| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365408 | A. Building<br>B. Wing | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Delaware | 2270 Warrensburg Road<br>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) |
|---|---|
| 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** 46613<br><br>Based on medical record review, staff interview, and policy review, the facility failed to notify a physician of change in resident's status. This affected one (#88) out of three residents reviewed for catheter care. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #88 revealed an admitted [DATE] with medical diagnoses of congestive heart failure (CHF), diabetes mellitus (DM), hypertensive heart disease, atherosclerosis heart disease (ASHD), cerebral infarction, and obstructive uropathy, Review of the medical record for Resident #88 revealed a discharge date of [DATE]. Review of the medical record revealed Resident #88 received Hospice services effective 06/27/24.<br><br>Review of the medical record for Resident #88 revealed an admission Minimum Data Set (MDS) assessment, dated 07/02/24, which indicated Resident #88 had moderate cognitive impairment and required set-up assistance for eating and was dependent for toilet hygiene, bathing, bed mobility and transfers. The MDS indicated Resident #88 had an indwelling catheter.<br><br>Review of the medical record for Resident #88 revealed a physician order dated 06/27/24 for hospice services for terminal diagnosis of hypertensive heart disease with heart failure and an order dated 07/03/24 to change indwelling catheter size to 16 French with 10 cubic centimeter (CC) balloon as needed.<br><br>Review of the medical record for Resident #88 revealed a nurse's note dated 07/03/24 at 8:04 A.M. with stated the State tested Nursing Assistant (STNA) informed the nurse that Resident #88 had pulled out his indwelling catheter with the balloon still inflated. The note stated Resident #88 refused to allow facility staff to insert a new indwelling catheter. The note continued to state the nurse reported to the incident to the next nurse and that nurse was to notify hospice about the situation. Review of the medical record for Resident #88 revealed no documentation to support the facility staff notified the hospice provider or Resident #88's physician that Resident #88 pulled out his indwelling catheter and refused to have a new catheter inserted.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medical record for Resident #88 revealed a Hospice note dated 07/03/24 by Hospice nurse #180 which stated upon arrival Resident #88's abdomen was soft, nontender and slight rigid prior to reinsertion of indwelling catheter. The note stated the facility staff had not notified the hospice provider that Resident #88 had pulled out his indwelling catheter earlier that morning. The note continued to state Hospice nurse #180 spoke with the facility nurse, aides, and Director of Nursing (DON) related to concerns that facility staff had not notified the hospice provider that Resident #88 had pulled out his indwelling catheter and that Resident #88 was found sitting in blood.<br><br>Interview on 08/20/24 at 1:41 P.M. with Hospice nurse #180 stated the hospice provider was not notified by the facility staff that Resident #88 had pulled out his indwelling catheter on 07/03/24. Hospice nurse #88 stated she visited Resident #88 on 07/03/24 and found the resident sitting in bed with blood on his sheet and noticed he did not have an indwelling catheter inserted. Hospice nurse #180 stated upon questioning the facility staff they informed her Resident #88 had pulled out his catheter about six hours prior to her visit. Hospice nurse #180 stated upon arrival Resident #88's abdomen was distended, and she was able to reinsert the indwelling catheter with minimal blood. Hospice nurse #180 stated Resident #88 had two liters of urine output upon insertion of indwelling catheter.<br><br>Interview on 08/22/24 at 9:27 A.M. with the DON confirmed the medical record for Resident #88 did not contain documentation to support the facility staff notified the hospice provider or Resident #88's physician that Resident #88 pulled out his indwelling catheter and refused to have the catheter reinserted.<br><br>Review of the facility policy titled, Notification of changes, revised 01/01/22, stated the facility would promptly inform the resident, consult the resident's physician, and notify, consistent with his/her authority, resident representative when there is change requiring notification. The policy stated circumstances requiring notification included circumstances that require a need to alter treatment or a significant change in the resident's physician, mental or psychosocial condition such as clinical complications.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. |

