarette and his lighter by staff to smoke this morning. 2. Review of the medical record for Resident #07 revealed an admission date of 06/17/25 with medical diagnoses of COPD, cellulitis to right lower extremity, hypertension (HTN) and anxiety. Review of an admission MDS assessment, dated 06/22/25, revealed Resident #07 was cognitively intact and required supervision with toilet hygiene, bathing, and transfers and was independent with bed mobility. The MDS indicated Resident #07 used tobacco products. Review of the Smoking Safety Screen, dated 06/17/25, revealed Resident #07 preferred to smoke in the morning, afternoon, evenings, and nights and the resident could light his own cigarette. The screen indicated Resident #07 was aware the facility needed to store his lighter and cigarettes and he was safe to smoke without direct supervision. Observation on 09/03/25 at 7:48 A.M. revealed Resident #07 was sitting in his wheelchair in the visitor parking lot smoking a cigarette. Concurrent interview with Resident #07 confirmed he was smoking on the facility property and was aware that he was supposed to go off the facility property to smoke. Resident #07 stated the nursing staff kept his smoking supplies at the nurses' station. Interview on 09/03/25 at 7:50 A.M. with HSK #228 confirmed Resident #07 was smoking in the facility parking lot. HSK #228 stated residents who did not require supervision while smoking were required to smoke off of the facility property. 3. Observation on 09/03/25 at 7:50 A.M. revealed multiple cigarette butts were on the ground along the sidewalk to the front entrance and in the parking lot, as well as in the mulch at the front entrance. Concurrent interview with HSK #228 verified the cigarette butts located on the ground in the facility parking lot, sidewalk, and in the mulch. Interview on 09/03/25 at 10:00 A.M. Licensed Practical Nurse (LPN) #249 revealed the designated smoking area for the residents was located on a patio off of the activity room. LPN #249 stated some residents would sign themselves out on leave of absence (LOA) and go off the facility property to smoke. LPN #249 confirmed residents were to smoke in the designated smoking area unless they were off facility property. Concurrent observation of the designated smoking area revealed several discarded cigarette butts in the mulch and in the grass. Further interview with LPN #249 confirmed an appropriate non-combustible container was available for the disposal of smoking materials; however, multiple cigarette butts were in the mulch and the grass area of the smoking area. Review of the facility policy titled, Smoking, revised 02/18/22, revealed the facility would establish and maintain safe resident smoking practices. The policy stated that prior to, or upon</p>		