STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365408	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Delaware	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a Self-Reported Incident (SRI), review of facility video, staff and resident interview, and facility policy review, the facility failed to ensure Resident #10 was free from abuse from Resident #20. This resulted in Actual Harm on 10/18/25 at 2:34 P.M. when Resident #20 walked up to Resident #10 in the hallway. Resident #20 pushed Resident #10, resulting in Resident #10 suffering nondisplaced fractures of the left superior and inferior pubic rami. This affected one, (Resident #10) of three residents reviewed for abuse. The facility census was 90. Findings Include: Review of the medical record for Resident #10 revealed an admission date of 08/27/25. Diagnoses included vascular dementia with behavior problems, encephalopathy, cerebrovascular accident (CVA), Type II Diabetes and depression. She resided in the secured memory care unit. Review of Resident #10's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was severely cognitively impaired and required the assistance of one person with activities of daily living. Resident #10 ambulated independently. Review of the medical record for the Resident #20 revealed an admission date of 07/11/25 from a hospitalization for altered mental status and aggressive behaviors. Diagnoses included dementia, Type II Diabetes, anemia, restlessness and other disorders of the brain. He resided in the secured memory care unit for safety related to wandering. Review of Resident #20's State Optional MDS assessment dated [DATE] revealed Resident #20 was mildly cognitively impaired and required supervision with his daily activities. Resident #20 had physical behaviors directed toward others during the one to three days of the look back period and verbal behaviors directed towards others four to six days of the look back period. Review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 was mildly cognitively impaired and independent with his daily activities. Resident #20 had physical behaviors directed toward others during the one to three days of the look back period and Resident #20 had no verbal behaviors. Review of Resident #20's Plan of Care dated 08/06/25 included the resident had behaviors related to cognitive impairment evidence by refusing medications, witnessed purposely sitting on the floor, physical aggression and verbal aggression. Interventions included to offer psychiatric services as needed, administer medications as ordered, communicate care to resident, and if resident resist care return and attempt care again later. Review of incident reports regarding Resident #20 revealed on 09/23/25 Resident #20 was yelling at his roommate and threatening to fight. The incident report documented an interview immediately after the incident in which Resident #20 admitted he punched his roommate two times. Review of Resident #20's electronic medical record revealed in the section Target Behavior Task documentation from 10/14/25 to 10/29/25 revealed he displayed physical aggression towards others on 10/14/25, 10/15/25, before the incident with Resident #10 and on 10/20/25, 10/22/25, 10/23/25, 10/26/25, 10/27/25, 10/28/25, and 10/29/25 after the incident with Resident #10. There was no documentation of what the behaviors were on those days, and no documentation the physician was made aware of Resident #20's behaviors. The task documentation indicated the resident was redirected after each episode of aggression. Review of the facility video of the secured memory care unit hallway on 10/29/25 at 10:55 A.M. with the Administrator and Director of Nursing (DON) revealed on 10/18/25 at 2:34 PM, Resident #20 was standing at the end of the hallway facing the camera near the exit door. No staff were seen in the hallway. Resident #10 was walking down the hallway towards the exit door alone with her back to the video camera; Resident #10 stopped when Registered Nurse (RN) #149 stepped out of a resident room and handed her a baby doll. Resident #10 proceeded to walk down the hall carrying the baby doll towards the exit doors. Resident #20 walked towards Resident #10 clapping his hands and stood directly in front of Resident #10. Resident #10 turned away from Resident #20. Resident #20 pushed Resident #10 and she fell to the floor. Staff exited a resident room and went to Resident #10, who was laying on the floor on her left side. Review of Resident #10's nurses progress notes revealed on 10/18/25, RN #149 heard a strange sound from the hallway. Upon checking, Resident #10 was lying on the floor. Resident #10 could not say what happened. Neuromuscular and skin assessments initiated, resident ambulated to her room with assistance. Resident holding left arm during assessments. Physician ordered to send Resident #10 to the emergency room for evaluation. Resident #10 left the facility at 3:45 P.M. Resident #10 returned to the facility on [DATE] at 2:03 A.M. with a diagnosis of a urinary tract infection with antibiotics ordered. On 10/21/25 at 11:38 A.M. Resident #10 was complaining of pain and discomfort of her left leg and hip area. The physician was notified and ordered mobile X-rays as soon as possible. At 3:32 P.M. X-ray results