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| | 365408 | A. Building<br>B. Wing | 08/22/2024 |

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| Arbors at Delaware | 2270 Warrensburg Road<br>Delaware, OH 43015 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>49794<br><br>Based on observations, staff and resident interviews, and policy review, the facility failed to maintain a clean and homelike environment. This affected three (#24, #4, and #8) of three residents reviewed for the physical environment. The facility census was 85.<br><br>Findings include:<br><br>1. Observation on 08/19/24 at of privacy curtain in middle of room for Resident #4 revealed curtain had small brown streaks scattered over the curtain.<br><br>2. Observation on 08/19/24 at 11:75 A.M. of the curtains in Resident #24's room revealed a brown streak on the middle of the curtain midway up, with black streaks and spots scattered along the bottom of the curtain.<br><br>3. Observation on 08/20/24 at 8:37 A.M. of privacy curtain for Resident #8 revealed curtain dirty with white spots and brown streaks scattered on the curtain.<br><br>Interview on 08/20/24 at 8:37 A.M. with Resident #8 confirmed curtain in room was dirty with white spots and streaks of brown scattered across the privacy curtain. Resident #8 confirmed if they were at home they would not allow their curtains to look like that and they would clean them.<br><br>Interview on 08/19/24 at 1:37 P.M. with Housekeeping Supervisor #185 confirmed brown smudge on curtains in the room of Resident #4 and a brown streak midway up in the middle of the curtains for Resident #24 and scattered black streaks along the bottom of the curtain. Housekeeping Supervisor #185 stated they had just transferred to this building and is unsure when the curtains were last cleaned. Housekeeping Supervisor #185 revealed the curtains should be cleaned during a deep clean of the room and as needed when they are dirty.<br><br>Interview on 08/19/24 at 2:32 P.M. with State tested Nursing Assistant (STNA) #111 revealed they are unaware of when privacy curtains get cleaned but does not think they have extras to be able to take them down to clean them.<br><br>Review of Healthcare Services Group, Inc. Housekeeping In-service dated 01/01/2000 revealed curtains should be checked with every room clean, and staff should report any soiled or damaged curtains to the housekeeping supervisor.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156859. |

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| Arbors at Delaware | 2270 Warrensburg Road<br>Delaware, OH 43015 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613<br><br>Based on medical record review, staff interviews, Hospice nurse interview, and review of the Resident Assessment Instrument (RAI) manual 3.0, the facility failed to ensure care plan was updated to include accurate Activities of Daily Living (ADL) information. This affected one (#88) out of the three residents reviewed for feeding assistance. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #88 revealed an admitted [DATE] with medical diagnoses of congestive heart failure (CHF), diabetes mellitus (DM), hypertensive heart disease, atherosclerosis heart disease (ASHD), cerebral infarction, and obstructive uropathy, Review of the medical record for Resident #88 revealed a discharge date of [DATE]. Review of the medical record revealed Resident #88 received Hospice services effective 06/27/24.<br><br>Review of the medical record for Resident #88 revealed an admission Minimum Data Set (MDS) assessment, dated 07/02/24, which indicated Resident #88 had moderate cognitive impairment and required set-up assistance for eating and was dependent for toilet hygiene, bathing, bed mobility and transfers. The MDS indicated Resident #88 had an indwelling catheter.<br><br>Review of the medical record for Resident #88 revealed an Activities of Daily Living (ADL) care plan, dated 06/07/24, which indicated Resident #88 required supervision with eating and to offer assistance with meal set-up as needed.<br><br>Review of the medical record for Resident #88 revealed a Hospice note dated 07/01/24 by the Hospice nurse that Resident #88 was noted to have food in his mouth upon her arrival and informed the facility nurse that Resident #88 was to be a feed assist and diet was changed to pureed diet. Further review of the Hospice notes revealed a note dated 07/26/24 by the Hospice Social Worker which stated upon arrival Resident #88 appeared disheveled with pieces of food on himself and his bed. The note stated the Hospice Social Worker asked Resident #88 if staff fed him his meals and Resident #88 stated no.