

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Delaware		STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015	

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)
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297</p> <p>Based on observation, record review, resident and staff interview, and policy review, the facility failed to provide comprehensive urostomy care for one (#40) of four residents reviewed for indwelling urinary drainage device. The facility identified one resident (#40) who had a urostomy used in his care. The facility census was 85.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident # 40, revealed the resident was admitted to the facility on [DATE]. Diagnoses included unspecified hydronephrosis, perinephric abscess and diabetes mellitus type two.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 was cognitively intact and was to have an indwelling catheter for his urinary elimination.</p> <p>Observation of Resident #40 on 06/24/24 at 2:40 P.M. revealed the resident had a bath basin lying on the floor on the left side of his bed that had a nephrostomy drainage bag lying on the bottom of the basin covered in liquid. The resident had a nephrostomy drainage bag anchored to the right side of his bed frame with a bath basin sitting on the floor under the drainage bag with a small amount of reddish liquid in the bath basin. Interview with Resident #40 at the same time, revealed his nephrostomy tubes were leaking and he had to go to an outside appointment to get them replaced. The resident stated the right bag had been leaking for a week and the left bag had been leaking for three weeks</p> <p>Observation and interview on 06/24/24 at 2:44 P.M. with the Director of Nursing (DON) in Resident #40's room confirmed the nephrostomy bags should not be leaking/draining into bath basins on the floor. The DON verified the left nephrostomy bag was lying in urine in the bath basin and should not be stored in that manner. The DON stated the facility had replacement nephrostomy bags that were delivered last week and available to use. The DON stated the right drainage bag did not have the stopper correctly in place and she corrected its placement and the bag stopped leaking.</p> <p>(continued on next page)</p>

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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Nephrostomy and Cystostomy Tube Care and Maintenance revised on 01/01/22, revealed residents with nephrostomy or cystostomy tubes will receive care consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. The care and maintenance of nephrostomy/cystostomy tubes shall be in accordance with physician orders.</p> <p>Review of facility policy titled Catheter Care Procedure-Urinary revised on 12/28/23 revealed, the facility is to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections, while maintaining their dignity and privacy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154952.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297</p> <p>Based on record review, observation, staff interview, and policy review the facility failed to ensure residents were free from significant medication errors. This affected one (#29) of the six residents observed for medication administration. The facility census was 85.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #29's revealed the resident was admitted on [DATE]. Diagnoses included diabetes mellitus, dementia, cerebrovascular accident (CVA/stroke) and coronary artery disease.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], Revealed Resident #29 was cognitively intact.</p> <p>Review of a physician's order dated [DATE], revealed Resident #29 was ordered to receive Regular Insulin (short acting insulin) 100 units/milliliter (mL) per sliding scale subcutaneously before meals and at bedtime for diabetes. If finger stick blood glucose (FSBG) is 151 milligrams per deciliter (mg/dL) to 200 mg/dL give two units; 201 mg/dL to 250 mg/dL give four units; 251 mg/dL to 300 mg/dL give six units; 301 mg/dL to 350 mg/dL give eight units; 351 mg/dL to 400 mg/dL give 10 units; 401 mg/dL to 450 mg/dL give 12 units and 451 mg/dL to 500 mg/dL give 14 units.</p> <p>Observation of a finger stick blood glucose (FSBG) accucheck for Resident #29 on [DATE] at 7:58 A.M. and completed by LPN #484 revealed a reading of 436 mg/dL.</p> <p>Observation of medication pass for Resident #29 on [DATE] at 8:00 A.M. revealed Licensed Practical Nurse (LPN) #484, removed a bag with a label affixed for Resident #29 which contained a vial of Aspart (rapid acting insulin) insulin. LPN #484 extracted 12 units of the insulin from the vial into an insulin syringe. Further inspection of the vial of insulin revealed the insulin belonged to Resident #40 and was Insulin Lispro (a short acting insulin). The vial was dated as being opened on [DATE]. LPN #484 was observed to proceed to Resident #29's door, knock on the door and announce she had the resident's insulin to administer. Upon entering the room, the surveyor stopped LPN #484 to question the insulin.</p> <p>Observation of the insulin vial on [DATE] at 8:02 A.M. revealed, LPN #484 verified the insulin vial she prepared for Resident #29 belonged to Resident #40 and was dated as being opened on [DATE]. LPN #484 verified the insulin was the wrong resident's insulin, and the insulin was expired.</p> <p>Review of a facility policy titled Medication Administration Subcutaneous Insulin revised on ,d+[DATE] revealed, the facility would administer subcutaneous insulin as ordered and in a safe, accurate and effective manner. The facility staff would check the prescriber's order for insulin,</p> <p>obtain the insulin, check the expiration date, and the date of vial after first use.</p> <p>Review of the facility policy titled Medication Administration revised on [DATE] revealed,</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medications are administered by license nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review the medication administration record (MAR) to identify medication to be administered, compare the medication source with MAR to verify the resident's name, medication name, form, dose, route, and time of administration.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154994 and OH00154453.</p>		