| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366302 | A. Building<br>B. Wing | 06/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aventura at Shiloh Springs | 3500 Shiloh Springs Road<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review , staff interviews, and policy review, the facility failed to ensure the physician was notified when a resident experienced a change in condition. This affected one resident (#43) of three reviewed for change in condition. The facility census was 61.Findings include:Review of the medical record for Resident #43 revealed an admission date of 05/19/25. Diagnoses included type II diabetes mellitus (DM II), emphysema, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure.Review of the physician order dated 09/24/25, revealed Resident #43 was ordered oxygen at two liters per minute (lpm) per nasal cannula as needed to maintain pulse oxygen saturation above 92 percent (%).Review of the most recent Smoking Safety Screening dated 02/26/26, revealed Resident #43 was not recorded as a current smoker.Review of Resident #43's care plan dated 03/20/26, revealed Resident #43 was at risk for injury related to smoking. The resident required supervision when smoking and utilized tobacco-cigarette products. Interventions included informing the resident and family of the smoking policy, observing the resident smoking in designated areas, nursing to maintain all smoking materials in designated area, and the resident to be supervised with smoking.Review of the physician order dated 04/14/26, revealed Resident #43 was ordered to receive Zinc oxide external cream one percent (%) for his nose every shift (twice daily) for skin irritation for 10 days and monitor and report signs or symptoms of infection.Review of the physician progress note dated 04/15/26 at 3:00 A.M., revealed Resident #43 was seen for skin burn. There were no additional details. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of the late entry progress note dated 06/09/26 and entered on 06/10/26 at 9:35 P.M., revealed Resident #43 was educated on the dangers of smoking with oxygen use. The resident verbalized understanding and that he would stop at the nurse's station prior to going to smoke.During an interview on 06/09/26 at 9:08 A.M., Resident #43 stated on 05/31/26, he was outside smoking with his oxygen on and caught himself on fire. Resident #43 reported he had burns to his nose from the nasal cannula catching on fire. Resident #43 stated he forgot to take his oxygen off prior to smoking. Resident #43 explained he had been putting cream on his burns that he received from similar incident when he was burned while smoking with his oxygen on.During an interview on 06/09/26 at 10:41 A.M., Registered Nurse (RN) #30 stated she was not aware Resident #43 sustained burns on 05/31/26. RN #30 stated the resident reported to her he had been burned in the past because of his oxygen being on.During an interview on 06/09/26 at 10:58 A.M., Licensed Practical Nurse (LPN) #20 stated she was alerted that Resident #06 was on the ground in the parking lot. LPN #20 reported Resident #43's oxygen saturation status was checked and gave him a cold rag per his request. LPN #20 stated she reported the incident with Resident #43 to RN #30.During an interview on 06/09/26 at 2:28 P.M., Regional Director of Clinical Services (RDCS) #105 stated she was unaware of the burn incidents on 04/14/26 and 05/31/26 involving Resident #43.Observation of Resident #43 on 06/09/26 at 2:33 P.M. with RDCS #105, revealed the resident had burned areas to bilateral nose/nostrils.During an interview on 06/09/26 at 2:35 P.M., alongside RDCS #105, Resident #43 stated he burned himself<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on 05/31/26 because he forgot to take off his oxygen. Resident #43 reported he had been applying the Zinc cream to his nose that he was given the last time a similar incident occurred about a month or so ago.During an interview on 06/09/26 at 3:05 P.M., Assistant Director of Nursing (ADON) #25, stated she was unaware of the 05/31/26 incident involving Resident #43 burning himself while smoking with oxygen on. ADON #25 reported she heard about the previous incident in April but was unaware of any investigation.During an interview on 06/09/26 at 3:10 P.M., Medical Director (MD) #100 stated he was unaware of the burning incident in April involving Resident #43. MD #100 stated he was not made aware of the burn incident on 05/31/26.Review of the facility policy titled, Change of Condition, revealed a significant change of condition was a decline or improvement in the resident's status that required interdisciplinary review and/or revision to the care plan. The center will notify the resident's physician and the resident's representative whenever there is a significant change in the resident's health, mental or psychosocial status. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff and resident interviews, and review of the facility's smoking policy, the facility failed to adequately assess and supervise residents identified as being supervised smokers to prevent them from smoking while oxygen was in place. This resulted in Immediate Jeopardy and serious life-threatening harm and/or injuries on 04/14/26 when Resident #43 lit a cigarette while wearing oxygen via nasal cannula and sustained burns to his face. On 05/31/25, Resident #43 again lit a cigarette while wearing oxygen and sustained additional burns to his face. This affected one (Resident #43) of three residents reviewed for accident hazards. The facility identified 28 residents (#04, #06, #08, #11, #12, #16, #22, #24, #26, #27, #28, #31, #32, #33, #36, #40, #41, #42, #43, #50, #53, #54, #57, #58, #59, #60, and #61) who smoked. The facility census was 61.On 06/10/26 at 12:58 P.M., the Administrator, Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #105, and Regional Director of Operations (RDO) #106 were notified that Immediate Jeopardy began on 04/14/26 when Resident #43, who was assessed as a non-smoker but care planned as a supervised smoker, went outside on the facility grounds with smoking materials he was allowed to keep with him and smoked while wearing oxygen. His oxygen tubing ignited, causing a small flame which burned Resident #43's face. He was ordered to receive Zinc Oxide to the burn. There was no documented assessment of Resident #43 at the time of the incident and there were no immediate interventions implemented to prevent similar incidences. On 05/31/26 at approximately 4:00 P.M., Resident #43 went outside in the parking lot with his smoking materials and smoked while wearing oxygen and again burnt his face. Resident #43 was never assessed after this incident, nor provided any treatment for his burns, the provider was never notified, the incident was not investigated by the facility nor was it documented in Resident #43's medical record. The Immediate Jeopardy was removed on 06/15/26 when the facility implemented the following corrective actions: On 06/09/26, Assistant Director of Nursing (ADON) #25 completed a skin assessment on Resident #43 and called to clarify the treatment order with Medical Director (MD) #100. Resident #43 was noted with left nostril burn measuring 1.8 centimeters (cm) by 0.8 cm. MD #100 gave an order for Silvadene cream one percent twice daily and the treatment order was entered in by ADON #25. On 06/09/26, Smoking Safety Evaluations were completed for the 28 residents with a history of smoking or who are current smokers by ADON #25. There were 22 residents assessed as independent smokers, and six residents were assessed to need supervision. There were four resident's smoking evaluations that required changes from their prior assessment: Resident #41 and Resident #40's prior evaluation was incorrectly coded as requiring supervision while smoking. The updated evaluation revealed Residents #41 and #40 were safe to smoke independently. Resident #60 was changed from able to smoke safely to being required supervision while smoking. Resident #43's prior evaluation inaccurately was coded as a non-smoker, and the updated evaluation revealed the resident was safe to smoke with supervision. On 06/09/26, Nursing Administration, (Registered Nurse [RN] #151, DON, and ADON #25) were educated by RDCS #105 on incident notification, updating facility smoking safety/skin assessment, incident reporting requirements, transcribing physician orders, documentation requirements, interventions for non-compliance and timeliness of smoking evaluations. On 06/09/26, LPN #152 (who worked on 04/14/26) and LPN #153 (who worked on 05/31/26) were educated by ADON #25 on incident notification, updating facility smoking safety/skin assessment, incident report requirements, transcribing physician orders and documentation requirements. On 06/09/26, a new Smoking Policy was implemented by RDO #106. Smoking Safety Evaluations will now be completed upon admission/re-admission, quarterly, annually, upon significant change or a change in condition and after a safety event. On 06/09/26, a new Independent Smoking Contract was implemented by RDO #106 and reviewed and signed by the six residents assessed to safely smoke independently on<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 06/10/26. For residents with signed independent smoking contracts and physician orders, they will be encouraged to first utilize the designated smoking area on facility property which is located through the activity room and has a key code entry to exit out to the courtyard. The residents will need to notify staff that they want to smoke and the staff will allow the residents to access the area. The residents will not have access to this area at all times due to there not being a key code entry on the outside to return inside. If residents are deemed competent to make their own decisions and have an order for leave of absence (LOA), they were re-educated on the LOA policy of notifying staff that they were leaving the building and the requirement to sign out and sign back in upon return. On 06/09/26, staff education was initiated by ADON #25, the