<br><br>Interview on 08/20/24 at 1:41 P.M. with Hospice Nurse #180 stated on multiple visits to Resident #88 after 07/01/24 for she would find his meal trays sitting on his bedside table set-up, but the meal was untouched. Hospice Nurse #88 stated staff had not provided feeding assistance as instructed on 07/01/24.<br><br>Interview on 08/21/24 at 11:43 A.M. with State tested Nursing Assistant (STNA) #111 confirmed she took care of Resident #88 when he was at the facility until he discharged . STNA #111 stated she would bring Resident #88's meal trays to his room and set-up his tray on the bedside table. STNA #111 stated at times she would assist Resident #88 with his meals but not all the time and stated she was not aware Resident #88 required staff to assist with feeding.<br><br>(continued on next page) |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/22/24 at 9:27 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #88 did not contain documentation to support the facility staff provided assistance with feeding Resident #88 his meals as recommended by Hospice on 07/01/24. DON also confirmed Resident #88's care plan did not contain documentation to support Resident #88 required extensive to dependent staff assistance for feeding of meals.<br><br>Review of the RAI manual, page 2-44, stated the facility Interdisciplinary Team (IDT) must evaluate the information gained to develop a care plan that addresses the resident's foals, preferences, strengths, problems, and needs. The manual also stated the care plan would need to be revised based on changing goals, preferences, and needs of the resident.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613<br><br>Based on medical record review, staff interviews, Hospice nurse interview, and policy review, the facility failed to ensure activity of daily living (ADL) assistance was provided for dependent resident. This affected one (#88) out of the three residents reviewed for feeding assistance. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #88 revealed an admitted [DATE] with medical diagnoses of congestive heart failure (CHF), diabetes mellitus (DM), hypertensive heart disease, atherosclerosis heart disease (ASHD), cerebral infarction, and obstructive uropathy, Review of the medical record for Resident #88 revealed a discharge date of [DATE]. Review of the medical record revealed Resident #88 received Hospice services effective 06/27/24.<br><br>Review of the medical record for Resident #88 revealed an admission Minimum Data Set (MDS) assessment, dated 07/02/24, which indicated Resident #88 had moderate cognitive impairment and required set-up assistance for eating and was dependent for toilet hygiene, bathing, bed mobility and transfers. The MDS indicated Resident #88 had an indwelling catheter.<br><br>Review of the medical record for Resident #88 revealed an Activities of Daily Living (ADL) care plan, dated 06/07/24, which indicated Resident #88 required supervision with eating and to offer assistance with meal set-up as needed.<br><br>Review of the medical record for Resident #88 revealed a physician order dated 07/01/24 for regular diet, pureed texture, thin liquids.<br><br>Review of the medical record for Resident #88 revealed a Hospice note dated 06/21/24 which stated upon the Hospice Social Workers arrival resident's breakfast tray was observed on bedside tablet despite it being almost lunchtime. The note stated the plate had a few scoops of eggs and oatmeal off of the tray however, the eggs were noted on Resident #88's tray and the oatmeal was on the bedside table. The note continued to state Resident #88's fork was on the floor beside the bed. Review of the Hospice notes revealed a note dated 07/01/24 by the Hospice nurse that Resident #88 was noted to have food in his mouth upon her arrival and informed the facility nurse that Resident #88 was to be a feed assist and diet was changed to pureed diet. Further review of the Hospice notes revealed a note dated 07/26/24 by the Hospice Social Worker which stated upon arrival Resident #88 appeared disheveled with pieces of food on himself and his bed. The note stated the Hospice Social Worker asked Resident #88 if staff fed him his meals and Resident #88 stated no.<br><br>Review of the medical record for Resident #88 revealed ADL documentation from 07/22/24-07/31/24 that staff provided set-up to supervision for all meals except for lunch on 07/28/24.<br><br>Interview on 08/20/24 at 1:41 P.M. with Hospice Nurse #180 stated on multiple visits to Resident #88 after 07/01/24 for she would find his meal trays sitting on his bedside table set-up, but the meal was untouched. Hospice Nurse #88 stated staff had not provided feeding assistance as instructed on 07/01/24.