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	07/01/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure falls were documented and investigated in a thorough manner. This affected one (#21) of three residents reviewed for safety. The facility census was 56. Findings include: Review of the medical record of Resident #21 revealed an admission date of 02/11/26. Diagnoses included major depressive disorder, chronic obstructive pulmonary disease, type 2 diabetes mellitus, morbid obesity, congestive heart failure, GERD, bipolar disorder.Review of the Morse Fall Scale dated 02/11/26, revealed Resident #21 was at a moderate risk for falls. Review of the plan of care dated 02/16/26, revealed Resident #21 was at risk for falls related to requiring assistance with ambulation and transfers. Interventions included assisting the resident with wheelchair or walker for mobility as needed. Review of the physician order for Resident #21 dated 05/29/26, revealed the resident was ordered to receive one-on-one (1:1) supervision until further notice. Review of the progress note for Resident #21 dated 05/30/26 and authored by Licensed Practical Nurse (LPN) #50, revealed the resident fell outside with her 1:1 supervision. The resident was assessed and did not have any injuries, and neurological (neuro) checks were implemented. The progress notes contained no additional details regarding how the fall occurred. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #21 had intact cognition. The resident utilized a wheelchair for mobility, was independent with bed mobility and walking short distances and required supervision for transfers. Review of the fall investigation for Resident #21 dated 06/02/26, revealed the Interdisciplinary Team (IDT) met to discuss Resident #21's fall on 05/30/26. The note indicated the resident had the potential for falls related to her diagnosis, no narcotics, was cognitively intact and able to understand safety education. The care plan was updated to reflect education on the proper use of the wheelchair. The investigation contained no details of the fall, including who was present, what happened or any witness statements. During an interview on 07/01/26 at 8:40 A.M., Certified Nursing Assistant (CNA) #30 stated on the morning of 05/30/26, she was providing 1:1 supervision to Resident #21 and took her outside to smoke. CNA #30 stated, when she was bringing Resident #21 back into the building, she pulled the resident up the ramp, backwards in her wheelchair, and the resident fell forward and out of the wheelchair. CNA #30 stated her method of handling the resident in her wheelchair was not appropriate. During an interview on 07/01/26 at 10:39 A.M., Regional Corporate Nurse (RCN) #40 verified Resident #21's fall on 05/30/26 did not contain a thorough investigation During an interview on 07/01/26 at 1:00 P.M., the Director of Nursing (DON) verified Resident #21's medical record did not contain sufficient information describing the resident's fall on 05/30/26. Review of the facility policy titled, Safety and Supervision of Residents, dated 10/2025, revealed with accident hazards are identified by the safety committee shall evaluate and analyze the cause of the hazards, The interdisciplinary care team shall analyze information obtained from assessments and observations to identify specific hazards or risks for individual or groups of residents.This deficiency is a recite to complaint survey completed 06/22/26.

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of online resources from the Centers for Disease Control and Prevention (CDC), policy review, the facility failed to ensure appropriate infection control practices were implemented. This affected four Residents (#47, #46, #16, and #38) of four residents reviewed for infection control. The facility census was 56. Findings include: 1) Review of the medical record of Resident #47 revealed an admission date of 01/16/26. Diagnoses included osteomyelitis of vertebra, paraplegia, carrier of Carbapenem-Resistant Acinetobacter Baumanni (CRAB) (highly resistant bacteria that cause deadly multidrug resistant infections in hospitalized patients in hospitals and nursing homes) and open wound to right lower leg. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/06/26, revealed the resident had intact cognition. The resident was dependent for bed mobility and transfers. Review of the physician orders for Resident #47 dated 06/10/26, revealed the resident was ordered to in contact precautions related to wounds, an indwelling foley catheter, and history of CRAB. Orders dated 06/30/26, revealed the resident was ordered to have dressing changes to his right posterior-lateral shin and right lateral foot Review of the medical record of Resident #46 revealed an admission date of 01/23/25. Diagnoses included lack of coordination, depression, adult failure to thrive, hyperlipidemia, hereditary hemolytic anemia, and repeated falls. There was no record of Resident #46 being in any type of isolation precautions. Review of the most recent quarterly MDS assessment, revealed Resident #46 had severely impaired cognition. Review of the June 2026 active physician orders for Resident #46, revealed the resident was not ordered to be any type of isolation precautions. Observation of Residents #46 and #47's room (roommates) on 06/30/26 at 4:02 P.M., revealed a sign on the door the door indicating the need for contact precautions with a gown and gloves to be worn when entering the room. Resident #46 was seated in her wheelchair in the room and Resident #47 was resting in bed on her side of the room. Licensed Practical Nurse (LPN) #20 entered the room without donning a gown nor gloves. LPN #20 cleared off Resident #47's bedside table, which contained numerous personal items, including empty food containers and other trash. LPN #20 exited the room to gather supplies for wound care. During an interview on 06/30/26 at 4:09 P.M., LPN #20 verified Resident #47 was in contact precautions related to CRAB. LPN #20 verified she did not don a gown nor gloves upon entrance into the room. LPN #20 stated she would not apply a gown and