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	01/08/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and staff interview, the facility failed to submit the Payroll Based Journal (PBJ) staffing information to Centers for Medicare and Medicaid Services (CMS) as required. This had the potential to affect all 55 residents residing in the facility. The facility census was 55. Findings include: Review of the PBJ Staffing Data Report [NAME] Report 1705D FY Quarter 3 2025 (April 1 - June 30) dated 12/26/25 revealed the facility failed to submit staffing data for the quarter. Interview with Corporate Human Resources (CHR #300) on 01/08/26 at 2:25 P.M. verified corporate received an alert notifying them of late submission for one of the quarters of fiscal year 2025.

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
	366302	A. Building B. Wing	01/08/2026

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure resident care plans were accurate to reflect the residents needs. This affected three (#2, #3, and #65) of 21 residents reviewed in the sample. The census is 55. Findings include: 1.Review of Resident #2's medical record revealed and admission dated of 12/04/25. Diagnoses listed included bacteremia, hypertension, cellulitis, type two diabetes mellitus, and osteomyelitis. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact. Further review of Resident #2's medical record revealed he was admitted with a urinary catheter (Foley) on 12/04/25 and the Foley remained in place until 01/06/26. Review of physician orders revealed Resident #2 had been ordered the narcotic pain medication oxycodone since admission [DATE]. Review of Resident #2 care plan dated initiated 12/204/25 revealed no focus, goals, or interventions related to a Foley or narcotic medication use. Interview with the Director of Nursing (DON) on 01/08/26 at 8:42 A.M. confirmed Resident #2's care plan did not have no focus, goals, or interventions related to a Foley or narcotic medication use. 2. Review of the medical record for Resident #03 revealed an admission date of 09/17/25 with medical diagnoses of intracranial hemorrhage, left hemiparesis, end stage renal disease (ESRD), and dependence on dialysis. Review of the medical record for Resident #03 revealed a quarterly MDS assessment, dated 12/18/25, which indicated Resident #03 was cognitively intact and required partial/moderate staff assistance with toilet hygiene and showers, and supervision with transfers. The MDS indicated Resident #03 was independent with bed mobility and Resident #03 received dialysis. Review of the medical record for Resident #03 revealed a physician order for dialysis on Monday/Wednesday/Friday at a dialysis center with a chair time at 11:45 A.M. Review of the medical record for Resident #03 revealed no documentation to support the facility developed a comprehensive person-centered dialysis care plan. 3. Review of the medical record for Resident #65 revealed an admission date of 10/03/25 with medical diagnoses of wedge compression fracture of lumbar vertebra, asthma, and convulsions. Review of the medical record for Resident #65 revealed an admission MDS assessment, dated 10/07/25, which indicated Resident #65 was cognitively intact and required partial/moderate staff assistance with bathing and toilet hygiene, substantial/maximum staff assistance with transfers, and (continued on next page)

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	366302	A. Building B. Wing	01/08/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision with eating. Review of the medical record for Resident #65 revealed a physician order dated 10/06/25 for docusate sodium 100 milligram (mg) one capsule by mouth two times per day for constipation, orders dated 10/07/25 for MiraLAX 17 gram per scoop, give one scoop by mouth daily for constipation and enema rectal to insert one applicator rectally one time only for constipation, and an order dated 10/08/25 for Colace one tablet by mouth daily for constipation. Review of the medical record for Resident #65 revealed no documentation to support the facility completed a comprehensive person-centered care plan for constipation. Interview on 01/08/26 at 8:34 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #03 did not have a dialysis care plan. DON also confirmed Resident #65 had received many medications for constipation and was at risk for constipation. DON confirmed the medical record for Resident #65 did have a constipation care plan. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, stated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs would be developed and implemented for each resident. The policy stated the care plan would describe services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.

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	366302	A. Building B. Wing	01/08/2026

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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** Based on medical record review, staff and resident interviews, review of information from Medscape and review of information from the National Library of Medicine, the facility failed to ensure bowel movements were monitored for residents at risk of constipation. This affected one (#2) out of two residents reviewed for constipation. The census was 55. Findings include: Review of Resident #2's medical record revealed and admission dated of 12/04/25. Diagnoses listed included bacteremia, hypertension, cellulitis, type two diabetes mellitus, and osteomyelitis. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact. Review of physician orders revealed an order dated 12/11/25 for oxycodone hydrochloride (narcotic pain medication) oral tablet 5 milligrams (mg) by mouth four times a day for pain. Further review of Resident #2's medical record revealed no documentation of bowel movements being monitored. There was not any documentation of Resident #2's last bowel movement. Interview with Resident #2 on 01/05/26 at 9:37 A.M. revealed it had been 10 days since he had a bowel movement. Resident #2 believed he had been given something to help but did not believe it was working. Interview with the Administrator on 01/07/26 at 10:10 A.M. confirmed there was no documentation of Resident #2 bowel movement being monitored. Review of Medscape revealed oxycodone hydrochloride may cause constipation. Review of information from the National Library of Medicine at https://medlineplus.gov/ency/patientinstructions/000120.htm revealed Constipation is when you do not pass stool as often as you normally do. Your stool may become hard and dry, and it can be difficult to pass. And under the section, When to contact a medical professional, Contact your provider if you have not had a bowel movement in 3 days. This deficiency represent non-compliance investigated under Complaint Number 2642439.