<br><br>(continued on next page) |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/21/24 at 11:43 A.M. with State tested Nursing Assistant (STNA) #111 confirmed she took care of Resident #88 when he was at the facility until he discharged . STNA #111 stated she would bring Resident #88's meal trays to his room and set-up his tray on the bedside table. STNA #111 stated at times she would assist Resident #88 with his meals but not all the time and stated she was not aware Resident #88 required staff to assist with feeding.<br><br>Interview on 08/22/24 at 9:27 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #88 did not contain documentation to support the facility staff provided assistance with feeding Resident #88 his meals as recommended by Hospice on 07/01/24. DON also confirmed Resident #88's care plan did not contain documentation to support Resident #88 required extensive to dependent staff assistance for feeding of meals.<br><br>Review of the facility policy titled, Activities of Daily Living, revised 12/28/23, stated a resident who is unable to carry out ADL's receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613<br><br>Based on medical record review, staff interviews, Hospice nurse interview, and policy review, the facility failed to properly assess and treat a resident's skin breakdown. This affected one (#88) out of three residents reviewed for skin breakdown. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #88 revealed an admitted [DATE] with medical diagnoses of congestive heart failure (CHF), diabetes mellitus (DM), hypertensive heart disease, atherosclerosis heart disease (ASHD), cerebral infarction, and obstructive uropathy, Review of the medical record for Resident #88 revealed a discharge date of [DATE]. Review of the medical record revealed Resident #88 received Hospice services effective 06/27/24.<br><br>Review of the medical record for Resident #88 revealed an admission Minimum Data Set (MDS) assessment, dated 07/02/24, which indicated Resident #88 had moderate cognitive impairment and required set-up assistance for eating and was dependent for toilet hygiene, bathing, bed mobility and transfers. The MDS indicated Resident #88 had an indwelling catheter. The MDS indicated Resident #88 was at risk for skin breakdown, did not have any skin issues, and application of dressing and ointments were done.<br><br>Review of the medial record for Resident #88 revealed an impaired skin integrity care plan, dated 07/05/24, which stated Resident #88 had moisture associated skin damage (MASD) and an intervention of treatment as ordered. Review of the medical record for Resident #88 revealed no other impaired skin integrity care plans.<br><br>Review of the medical record for Resident #88 revealed a physician order dated 07/06/24 for sacral wound to cleanse with normal saline, pat dry, apply triad paste, and cover with foam dressing. The order was discontinued on 07/08/24. Review of the medical record revealed an order dated 07/09/24 for weekly skin assessments. Review of the medical record for Resident #88 revealed no documentation to support any other wound/skin breakdown treatments were ordered.<br><br>Review of the medical record for Resident #88 revealed weekly skin assessments completed as ordered and no skin issues were noted. Review of the medical record for Resident #88 revealed no documentation to support any wound/skin breakdown measurements were completed by the facility staff.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the medical record for Resident #88 revealed a hospice nurse note dated 07/01/24 which stated Resident #88 was observed to have skin tear to top of coccyx about the size of a dime and the facility nurse was notified. Further review of hospice nurse notes revealed a note dated 07/03/24 that stated Resident #88 has a small wound on coccyx which was 1-1.5 centimeters (cm) in length, open, no tunneling, blanchable and the facility nurse was notified. Review of a hospice nurse note dated 07/05/24 stated Resident #88 had a small skin tear to top of coccyx and was being treated appropriately. A hospice nurse note dated 07/09/24 stated the area to Resident #88's coccyx was healing, closed, blanchable and dressing was in place. Review of a hospice nurse note dated 07/26/24 stated that Resident #88 was noted to have a dark purple, non-blanchable area to coccyx which measured 1 cm by 1.5 cm and a dressing was applied. The note also stated Resident #88 had skin tear to three toes on right foot and the facility nurse was updated on skin breakdown. Further review of the medical record revealed a hospice nurse note dated 07/31/24 which stated Hospice nurse #180 provided incontinence care for Resident #88 and at the time of the care Resident #88 was noted to have the same dressing in place to his coccyx that was applied on 07/26/24 by Hospice nurse #180. The note stated upon removal of the old dressing the coccyx wound was noted to be larger, wet and deep and another pressure ulcer was noted. The note stated the hospice staff expedited Resident #88's transfer from the facility to another facility due to concerns related to care. The note did not contain documentation to support wound measurements were completed while at the facility.