Administrator and RDCS #105 and was completed on 06/10/26. Those not educated in person were educated via phone and the staff that did not receive the education, will be educated in person prior to working their next shift. The staff were educated on new smoking policy, behavior smoking contracts and independent smoking contracts with safety for residents with oxygen, LOA Policy and notification of resident's failure to comply with safe keeping of materials, signing out and back in, resident conduct and the facility's policy on abuse/neglect. The same items were sent to the staffing Agency Group and uploaded into the portal for shift pick-ups where agency staff must review items sent prior to working. The confirmation is sent to the building upon completion. Additionally, the staff nurses were educated on Smoking Safety Evaluation and frequency required, incident reporting, documentation of physician notification, transcription of physician orders, accuracy of assessments, non-compliance interventions, updated Smoking Guidelines and Policy. The same items were sent to the staffing Agency Group and uploaded into the portal for shift pick-ups where staff must review items sent prior to working. The confirmation is sent to the building upon completion. On 06/09/26, the 28 residents identified as being smokers had the new smoking policy and guidelines reviewed with them by the Administrator, ADON #25 and/or RDCS #105. On 06/09/26, new physician orders were obtained for the 28 smokers which included those needing supervision or assessed as safe to smoke independently and the orders were entered on 06/10/26 by RDCS #105. The responsible parties and/or guardians were notified by ADON #25. A total of seven residents (Residents #43, #23, #33, #54, #12, #41 and #50) that smoked were identified with orders for oxygen. Those seven residents had updated orders for the removal of oxygen prior to smoking entered on 06/09/26 and 06/10/26 by RDCS #105 to remove oxygen prior to smoking with the responsible parties and/or guardians notified by ADON #25. On 06/09/26, an audit of the progress notes from 04/01/26 to current was conducted for related incidents by RDCS #105. There were no further incidents identified other than the incidences on 04/14/26 and 05/31/26 involving Resident #43. On 06/09/26, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with Administrator, ADON #25, RDCS #105, RDO #106 MD #100, Corporate [NAME] President of Clinical Services #160, Corporate Clinical Specialist #162 and [NAME] President of Operations #164. The QAPI team discussed the Root Cause Analysis (RCA). MD #100 verbalized understanding the abatement plan being put in place and had no additional items to add. On 06/10/26, the residents deemed safe to smoke independently were issued lock boxes by the Administrator for their smoking materials that they are to lock up after completing their smoke breaks. On 06/10/26, MD #100 was notified of the Immediate Jeopardy by RDO #106. On 06/10/26, a new Smoking Behavior Contract was implemented for the 28 residents identified as smokers by RDO #106. On 06/10/26, RDCS #105 updated the care plans for the 28 residents identified as smokers which included supervision, independent and/or the need for oxygen removal prior to smoking. Beginning 06/10/26, the DON/designee began auditing the 24-hour report (report that pulls over progress notes, medication administration records (MAR), treatment administration records (TAR), incident reports and other items that require coding), LOA log notes for non-compliance, and behavior documentation five times per week for four weeks. Beginning 06/10/26, the DON/designee began auditing new/de-admissions, change in conditions, Annual and Quarterly Smoking Safety Screens three times per week for four weeks to ensure accuracy and completeness with assessments, physician orders, care plan<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | updates/safety equipment and lock box needs. Beginning 06/11/26 Interdisciplinary Team (IDT)/QAPI meetings will be held weekly to review results of observations and monitoring activities for four weeks followed by monthly QAPI meetings on the third Wednesday of every month for three months. On 06/15/26, the Administrator and RN #166, held a follow-up care plan meeting with Resident #43 and advised the resident that due to the safety incidents on 04/14/26 and 05/31/26, the smoking safety evaluation was redone on 6/15/26 with an outcome of the resident needing supervision while smoking. Smoking materials would be placed in a designated locked cart, and the staff had to provide the smoking materials. The resident would smoke at the designated times with all other residents who required supervision by staff and there would be a 30-day period to supervise him to ensure he is practicing safe smoking practices. Due to the resident's history of non-compliance with the smoking policy and he maintained a Brief Interview Mental Status (BIMS) of 15 (indicating the resident was cognitively intact), they re-educated resident on the facility's LOA policy and if he chose to go off property he was required to alert a staff member and sign out and back in upon return. Resident #43 was informed that any non-compliance would result in a thirty (30) day intent to discharge. The Smoking Behavior Contract signed by the resident on 06/09/26 remained in effect with a re-evaluation for independent smoking status in thirty (30) days. Resident #43's physician was contacted and orders and a plan of care were updated by the RDCS #105. Although the Immediate Jeopardy was removed on 06/15/26, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include:Review of the medical record for Resident #43 revealed an admission date of 05/19/25. Diagnoses included type II diabetes mellitus (DM II), emphysema, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of the physician order for Resident #43 dated 09/24/25, revealed the resident was ordered to receive oxygen at two liters per minute (lpm) per nasal cannula as needed (PRN) to maintain pulse oxygen saturation above 92 percent. Review of the Smoking Safety Screen for Resident #43 dated 02/26/26, revealed the resident was not a current smoker. Review of the care plan for Resident #43 dated 03/20/26, revealed the resident was at risk for injuries related to smoking and needed supervision when smoking and utilizing tobacco-cigarette products. Interventions included informing the resident and the family of the smoking policy, observing the resident smoking in designated areas, nursing to maintain all smoking materials in a designated area, and the resident to be supervised when smoking. Review of the physician order dated 04/14/26, revealed Resident #43 was ordered zinc oxide external cream one percent to be applied to nose twice daily for skin irritation for 10 days and monitor and report signs or symptoms of infection. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 had intact cognition. Review of the physician progress note dated 04/15/26 at 3:00 A.M. and authored by MD #100, revealed Resident #43 was seen for a skin burn. There was no additional documentation related to the burn, how it occurred, any interventions to prevent it from happening again or a treatment plan. During an interview on 06/08/26 at 3:05 P.M., the current Administrator stated she did not know about the smoking incident on 05/31/26 involving Resident #43 getting burned while smoking with oxygen. During an interview on 06/09/26 at 8:53 A.M., Resident #06 stated on 05/31/26 around 4:00 P.M., he was outside in the front parking lot with Resident #43. Resident #06 stated Resident #43 lit his cigarette while wearing his oxygen via nasal cannula, and Resident #43's face caught on fire around his nose and up his ears. Resident #06 stated he panicked and attempted to move his wheelchair, but the brakes were locked, so he jumped out of his wheelchair in fear Resident #43's oxygen tank was going to explode. Resident #06 stated he laid on the ground for approximately twenty minutes before staff responded.During an interview on 06/09/26 at 9:08 A.M., Resident #43 stated on 05/31/26, he was outside smoking with his oxygen on and caught himself on fire. Resident #43 stated he had burns to his nose and forgot to take his oxygen off prior to smoking. Resident #43 stated he had been putting cream on his burns that he had from<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | previous incident in April from being burned while smoking with his oxygen on. During an observation at the time of the interview, Resident #43 had white cream around his nose. During an interview on 06/09/26 at 10:41 A.M., RN #30, who stated she was assigned to care for Resident #43 on 05/31/26, denied any knowledge of Resident #43 sustaining any burns from smoking with his oxygen on. RN #30 stated the resident told her he was burned in the past because of his oxygen being on. During an interview on 06/09/26 at 10:50 A.M., Certified Nursing Assistant (CNA) #10, who stated she was assigned to care for Resident #43 on 05/31/26, stated she heard about the incident on 05/31/26. Resident #43 asked her for ice three or four times that evening for his burn injuries. CNA #10 also stated she was never asked about the incident or asked to complete a witness statement. During an interview on 06/09/26 at 10:58 A.M., LPN #20, who stated she was assigned to care for Resident #06 on 05/31/26, said she was alerted that Resident #06 was on the ground in the parking lot. LPN #20 stated Resident #43's oxygen saturation status was checked, and she gave him a cold rag per his request. LPN #20 stated she reported the incident involving Resident #43 to RN #30.During an interview on 06/09/26 at 11:23 A.M., LPN #22, who reported she was the night shift nurse on 05/31/26, stated she was never informed during the shift-to-shift report or by Resident #43 that he had sustained burns related to smoking while using his oxygen. During an interview on 06/09/26 at 11:32 A.M., LPN #21 stated he responded to the parking lot where the incident took place on 05/31/26 involving Resident #06 and Resident #43. LPN #21 stated Resident #43 had a singed nasal cannula and burns due to smoking with oxygen in use. LPN #21 stated Resident #06 reported Resident #43's oxygen tank was on while he was started smoking, and the resident caught on fire briefly. LPN #21 stated there was a similar incident involving Resident #43 smoking with oxygen on and burning himself but was unsure when. During an interview on 06/09/26 at 2:28 P.M., RDCS #105 stated she was unaware of the burn incidents on 04/14/26 and 05/31/26 involving Resident #43. Observation of Resident #43 on 06/09/26 at 2:33 P.M. with RDCS #105, revealed the resident had burned areas to his nose and nostrils. During an interview on 06/09/26 at 2:35 P.M., alongside RDCS #105, Resident #43 stated he burned himself on 05/31/26 because he forgot to take off his oxygen when he smoked. Resident #43 reported he had been applying the cream to his nose that he was given the last time a similar incident occurred which was about a month or so ago. During an interview on 06/09/26 at 3:05 P.M., ADON #25 stated she was unaware of the burn incident on 05/31/26 involving Resident #43. ADON #25 stated she heard about a similar incident in April but was unaware of any investigation.During an interview on 06/09/26 at 3:10 P.M., MD #100 stated he was aware of a burning incident in April 2026 involving Resident #43, but he had no other details of the incident. MD #100 stated he was not made aware of the burn incident on 05/31/26 involving Resident #43. Review of the progress note for Resident #43 dated 06//09/26 written as a late entry on 06/10/26 at 9:35 P.M. and authored by RDCS #105, revealed the resident was educated on the dangers of smoking with oxygen use. The resident verbalized understanding and stated he would stop at the nurse's station prior to going to smoke.During an interview on 06/10/26 at 10:03 A.M., former Administrator #200 stated he was the Administrator during the incident on 04/14/26; however, he was unaware of Resident #43 being burned on 04/14/26. Former Administrator #200 stated his last day working in the facility was Friday 05/29/26.Review of the Smoking Safety Screen for Resident #43 dated 06/15/26 at 2:26 P.M. and authored by RDCS #105, revealed the resident was an active smoker and required supervisionDuring an interview on 06/16/26 at 2:34 P.M., RDO #106 stated Former #200's last day working was Friday 05/29/26 and the Current Administrator started on 05/30/26. RDO #106 stated she assisted with covering the facility and stated she was never informed of the incident on 5/31/26 involving Resident #43. RDO #106 stated she had no knowledge of the April 2026 incident involving Resident #43. Review of the facility policy titled, Smoking Policy - Residents, revised October 2023, revealed the facility had established and maintained safe resident smoking practices. Smoking was only permitted in designated resident smoking areas, which were located outside of the building. Oxygen use was prohibited in smoking areas. Any resident with smoking privileges requiring<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. The residents who have independent smoking privileges were permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. The residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. This deficiency represents non-compliance investigated under Complaint Number 3035005. This deficiency is a recite to complaint survey completed 05/21/26. |

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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 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure the physician progress notes were written, signed and dated at the time of the visit. This affected three Residents (#33, #50, and #62) of three residents reviewed for physician visits. The facility census was 61. Findings include:1) Review of the medical record for Resident #33 revealed an admission date of 10/17/24. Diagnoses included Chronic obstructive Pulmonary Disease (COPD), bipolar disorder, depression, and type II diabetes mellitus (DM II).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #33 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of the physician notes for Resident #33 authored by Medical Director (MD) #100, revealed she was seen on 04/01/26 and the progress note was written and signed by MD #100 on 04/19/26. The resident was seen again on 05/01/26 and the progress note was written and signed by MD #100 on 05/03/26. The resident was seen again on 05/27/26 and the note was written and signed by MD #100 on 05/29/26.During an interview on 06/11/26 at 9:49 A.M., Regional Director of Clinical Services (RDCS) #105 verified Resident #33's physician notes were not signed by MD #100 at the time of visit for 04/01/26, 05/01/26, and 05/27/26.2) Review of the medical record for Resident #50 revealed an admission date 12/08/21. Diagnoses included acute respiratory failure with hypoxia, DM II), dementia, and anxiety disorder.Review of the Medicare-Five day MDS assessment dated [DATE], revealed Resident #50 had intact cognition as evidenced by a BIMS score of 14. Review of the physician notes for Resident #50 and authored by MD #100, revealed the resident was seen on 04/01/26 and the progress note was written and signed on 04/19/26. The resident was seen on 04/08/26 and the progress note was written and signed by MD #100 on 04/14/26. The resident was seen on 05/01/26 and the progress note was written and signed by MD #100 on 05/03/26. The resident was seen on 05/08/26 and the progress note was written and signed by MD #100 on 05/11/26.During an interview on 06/11/26 at 9:49 A.M., RDCS #105 verified Resident #50's physician notes were not signed at the time of visit by MD #100 for 04/01/26, 04/08/26, 05/01/26, and 05/08/26.3) Review of the medical record for Resident #62 revealed an admission date of 04/22/25 with a discharge date of 05/06/26. Diagnoses included DM II, osteomyelitis of right ankle and foot, depression, and venous insufficiency.Review of the Annual MDS assessment dated [DATE], revealed Resident #62 had intact cognition as evidenced by a BIMS score of 15. Review of the physician notes for Resident #62 and authored by MD #100, revealed the resident was seen on 03/18/26 and the progress note was written and signed by MD #100 on 03/22/26. The resident was seen on 04/01/26 and the progress note was written and signed by MD #100 on 04/19/26. The resident was seen on 04/11/26 and the progress note was written and signed by MD #100 on 04/13/26. The resident was seen on 05/01/26 and the progress note was written and signed by MD #100 on 05/03/26.During an interview on 06/11/26 at 9:49 A.M., RDCS #105 verified Resident #62's physician notes were not signed at the time of visit by MD #100 for 03/18/26, 04/01/26, 04/11/26, and 05/01/26.Review of the facility policy titled, Charting and Documentation, dated July 2017 revealed all services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Documentation of procedures and treatments will include care-specific details including: the date and time the procedure/treatment was provided, the assessment data and/or any unusual findings obtained during the treatment, the signature and title of the individual documenting. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366302 | A. Building<br>B. Wing | 06/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aventura at Shiloh Springs | 3500 Shiloh Springs Road<br>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) |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure resident's records were complete and accurately documented. This affected one (#43) of three residents reviewed for documentation. The facility census was 61.Findings include:Review of the medical record for Resident #43 revealed an admission date of 05/19/25. Diagnoses included type II diabetes mellitus (DM II), emphysema, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure.Review of the nurse's progress notes for Resident #43 from 04/14/26 through 05/31/26, revealed no documentation related to the incidents 04/14/26 and 05/31/26 when the resident was burned when he was smoking with oxygen on. Review of the physician progress note dated 04/15/26 at 3:00 A.M. and authored by Medical Director (MD) #100, revealed Resident #43 was seen for skin burn.Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. During an interview on 06/09/26 at 9:08 A.M., Resident #43 stated on 05/31/26, he was outside smoking with his oxygen on and caught himself on fire. Resident #43 stated he had burns to his nose from the nasal cannula catching on fire. Resident #43 stated he forgot to take his oxygen off prior to smoking. Resident #43 explained he had been putting cream on his burns that he had from a previous incident when he was burned while smoking with his oxygen on.During an interview on 06/09/26 at 2:28 P.M., Regional Director of Clinical Services (RDCS) #105 stated she was unaware of either burn incidents involving Resident #43. RDCS #105 verified there was no documentation in the medical record for Resident #43 regarding the incidents on 04/14/26 and 05/31/26During an interview on 06/09/26 at 2:35 P.M., alongside RDCS #105, Resident #43 stated he burned himself on 05/31/26 because he forgot to take off his oxygen. Resident #43 reported he had been applying the Zinc oxide cream to his nose that he was given the last time the incident occurred about a month or so ago.During an interview on 06/09/26 at 3:05 P.M., Assistant Director of Nursing (ADON) #25 stated she was unaware of the incident on 05/31/26 when Resident #43 burned himself while smoking with oxygen on. ADON #25 stated she heard about the previous incident in April but was unaware of any investigation.During an interview on 06/09/26 at 3:10 P.M., Medical Director (MD) #100 stated he was unaware of the incident in April 2026 when Resident #43 was burned while smoking with oxygen on. MD #100 stated he was not made aware of the burn incident on 05/31/26.Review of the facility policy titled, Charting and Documentation, dated July 2017 revealed all services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. |