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	366302	A. Building B. Wing	01/08/2026

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations and staff and resident interviews, the facility failed to ensure a resident's indwelling urinary catheter (Foley) was attempted to be removed as ordered. This affected one (#2) of one reviewed for Foley catheter care. The census was 55. Findings include: Review of Resident #2's medical record revealed and admission dated of 12/04/25. Diagnoses listed included bacteremia, hypertension, cellulitis, type two diabetes mellitus, and osteomyelitis. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact. Review of physician orders revealed an order dated 12/30/25 to clamp Foley times four hours then release times 15 minutes, repeat times 24 hours then discontinue Foley. If no voiding may straight catheter every four to six hours and as needed. If post void residual is greater than 500 milliliters times two times replace foley. Further review Resident #2's medical record revealed no documentation of Resident #2's Foley being removed or being attempted to be removed on 12/20/26. Review of progress notes revealed Resident #2 Foley was removed on 01/06/25 per order. Resident #2 was sent to the emergency room (ER) for elevated temperature, elevated pulse rate, and decreased blood pressure. Observation and interview with Resident #2 on 01/05/26 at 12:15 P.M. revealed Resident #2 had an indwelling Foley catheter in place. Resident #2 stated the nurse told him the Foley didn't look right. Interview with the Administrator and the Director of Nursing (DON) on 01/06/25 at 2:25 P.M. confirmed there was no documentation of Resident #2's Foley being removed or attempted to be removed. The DON stated she thought Resident #2's Foley was removed and put back in but confirmed no documentation. This deficiency represents non-compliance investigated under Complaint Number 2650877 and Complaint Number 2650899.

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	366302	A. Building B. Wing	01/08/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview, and review of facility policy, the facility failed to ensure staff cared for a resident's tracheostomy appropriately. This affected one (#10) of one residents reviewed for tracheostomy care. The census was 55. Findings include: Review of Resident #10's medical record revealed an admission date of 01/21/25. Diagnoses listed included chronic obstructive pulmonary disease, coronary artery disease, anxiety disorder, hemiplegia, encephalopathy, and psychotic disturbance. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was rarely understood by staff and received tracheostomy (trach) care. Review of Resident #10's medical record revealed the resident had a trach which was being cared for by nursing staff. Resident #10's tracheostomy care being completed by Licensed Practical Nurse (LPN) #201 was observed on 01/07/25 at 2:05 P.M. LPN #201 removed gloves used during feeding tube care. LPN #201 did not sanitize or wash hands after removing gloves. LPN #201 then opened a tracheostomy care pack that contained sterile gloves, a sterile suction catheter, and sterile box container used for sterile water. LPN #201 did not down any gown or facemask. LPN #201 then unfolded the sterile box and poured sterile water into it. LPN #201 donned sterile gloves and attached the sterile suction catheter to the suction tubing. Wearing sterile gloves, LPN #201 then turned on the suction machine. Both of LPN #201's hands touched the suction machine. LPN #201 then removed Resident #10's inner trach canula with her left hand and discarded it. LPN #201 then used her left hand to guide the suction catheter into Resident #10's trach and suctioned three times, each time clearing the tubing with sterile water. LPN #201 then put in place Resident #10's inner canula using he same sterile gloves used for suctioning. LPN #201 did not change any gloves during the procedure and did not keep any hand sterile. Interview with LPN #201 on 01/12/26 at 2:20 P.M. confirmed she did not down a gown or facemask while performing Resident #10's trach care. LPN #201 confirmed she did not wash or sanitize her hands between gloves changes and also use sterile gloves while touching non-sterile items during the procedure.Review of the facility policy titled Tracheostomy Care dated October 2023 revealed General Guidelines included:1. Aseptic technique must be used:a. during cleaning and sterilization of reusable tracheostomy tubes;b. during all dressing changes until the tracheostomy wound has granulated (healed); andc. during tracheostomy tube changes, either reusable or disposable.2. Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures.3. A mask and eyewear must be worn if splashes, spattering, or spraying of blood or body fluids is likely to occur when performing this procedure.4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly).5. Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies.6. A replacement tracheostomy tube must be available at the bedside at all times.7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times.