gloves until she was ready to complete the wound treatments. LPN #20 verified the sign on the door to the resident's room indicated instructions to don a gown and gloves at the door before entering the room. Observation of wound care for Resident #47 on 06/30/26 at 4:12 P.M., LPN #20 donned a gown and gloves and entered the resident's room to begin the resident's wound treatment. LPN #20 removed the existing dressing from Resident #47's right shin and placed it in a bag on the bed. LPN #20 then used the same gloved hand and retrieved a clean gauze pad and wound wash from the bedside table, applied the wound wash on the wound, and dried it with the gauze pad. LPN #20 removed her gloves and applied new gloves without performing any hand hygiene between the glove change. LPN #20 applied alginate and a dry dressing. At 4:19 P.M., LPN #20 removed her gloves, utilized a marker to write the date on the new dressing, and applied new gloves. LPN #20 did not perform hand hygiene between the glove change. LPN #20 then applied wound wash and a dry dressing, gathered her supplies, doffed the gown and gloves, and washed her hands before leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/30/26 at 4:24 P.M., LPN #20 verified she did not don clean gloves after removing the dirty dressing and before applying the wound wash and did not perform hand hygiene between glove changes. During an interview on 07/01/26 at 9:56 A.M., the Administrator verified Residents #46 and #47 were cohorted in the same room. The Administrator verified Resident #47 required contact precautions due to CRAB and Resident #46 did not require any type of isolation precautions. The Administrator verified there were rooms available within the facility which could be used instead of cohorting Residents #46 and #47 together. During an interview on 07/01/26 at 10:30 A.M., the Director of Nursing (DON) stated the staff should don a gown and gloves at the door for residents who are in contact precautions. Review from online resources from CDC (https:www.cdc.gov), revealed CRAB infections don't respond to common antibiotics and some CRAB are resistant all available antibiotics and large outbreaks have been reported in hospitals and nursing homes. CRAB spreads through direct and indirect contact with patients infected or colonized with CRAB or contaminated environmental surfaces and equipment. It is usually transmitted from person to person, often via the hands of healthcare personnel or on contaminated shared medical equipment, like intravenous (IV) poles and blood pressure machines. CRAB can cause large outbreaks in healthcare facilities. Without effective cleaning and disinfection, CRAB can persist in the environment and on medical equipment for days to weeks, even in dry conditions. CRAB can contaminate a healthcare worker's hands and clothes while they care for a patient infected or colonized (bacteria colonization means bacteria are living and multiplying on or in your body without causing disease or symptoms with CRAB or work in their environment. This puts the patients who are cared for afterwards at risk of getting CRAB. If private rooms are unavailable, residents with CRAB should only be cohorted with other patients who have already tested positive for CRAB. They should never share a room with a non-CRAB patient. Review of online resources from CDC (https://www.cdc.gov/handhygiene/providers/guideline.html) dated 01/30/20, revealed healthcare personnel should complete hand hygiene before moving from a work area of a soiled body part to a clean body site on the same patient and healthcare personnel were to perform hand hygiene in accordance with the CDC recommendations. Review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, dated 2001, revealed contact precautions are implemented for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The individual on contact precautions is placed in a private room, if possible. The staff were to wear gloves and a disposable gown when entering the room. Gloves should be changed after having contact with infective material, and hand hygiene performed after removing gloves. 2) Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included unspecified asthma, immune reconstitution syndrome, and nonrheumatic mitral insufficiency. Review of the most recent MDS 3.0 assessment dated [DATE], revealed Resident #38 cognitively intact. Observation of medication administration on 06/30/26 at 9:22 A.M., by Registered Nurse (RN) #60, revealed she was preparing medications for Resident #38. RN #60 prepared all 11 of Resident #38's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:00 A.M. medications by pushing the medications through the blister foil on medication card and placing each of the medications in her bare hand and then placing the medications into the medication cup. RN #60 administered the medications to Resident #38. RN #60 acknowledge she placed the medications in her bare hand and stated she did not do anything wrong since she used hand sanitizer prior to preparing the medications. 3) Review of the medical record of Resident #21 revealed an admission date of 02/11/26. Diagnoses included major depressive disorder, chronic obstructive pulmonary disease, type 2 diabetes mellitus, morbid obesity, congestive heart failure, GERD, bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #21 had intact cognition. Observation of medication administration on 06/30/26 at 10:40 A.M. by LPN #10, revealed she was preparing medications for Resident #21 when she dropped a dapagliflozin (for diabetes) tablet directly on top of the medication cart. LPN #10 picked up the medication with her bare hand, placed it in the medication cup then administered the medication to Resident #21. LPN #21 verified the observation and stated she should have discarded the medication table that was dropped onto the medication cart. Review of the policy titled, Administering Medications, dated 04/2019 revealed staff followed established facility infection control procedures, examples handwashing, antiseptic technique, gloves, isolation procedures, for the administration of medications, as applicable.