Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 09/12/2024
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49793 Based on medical record review, review of facility investigation, review of personnel files, review of inservice logs, resident and family interiews, and staff interview, the facility failed to ensure residents were treated with dignity and respect. This affected two (#83 and #75) residents of six residents reviewed for respect and dignity. The facility census was 84. Findings include: 1. Record review of Resident #83 revealed an admission on 08/16/24. Diagnoses included congestive heart failure, obstructive sleep apnea, type II diabetes, and morbid obesity. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #83 had intact cognition. Review of the physician's orders dated 09/05/24 revealed Resident #83 can receive diphenhydramine (Benadryl) 50 milligrams (mg) orally every six hours as needed (prn) and oxycodone 10 mg orally every six hours prn for pain relief. Review of Licensed Practical Nurse (LPN) #138's personnel record revealed Performance Improvement Form dated 08/05/24 for LPN #138 with expectations LPN #138 will conducte herself in a professional manner with residents and family members. LPN #138 will not slam items. Review of an inservice log dated 08/13/24 revealed LPN #138 attended inservice education regarding customer service. Review of the Quality Assurance Form dated 08/26/24 revealed Resident #83 reported LPN #177 was rude. LPN #18 was terminated. Review of the facility investigation related to an allegation of poor resident customer service, created by the facility on 08/31/24 and 09/06/24, revealed Resident #83 stated LPN #138 exhibited poor customer service while providing morning care and medication administration upon the request of the resident. Other residents on the same unit were interviewed and Resident #75 stated LPN #138 could be rude at times. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation revealed an interview dated 09/06/24 with Resident #83 who stated LPN #138 was harsh, caused her to be upset, uncomfortable, and spoke to her disrespectfully. Review of investigation revealed a Disciplinary Action Form within the 09/06/24 facility investigation, dated 09/06/24, which revealed LPN #138 received a final written warning for poor customer service with verbal and body language appearing rude to residents. Improvement needed was noted to be LPN #138 needed to work on her customer service and had been educated two times previously. She needed to watch her tone with the residents as well as her body language. Interview on 09/09/24 at 12:04 P.M. with Resident #83 revealed the past weekend the resident had placed her light on and the state tested nurse aide (STNA) came in a timely manner and asked of her request. Resident #83 told the STNA she wanted to have pain medication and a Benadryl, which are prn orders. The STNA stated she would deliver the request to the nurse on duty, LPN #138. The nurse came in with the pain pill and acted really snotty. Resident #83 stated She really had an attitude. Resident #83 asked her if she could give her the Benadryl table as well and the nurse got huffy and stormed out of the room slamming the door. In the mean time she received a call from a family member and the nurse came back in with the Benadryl tablet. The resident stated she verbalized in a civil tone her displeasure with the nurse's rude behaviors and the nurse stated Do you want the pill or not? so the resident took the tablet from her and requested she leave my room. When she left, she slammed the door again. Interview on 09/09/24 at 1:28 P.M. with the family of Resident #83 revealed on 08/31/24 at approximately 1:30 AM, the family member was on the phone with her sister, Resident #83, talking to her about her inability to sleep and having some pain. The family member advised her to request some pain medications. While still on the phone, Resident #83 put on the call light and a State tested Nurse Aide (STNA) arrived to receive Resident #83's request for pain meds, which she has as prn orders to have. Resident #83 requested a pain pill and a Benadryl for sleep assistance. The STNA verified the request and stated she would report this to the nurse. While still on the phone with Resident #83, the nurse, LPN #138, came in the room with very strong attitude about having to get the medications, slamming the door when she left the room. When the nurse came back she was very disrespectful and rude to the family member's sister. When Resident #83 asked about the Benadryl, the nurse seemed to get angry and left the room again slamming the door. The nurse returned to the room and Resident #83 addressed the way the nurse was making her feel as disrespectful and rude. The nurse was overheard stating Are you going to take this or not? Resident #83 stated Yes I will take the pill and then you can leave my room. When the nurse left the room, she slammed the door a third time. Resident #83 then stated to the family member she was upset with the treatment from the nurse and was hesitant on turning her call light on for other requests in fear the same nurse will come back and mistreat her again. Interview on 09/10/24 at 10:00 A.M. with the Director of Nursing (DON) revealed there were two staff identified for being rude with poor customer service. This included a prior incident with LPN #177 who's employment was terminated and LPN #138 who was disciplined with a final written warning. Both staff members were trained upon hire and received continuous education along with quarterly meetings/trainings which have included customer service. The DON stated she had one report of a resident treated poorly since they let go of LPN #177. This new report happened the prior week when a resident's family member called in a complaint, which they addressed. The DON stated there have been no other resident's complaining to their daily care consultants at this point. The DON stated LPN #138 had just received an in-service on customer service and resident rights on 08/13/24. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional interview on 09/10/24 at 2:15 P.M. with Resident #83 revealed LPN #138 comes in and behaves as if she is too busy to help them, storms around huffing and puffing and slamming doors. The resident stated both times the LPN had to come in and assist her she had to ask her to leave because of the way she was making her feel which she does not get from any other nurse at the facility. 2. Record review revealed Resident #75 was initially admitted to the facility on [DATE]. Diagnoses included diabetes with neuropathy, frequent falls, bladder neuropathies, muscle weakness, heart disease, morbid obesity and major depressive disorder. Review of Resident #75's MDS assessment, dated 06/23/24, revealed the resident had intact cognition. Interview on 09/09/24 at 10:20 A M with Resident #75 revealed most of the staff will answer call lights in a timely fashion and it all depends on who is working. One nurse, LPN #138, has a bit of an attitude. Resident #75 stated LPN #138 doesn't treat her abusively or neglectfully but carries around an attitude and was just not nice to her. Resident #75 stated if she knows LPN #138 is on duty, she will refuse to use her call light because she don't feel she needs to be disrespected by a nurse. Resident #75 stated she has reported this to the DON. Interview on 09/10/24 at 10:00 A.M. with the Administrator confirmed she was unaware of any other reports of poor customer service from staff, including LPN #138, to any other resident as there were no other interviews completed other than daily caring partner visits. The Administrator explained LPN #138 was recently in-serviced on 08/31/24 on customer service. Interview on 09/10/24 at 10:00 A.M. the DON stated she was unaware of Resident #75 having a report of LPN #138 being mean or rude. The non-compliance substantiates Complaint Number OH00157666.