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	366302	A. Building B. Wing	01/08/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, staff interview, interview with dialysis staff, review of dialysis treatment logs, and policy review, the facility failed to ensure pre and post dialysis evaluations were completed, failed to ensure communication with dialysis center was consistently done, failed to ensure the medical record contained documentation related to missed dialysis treatments, and failed to ensure the physician was notified of missed dialysis treatments. This affected the one (#03) of one residents reviewed for dialysis services. The facility census was 55. Findings include: Review of the medical record for Resident #03 revealed an admission date of 09/17/25 with medical diagnoses of intracranial hemorrhage, left hemiparesis, end stage renal disease (ESRD), and dependence on dialysis. Review of the medical record for Resident #03 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, which indicated Resident #03 was cognitively intact and required partial/moderate staff assistance with toilet hygiene and showers, and supervision with transfers. The MDS indicated Resident #03 was independent with bed mobility and Resident #03 received dialysis. Review of the medical record for Resident #03 revealed a physician order for dialysis on Monday/Wednesday/Friday at a dialysis center with a chair time at 11:45 A.M. Review of the December 2025 Treatment Administration Record (TAR) indicated Resident #03 received dialysis as scheduled except on 12/08/25, 12/21/25, and 12/23/25. Review of the dialysis center treatment logs for December 2025 revealed Resident #03 refused dialysis on 12/01/25, 12/05/25, 12/29/25, and 12/31/25. Further review of the dialysis treatment logs, revealed Resident #03 missed treatments on 12/03/25, did not receive full dialysis treatment on 12/10/25, 12/15/25, 12/17/25, 12/21/25, and 12/23/25, and the dialysis treatments on 12//22/25 and 12/24/25 were rescheduled. Review of the medical record for Resident #03 revealed no documentation to indicate why Resident #03 had not received dialysis on 12/21/25 or 12/23/25. Further review of the medical record for Resident #03 revealed no documentation to support the facility notified the physician of missed dialysis treatments or the facility completed pre and post dialysis treatment evaluations. Review of the medical record for Resident #03 revealed a dialysis communication form, dated 12/19/25, which stated Resident #03 did not receive a full dialysis treatment. Review of the medical record revealed no other communication forms for December or January 2025 had been completed by the facility. Interview on 01/06/26 at 11:33 A.M. with Dialysis Nurse #320 stated Resident #03 had a history of refusing treatments or not completing a full dialysis treatment. Dialysis Nurse #320 stated Resident #03 last dialysis treatment in December 2025 was on 12/23/25. Dialysis Nurse #320 stated Resident #03 refused her dialysis on 12/31/25 and the nurse informed the facility that Resident #03 would need to get stat potassium levels completed at the hospital before she returned to dialysis. Dialysis Nurse #320 confirmed Resident #03 had not been to the dialysis center since 12/31/25. Interview on 01/08/26 at 8:34 A.M. with the Director of Nursing (DON) confirmed Resident #03's medical record did not have documentation to support the facility staff completed pre/post dialysis evaluations after each treatment, did not have documentation to support the facility communicated with the dialysis center regarding Resident #03's treatments, or that the facility notified the physician of the missed treatments. DON also confirmed the facility had not completed the stat potassium levels as requested by the dialysis center on 12/31/25. DON also confirmed Resident #03's medical record did not have documentation related to missed treatments or partial treatments. Review of the facility policy titled, Hemodialysis Catheters, revised June 2025 stated the nurse should document in the resident's medical record every shift the location of the catheter, condition of dressing, if dialysis was done during shift, any part of report from the dialysis nurse post-dialysis given and observations post dialysis.

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	366302	A. Building B. Wing	01/08/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, and review of facility policy, the facility failed to ensure medications were not left at a resident's bedside. This affected one (#50) out of 55 residents observed during the initial pool. The census was 55. Findings include: Review of Resident #50's medical record revealed an admission date of 09/18/25. Diagnoses listed include atrial fibrillation, heart failure, hypertension, malnutrition, and post-traumatic stress disorder. Review of a quarterly Minimum data Set (MDS) dated [DATE] revealed Resident #50 was cognitively intact. Further review of Resident #50's medical record revealed the nursing staff were to administer the residents medication and there was no assessment, order or care plan for the resident to self-administer medications. Observation on 01/05/26 at 11:22 A.M. revealed several pills in a medication cup and a bottle of Flonase (nasal spray) on a bedside table in Resident #50's room. Interview and observation with Licensed Practical Nurse (LPN) #275 on 01/05/26 at 11:25 A.M. confirmed 14 pills in a medication cup and a bottle of Flonase on Resident #50's bedside table. LPN #275 denied leaving the medications on the bedside and was unsure when they were left there. Resident #50 stated he believed they were left there from the morning. Review of the facility's policy titled Medication Labeling and Storage dated revised February 2023 revealed medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.