<br><br>Interview on 08/20/24 at 1:41 P.M. with Hospice nurse #180 stated Resident #88 was noted to have a area to his coccyx on 07/26/24 and a treatment was applied and the facility nurse was updated on the area and the treatment orders. Interview with Hospice nurse #180 stated she visited Resident #88 on 07/31/24 and when assisted the hospice aide with incontinence care for Resident #88 noted the same dressing was in place to his coccyx that she had placed on 07/26/24. Hospice nurse #180 stated she had dated the dressing on 07/26/24 and that was how she knew the dressing had not been changed. Hospice nurse #180 stated upon removal of the coccyx dressing there was an odor to the wound, it had opened, and had tunneling. Hospice nurse #180 stated the wound was not measured because the hospice staff started working on transferring Resident #88 to another facility. Hospice nurse #180 stated Resident #88 discharged to another facility on 07/31/24.<br><br>Interview on 08/21/24 at 11:35 A.M. with Licensed Practical Nurse (LPN) #114 stated she completed a skin assessment on Resident #88 on 07/30/24 and did not see any skin issues.<br><br>Interview on 08/22/24 at 9:27 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #88 did not contain documentation to support the facility had not assessed, documented, or obtained treatment orders for the skin breakdown noted by the hospice provider on 07/01/24, 07/03/24, 07/05/24, and 07/26/24.<br><br>Review of the facility policy titled, Pressure ulcer/skin breakdown protocol, revised 03/20/24 stated all pressure ulcers or other skin related issues are measured and documented in the medical record. The policy stated the staff would notify physician and RR of all new and/or non-healing/worsening pressure ulcers and the physician would authorize pertinent orders related to wound treatments.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. |

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| (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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613<br><br>Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure residents were from significant med errors. This affected two (#20 and #85) residents out of the six residents reviewed for medication administration. The facility census was 85.<br><br>Findings include:<br><br>49794<br><br>1. Review of medical chart for Resident #85 revealed and admitted [DATE]. Diagnoses include Parkinson's, cerebral infarction, atrial fibrillation, hypertension, abdominal aortic aneurysm, and anemia.<br><br>Review of the Minimum Data Set (MDS) dated [DATE] for Resident #85 revealed resident cognitively impaired. MDS for Resident #85 indicates resident requires extensive assistance with transfers, eating, toileting, and bed mobility.<br><br>Review of orders for Resident #85 revealed orders including an order dated 07/19/24 for lisinopril oral tablet 20 milligrams (mg), give one tablet by mouth one time a day related to essential hypertension. Hold for systolic blood pressure less than 110.<br><br>Review of blood pressure (BP) readings for Resident #85 revealed resident's blood pressure recorded on 08/11/24 was 97/61 at 11:55 A.M.<br><br>Review of medication administration record (MAR) for August revealed resident dose of lisinopril scheduled for 9:00 A.M. administration. Review of MAR shows resident received lisinopril every day in August, including on 08/11/24.<br><br>Interview on 08/21/24 at 12:20 P.M. with the Director of Nursing (DON) confirmed Resident #85 has an order to hold the lisinopril if the systolic blood pressure is less than 110. The DON confirmed Resident #85 received the lisinopril on 08/11/24 despite the residents blood pressure being 97/61.<br><br>2. Review of medical chart for Resident #20 revealed an admitted d of 01/21/22. Diagnoses include atherosclerotic heart disease, hemiplegia and hemiparesis following cerebral infarction, hypertension, and hyperlipidemia.<br><br>Review of the MDS dated [DATE] for Resident #20 revealed resident cognitively intact. MDS for Resident #20 revealed resident dependent for toileting, dressing, and transferring.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365408 | A. Building<br>B. Wing | 08/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Delaware | 2270 Warrensburg Road<br>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.

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of order for Resident #20 revealed orders include an order date 11/14/22 for lisinopril tablet 30 milligrams mg give one tablet by mouth one time a day related to hypertension. Hold for systolic less than 110, an order date 11/14/22 for metoprolol succinate extended-release tablet 24-hour 100 mg give one tablet by mouth one time a day for beta blocker related to hypertension. Hold for systolic lower than 110 or heart rate lower than 55, and order dated 08/02/24 metoprolol succinate extended release 24-hour 50 mg give one tablet by mouth one time a day for beta blocker related to hypertension<br><br>Review of blood pressure (BP) documentation for Resident #20 revealed BP reading of 108/66 on 08/14/24 and 106/66 on 08/21/24.<br><br>Review of August Medication Administration Record (MAR) for Resident #20 revealed administration of lisinopril 30 mg tablet administered every day on August, including on 08/14/24 and 08/21/24.<br><br>Review of August MAR for Resident #20 revealed administration of metoprolol succinate extended release 24 hours 100 mg administered every day in August, including 08/14/24 and 08/21/24.<br><br>Interview on 08/21/24 at 12:20 P.M. with the DON confirmed Resident #20 received their blood pressure medications on 08/14/24 and 08/21/24 despite the residents blood pressure being out of the physician orders parameters to hold the medication.<br><br>Review of Medication Administration policy dated 10/30/2020 revised 1/17/2023 revealed medications will be administered as ordered by the physician and in accordance with professional standards or practice.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. This deficiency represents ongoing noncompliance from the complaint surveys completed 06/26/24 and 07/24/24. |

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| Arbors at Delaware | 2270 Warrensburg Road<br>Delaware, OH 43015 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613<br><br>Based on medical record review, staff interview, Hospice nurse interview, and policy review, the facility failed to ensure coordination of care and services with the Hospice provider. This affected one (#88) out of the three residents reviewed for catheter care. The facility census was 85.<br><br>Findings include:<br><br>Review of the medical record for Resident #88 revealed an admitted [DATE] with medical diagnoses of congestive heart failure (CHF), diabetes mellitus (DM), hypertensive heart disease, atherosclerosis heart disease (ASHD), cerebral infarction, and obstructive uropathy, Review of the medical record for Resident #88 revealed a discharge date of [DATE]. Review of the medical record revealed Resident #88 received Hospice services effective 06/27/24.<br><br>Review of the medical record for Resident #88 revealed an admission Minimum Data Set (MDS) assessment, dated 07/02/24, which indicated Resident #88 had moderate cognitive impairment and required set-up assistance for eating and was dependent for toilet hygiene, bathing, bed mobility and transfers. The MDS indicated Resident #88 had an indwelling catheter.<br><br>Review of the medical record for Resident #88 revealed a physician order dated 06/27/24 for hospice services for terminal diagnosis of hypertensive heart disease with heart failure and an order dated 07/03/24 to change indwelling catheter size to 16 French with 10 cubic centimeter (CC) balloon as needed.<br><br>Review of the medical record for Resident #88 revealed a nurse's note dated 07/03/24 at 8:04 A.M. with stated the State tested Nursing Assistant (STNA) informed the nurse that Resident #88 had pulled out his indwelling catheter with the balloon still inflated. The note stated Resident #88 refused to allow facility staff to insert a new indwelling catheter. The note continued to state the nurse reported to the incident to the next nurse and that nurse was to notify hospice about the situation. Review of the medical record for Resident #88 revealed no documentation to support the facility staff notified the hospice provider or Resident #88's physician that Resident #88 pulled out his indwelling catheter and refused to have a new catheter inserted.<br><br>Review of the medical record for Resident #88 revealed a Hospice note dated 07/03/24 by Hospice nurse #180 which stated upon arrival Resident #88's abdomen was soft, nontender and slight rigid prior to reinsertion of indwelling catheter. The note stated the facility staff had not notified the hospice provider that Resident #88 had pulled out his indwelling catheter earlier that morning. The note continued to state Hospice nurse #180 spoke with the facility nurse, aides, and Director of Nursing (DON) related to concerns that facility staff had not notified the hospice provider that Resident #88 had pulled out his indwelling catheter and that Resident #88 was found sitting in blood.<br><br>(continued on next page) |

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| | 365408 | A. Building<br>B. Wing | 08/22/2024 |

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| Arbors at Delaware | 2270 Warrensburg Road<br>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.

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/20/24 at 1:41 P.M. with Hospice nurse #180 stated the hospice provider was not notified by the facility staff that Resident #88 had pulled out his indwelling catheter on 07/03/24. Hospice nurse #88 stated she visited Resident #88 on 07/03/24 and found the resident sitting in bed with blood on his sheet and noticed he did not have an indwelling catheter inserted. Hospice nurse #180 stated upon questioning the facility staff they informed her Resident #88 had pulled out his catheter about six hours prior to her visit. Hospice nurse #180 stated upon arrival Resident #88's abdomen was distended, and she was able to reinsert the indwelling catheter with minimal blood. Hospice nurse #180 stated Resident #88 had two liters of urine output upon insertion of indwelling catheter.<br><br>Interview on 08/22/24 at 9:27 A.M. with the DON confirmed the medical record for Resident #88 did not contain documentation to support the facility staff notified the hospice provider or Resident #88's physician that Resident #88 pulled out his indwelling catheter and refused to have the catheter reinserted.<br><br>Review of the facility policy titled, Hospice, revised 10/26/23 stated when a resident chooses to receive Hospice care and services, the facility would coordinate and provide in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. The policy stated the facility would immediately contact and communicate with the hospice staff, attending physician/practitioner, and family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156464. |

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| Arbors at Delaware | 2270 Warrensburg Road<br>Delaware, OH 43015 |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>49794<br><br>Based on observations, staff and resident interviews, and policy review, the facility failed to maintain pest control in hallways and resident rooms. This affected two (#4 and #24) of three residents reviewed for the effective pest control. The facility census was 85.<br><br>Findings included:<br><br>1. Observation and interview on 08/19/24 at 11:48 A.M. with Resident #4 revealed a lot of flies and a few gnats in the room especially around the privacy curtain in the middle of the room. Resident #4 confirmed the flies really bothered them and they want them gone from the room.<br><br>2. Observation and interview on 08/19/24 at 11:57 A.M. with Resident #24 revealed some flies and gnats in the room, especially by the privacy curtain in the middle of the room. Resident #24 said the flies drive them crazy and they have to sleep with a blanket over their head to keep the flies off of them. Resident #24 revealed they had asked staff to please get them a fly strip to get rid of the flies.<br><br>Interview on 08/19/24 at 2:32 P.M. with State tested Nursing Assistant (STNA) #111 confirmed the presence of flies and gnats in hallway and Resident #24 and #4's rooms. STNA #111 revealed when flies and gnats are noted they let housekeeping know and try to go into rooms and look for food and trash and clean up the room. If cleaning doesn't help, then it is reported to maintenance through a facility communication system.<br><br>Interview on 08/19/24 at 1:37 P.M. with Housekeeping Supervisor confirmed the presence of flies in the room of Resident #24 and #4.<br><br>Interview on 08/19/24 at 2:20 P.M. with Maintenance #163 confirmed the presence of flies in the hallway and rooms for Resident #24 and Resident #4. Maintenance #163 revealed Pest Control Company #9 comes once a month per their contract with the facility but would come more often if needed. Maintenance #163 revealed if they can fix the pest issue then they will, but if they cannot they contact Pest Control Company #9. Staff put report in the facility communication system and that tells him what he need to take care of.<br><br>Review of facility policy titled Pest Control Program, dated 08/14/20, revealed it is the facility policy to maintain an effective pest control program that eradicates and contains common household pests and rodents.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00156859. |