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	366302	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure laboratory (labs) values were obtained as per physician orders. This affected three (#02, #03, and #09) residents out of five residents reviewed for lab services. The facility census was 55. Findings include: 1. Review of the medical record for Resident #03 revealed an admission date of 09/17/25 with medical diagnoses of intracranial hemorrhage, left hemiparesis, end stage renal disease (ESRD), and dependence on dialysis. Review of the medical record for Resident #03 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, which indicated Resident #03 was cognitively intact and required partial/moderate staff assistance with toilet hygiene and showers, and supervision with transfers. The MDS indicated Resident #03 was independent with bed mobility and Resident #03 received dialysis. Review of the medical record for Resident #03 revealed a physician order dated 09/29/25 for complete blood count (CBC) and basic metabolic panel (CMP) to be done weekly and faxed to the dialysis center every Monday. Review of the medical record for Resident #03 revealed on 12/22/25 Resident #03 refused CBC and BMP to be done. Review of the medical record revealed no documentation to support the facility obtained or attempted to obtain the CBC and BMP any other dates in December 2025. 2. Review of the medical record for Resident #09 revealed an admission date of 10/17/24 with medical diagnoses of chronic obstructive pulmonary disease (COPD), bipolar disorder, diabetes mellitus, and hypertension. Review of the medical record for Resident #09 revealed a quarterly MDS assessment, dated 12/28/25, which indicated Resident #09 was cognitively intact and required partial/moderate staff assistance with toilet hygiene, showers, and set-up assistance with eating and transfers. Review of the medical record for Resident #09 revealed a physician order dated 10/06/25 for CBC and BMP to be done weekly. Review of the medical record for Resident #09 revealed no documentation to support the facility obtained or attempted to obtain the labs as ordered in November 2025 except on 11/20/25. 3. Review of Resident #02's medical record revealed and admission dated 12/04/25. Diagnoses listed included bacteremia, hypertension, cellulitis, type two diabetes mellitus, and osteomyelitis. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #02 was cognitively intact. Review of progress notes dated 12/30/25 at 4:57 P.M. reviewed laboratory values were reviewed with nurse practitioner (NP) and a new order for a Stat (urgent) chest X-radiation (X-ray) and complete blood count (CBC) on the next laboratory day. Review of physician orders revealed an order dated 12/30/25 for CBC to be drawn next lab day. Review of laboratory results revealed the specimen was obtained on 12/31/25 and noted to be clotted. The results were reported on 01/01/26. Further review of Resident #02's medical record revealed no documentation of the CBC being attempted to be re-drawn or of Resident #02's physician being notified. Resident #02 was discharged to the emergency room (ER) on 01/06/25. Interview on 01/08/26 at 8:40 A.M. with Director of Nursing (DON) confirmed the medical records for Residents #03, #09 and #02 did not contain documentation to support the facility obtained labs as per physician orders. Review of the facilities policy titled Lab and Diagnostic Test Results - Clinical Protocol dated revised November 2018 revealed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs, staff will process test requisitions and arrange for tests, laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.

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	366302	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure staff implemented enhance barrier precautions (EBP). This affected one (#10) of five reviewed for transmission-based precautions (TBP). The census was 55. Findings include: Review of Resident #10's medical record revealed an admission date of 01/21/25. Diagnoses listed included chronic obstructive pulmonary disease, coronary artery disease, anxiety disorder, hemiplegia, encephalopathy, and psychotic disturbance. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was rarely understood by staff and received tracheostomy care. Review of physician orders revealed an order date 09/24/25 for EBP due to the presence of a tracheostomy and feeding tube. Observation of Resident #10's trach care and medication administration per feeding tube on 01/07/2026 2:05 P.M. revealed Licensed Practical Nurse (LPN) #201 did not don a gown when providing care. LPN #201 accessed Resident #10's to administer medications and completed his trach care including deep suctioning. LPN #201 did not down a facemask when performing deep suctioning. Interview with LPN #201 on 01/12/26 at 2:20 P.M. confirmed she did not don a gown during Resident #10's care and that there was a sign posted on the entrance to Resident #10's room informing of staff of EBP. Review of the facility's policy titled Enhanced Barrier Precautions dated December 2024 revealed Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing; bathing/showering; providing hygiene or grooming; changing briefs or assisting with toileting; transferring; providing bed mobility; changing linens; prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing).